‘From Street to Home’

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Executive summary

The main empirical source on **violence against women in Germany** – a large representative study from 2003 comprising over 10.000 women between 16 and 85 – revealed the following **prevalence**:

- 37% of the respondents have experienced at least one form of physical attack or violence.
- 13%, that is, almost one woman in seven, had experienced some form of sexual violence since the age of 16 (based on a narrow definition of criminally forced sexual acts).
- 40% of the women have experienced either physical or sexual abuse or both – independent of the victim-perpetrator context – after the age of 16.
- 58% of the women interviewed report various forms of sexual harassment.
- 42% of all interviewees report forms of psychological violence, beginning with intimidation and aggressive yelling, on to slander, threats and humiliation, and up to psycho-terror.
- Around 25% have experienced forms of physical or sexual abuse, or both, from current or previous male or female partners.

The survey indicates as **main findings** that:

- violence against women takes place predominantly in domestic situations and with the partner as perpetrator
- all forms of violence can contribute extensively to psychological, psycho-social and health problems for those women affected
- early help, intervention and prevention are necessary
- improvements above all in the areas of police intervention have been seen, however, at this time, not in the areas of the legal system or court interventions
- measures for help and prevention should be more strictly oriented on risk factors.

While **prostitutes**, **prisoners** and **refugee women** were affected by violence, physical, sexual, psychological, as well as sexual harassment, to a markedly greater degree, **immigrants** experienced sexual harassment and psychological violence about as often as the women in the main survey; but the incidence of physical violence was greater. Turkish women reported more physical but less sexual violence and East European women more sexual violence.

In group discussions with women regarding **help and support requirements,** psychological and sexualised violence became apparent as relevant aspects concerning ***domestic violence,*** as well as internal and external barriers to seeking support. While children need special support, ending the violence and separation are major challenges. An important factor for help and prevention is the social environment and physicians can play a central role in supporting while police intervention, in spite of its potential, is felt to be a high threshold measure. Generally, the system of aid and assistance is challenged. Regarding ***sexualised violence from known or***

unknown perpetrators special reluctance thresholds exist in the search for support by victims. Police intervention must be further improved and social environments and help systems are challenged.

The current **Action Plan of the Federal Government of Germany** basing on the survey and evaluation research on intervention projects includes stronger protection of female migrants, a focus on handicapped women, early as possible prevention for children and situations of separation as specific risks for women. Regarding protection the health sector is to be addressed as well as the justice system and persons from the close social environment and low-threshold and easy access to the help-system is to be enabled. Responsibility and behaviour changes of perpetrators are issues as well as the extension of cooperation between Federal State, “Laender” and non-governmental organisations.

In 2011/2012 there were 353 **women´s shelters** and at least 41 shelter and refugee apartments in Germany with more than 6000 places where 15.000 – 17.000 women with their children (altogether 30.000 – 40.000 persons) per year can find protection and support (extrapolation). In most of the Laender there is a mixed financing by daily rates and funding from the federal state and/ or the local community. Daily rates can be covered on the basis of individual claims of the women according to different laws on social welfare funding. All in all, funding is very heterogeneous and often insufficient.

According to a new survey in autonomous women´s shelters **key factors for success** are ensuring a sufficiently long length of stay in the shelter**,** sufficient human (and material) resources for the professional support of this process, sufficient human resources for the care and support of children and appropriate structural and spatial features, which are also suitable for a longer stay. But these conditions are only inadequately met since understaffed facilities complicate the fast and non-bureaucratic access to protection and assistance and inevitably affect the success of the only effective long-term performance. Autonomous women's shelters are far more than shelters for abused women, but a central feature is the support on the road to an independent, non-violent liberated life, a process that needs adequate time in a safe and supportive environment in order to develop a new perspective on life as well as high professionalism, lot of time and energy of the staff.

Qualitative fieldwork addressed stakeholders and women involved. Twelve semi-structured interviews were conducted with experts from **stakeholders** with different focuses. Most of them are exclusively concerned with domestic violence against women and accommodation and social support. A religious based charity provides support and different forms of accommodation for a broader group of women with various problems. A secular charity running amongst others a homeless shelter deals with women with multiple needs as a part of its clients including also male clients at risk.

In general stakeholders describe ***funding*** as precarious, difficult and too low. It basically depends on public resources, i.e. regional or local authorities and social benefits for jobless persons in case the women are eligible. Women with own income have to pay for their stay but according to considerably different rules. Additional funding are unreliable donations and monetary fines.

Besides shelters putting their focus on temporary accommodation and counselling for women affected by – domestic – violence and their children there are offers for broader groups of women as well as support for vulnerable people with female ***clients*** as a part. A religious based charity provides various offers for "single women and mothers with children being in affliction" and the clients of a secular charity running a homeless shelter for adults include a female subgroup as well as the local drug scene of adults where the same organisation is working. Experiences of violence, drug addiction, psychic illness or prison characterise all these clients to different degrees.

Exclusion criteria vary considerably. Autonomous women´s shelters exclude acute drug or alcohol addicts in principle as well as a religious charity which also excludes acute psychotic and aggressive persons. A secular homeless shelter accepts acute drug problems but no transmittable diseases. Foreign citizenship can hinder the access to shelters regarding necessary residence permit or lacking social benefit claims.

Since the sample of stakeholders comprise experts from different organisations with different focuses and tasks – homeless shelter, shelter for women in general, women´s shelter for victims of domestic violence, street worker, consultants – the statements on **key needs of the clients** can be summarised only partly. Some general features emerge: Stabilisation of the clients and providing a social framework is in the focus of experts from all shelters and also support in daily life and regarding basic needs is of concern for all kind of experts – varying in form and degree according to clients. Transfers to other agencies or professionals if necessary regarding particular needs are in some way also in the focus of all kind of experts. Again, the focuses of support in legal, administrative or financial issues ("paper work") or in front of authorities vary according to clients. Additionally, specific offers and supports depend on the focus of the shelters or professionals and the kind of clients and their multiple needs.

Partnership working aims at better and more comprehensive provision of clients by the stakeholders as well as at better and more satisfying work conditions of the professionals. The statements on networking generally show the stakeholders integrated in large networks which can include exchange with facilities providing the same or similar offers or cooperation with stakeholders providing varying supplemental or complementary offers for their clients out of their own focus or their professional competence – including facilities of the same as well as different concepts, e.g. religious based or secular. According to the organisations own clients and competences partnership working includes cooperation with the health sector, especially concerning drug dependence and mental health problems, as well as supplemental and complementary counselling and support in specific fields. There can be made a distinction between partners within the social and health sector, basically non-profit organisations positioned in the civil society on the one hand, and public or local authorities in the area of social control and policy on the other hand which might be problematic.

Regarding the **impact of current policy and legislation** a main political issue reported by the stakeholders is lacking or insufficient funding in general or respective legislation to assure such funding resulting in time and resource consuming work to get more money. An immediate consequence of this situation is lacking or insufficient accommodation in general resulting in denials and for specific groups of women in particular. Experts working in VoV refugees observe

an inadequate public awareness and discussion of the issue “violence against women” including the assessment of specific laws as problematic. Considerations and proposals to increase effectiveness of interventions put the focus mainly on cooperation of players working on different aspects of the field as well as more overarching and holistic approaches.

Nine narrative interviews were conducted with **women with multiple needs** including domestic violence in particular. All interviewed women were contacted through social workers of various organisations.The **access** was difficult and time-consuming, especially to all-women shelters. Homeless shelters and services addressing drug addiction and multiple needs rather than solely domestic violence were easier to access. But once found, the interviewed women seemed motivated and happy to tell about their life.

Regarding the **demographic and social structure**, all women interviewed were German. The average age was 47. Most interviewees had completed a vocational training after finishing school and were able to work for some time. Their income consisted mostly of an invalidity pension, social welfare or unemployment benefits. Some of them had a small job in addition. All interviewed women except one had a rather unhappy ***childhood and youth***. Most interviewed women experienced early partnerships and some early pregnancies with a feeling of “failing” motherhood.

Concerning **domestic violence**, two women were abused as children. Seven of the nine women were abused by their husband or partner, two of these for about 20 years. In all cases, the ***acts of abuse*** and domestic violence were massive but the intensity and effects varied: physical and psychic wounds, many times entailing drug use as coping strategy. None of the women have pressed ***charges against their main perpetrator*** for the following reasons: fatal dependencies to partner or family, fear, feeling of guilt and lack of self-esteem, lack of formal support and inadequate responses from police and legal authorities. Most of the interviewed women had significant mental ***health problems*** and some somatic health problems as well.

Regarding experiences with **institutions of social control and compulsory public measures**, five of the interviewed women spent some time in prison, always due to drug-related infringements. Two of the three women interviewed who have children could not bring them up (but foster parents) due to their drug addiction. As concerns ***other closed institutions***, four of the women had to stay in closed psychiatric clinics which they didn’t find helpful and thought it even worsened their situation: Psychotherapies as they exist today could have changed the course of their life.

As regards **addictions**, six from the nine women interviewed are drug users or former drug users. Out of the six women with drug addictions, four were big victims of domestic violence and for them, domestic violence was the cause of their starting with drugs or in the case of the women addicted to pills, the cause of enlarging and worsening her addiction to other drugs. Two women never prostituted to be able to buy drugs. Early starting age and experience of DV seem to worsen the healing prospects of drug addiction. Concerning ***detoxification, drug therapy and substitution***, the six women have all had several detoxifications, partly cold detox, for example in some prisons. Some of them also had one or more long term drug therapies including aftercare and rehabilitation measures – which seemed to be quite successful -, some also as “therapy instead of prison”. Most of

them had many relapses but all substituted women have finally succeeded in reducing their concomitant drug use, which represents a big achievement for them.

Regarding the **therapies** (other than for drug addiction), three of the nine interviewed women have had psychotherapy which they found helpful but feel they still need further sessions. All three complain that they would have needed psychotherapy at an earlier stage but in the seventies and eighties, psychic problems like anxiety disorders, suicide attempts, etc. were only treated with pills and medical drugs, many times in stigmatised closed institutions which rather worsened the situation for the patient. Two women made couple therapies with their husband. Two women with psychic disease visit a day centre with occupations and activities to structure their day which is very helpful to them. Only one woman (victim of DV over 20 years) made a trauma therapy as an inpatient in a specialized clinic which she found very helpful.

As regard **homelessness**, eight of the nine women lost their home for various reasons and six of them were homeless for some time. Five women had to leave their flat because they couldn't pay the rent anymore due to drug consumption. Of the six women who had lived on the street, four first found a ***provisory home*** in a homeless shelter and two in a long term drug therapy centre. One woman fled with her three young children in a women shelter due to her violent husband. The woman who had to leave her flat to stay in a psychiatric clinic then spent several years in a rehabilitation establishment for persons with a psychic disease.

Concerning **social relationships**, most women interviewed have not many friends or supportive family and feel quite alone. All nine women interviewed are not living with a partner currently. For the two women who suffered of domestic violence over the longest periods, the separation from their perpetrator made their life even worse *at first* due to fatal dependencies. The most supportive relationships of most of the interviewed women have been both or one of their parents. From the three women having children, all three find some raison d'être and motivation in their children. Five women have received support from their friends. One woman felt having experienced negative influence from her environment. Two women had a dog which meant a lot of comfort to them.

When asked about **decisive situations making life worse**, eight of the nine women mentioned not having had a happy childhood. Eight women suffered of domestic violence. Six women became addicted to drugs. Most women experienced a low-point or even hit rock bottom through a separation or a massive change: For the two women who suffered of domestic violence over the longest periods, the separation from their perpetrator made their life even worse *at first*. Several women expressed that changes of home, occupation and relationships were difficult to cope with. Disease made life worse for several women.

As regards **decisive situations making life better**, the women mentioned in the first place having of a safe accommodation linked to the concomitant provision of social assistance (in women or homeless shelters, drug therapy centers, assisted accommodations). They also mentioned having supportive social relationships and a stable day structure as important factors. Furthermore, successful therapies (psychotherapy, trauma therapy, long term drug therapy and substitution program) played a primordial role in making their life better. For several women, hitting rock bottom (through homelessness, separation of violent partner) was the beginning of an upturn and life improvement.

Regarding their **prospects**, there is a general desire to make a new start and rebuild their life and most of them are already trying even if they are not sure to succeed. They need an appropriate accommodation, an occupation or a job to structure their day and for all women it is essential to continue getting social support from organizations and from relatives and friends. All six drug addicted women or former drug users want to stay “clean”. Most of the women would like to improve their health.

To conclude, the women reflected on **effective formal support by organisations**. All women interviewed have become support *within* the framework of their different types of accommodation. Additionally, they have received support covering a broad range of needs from organisations not directly linked to their accommodation. Most women with multiple needs found the assistance provided helpful and effective, especially within the framework of a safe and stable home like an assisted accommodation, which allows independence linked with non-invasive psycho-social support. Many interviewed women were able to start improving their life with the help of effective long-term therapies. Women with drug addiction in addition to DV seemed to be better helped than women “solely” victims of DV.

The field study showed that the provision of joined-up accommodation and social support for women with multiple needs already exists in Germany but recommendations were given for improvements on various levels: early prevention of sexual abuse against children and teenagers; improved support for women being “solely” victim of DV; integrated help for victims of DV and drug addictions; improved police and court interventions towards victims of DV; improved access to long-term therapies and to assisted accommodations.

1 Introduction

At first, a literature review informs about main features of domestic violence against women in Germany in general and in specific subgroups including help and support requirements in the view of women as well as the general politics of the Federal Government of Germany addressing these issues. Moreover, structural issues of support for women and women´s shelters in particular are sketched followed by main results of a new study on women living in such shelters.

In the main empirical chapter, the results of the field studies are presented starting with brief descriptions of the samples – stakeholders and women involved – and the features of the methodology applied. On the base of semi-structured expert interviews with professionals working in support structures for women and documents of the single organisations the perspective of stakeholders on their clients and their needs as well as existing offers and perceived problems is shown as a form of "objective" background. Based on more narrative interviews the life stories and experiences of women with multiple needs including domestic violence in particular reveal the "subjective" perspective of women involved, i.e. their view on their problems and experiences with existing support structures as well as expected but still missing offers. Structural and comprehensive analyses are followed by summaries of single biographies.

Finally, conclusions and recommendations on the improvement of support, i.e. housing and social assistance, for vulnerable women with multiple needs and experiences of domestic violence in particular are formulated based on the literature review but mainly on the evidence from the field work – the biographical experiences of women involved and expert views of professionals.

2 Literature review

2.1 Overview on basic literature concerning Germany

The main empirical source on violence against women in Germany is a large representative study from 2003 with a sample of more than 10.000 women aged 16 to 85 including several sub-surveys on their experiences with violence, their feelings of personal safety and their psychosocial and physical health situation (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 2004a). The study was reissued in German in 2013 (Bundesministerium für Familien, Senioren, Frauen und Jugend 2013a). Using these data further secondary analyses were conducted concerning health, violence and migration – a comparative analysis of women with and without a background of migration (Bundesministerium für Familien, Senioren, Frauen und Jugend 2009) – or on violence against women in relations with partners and differences concerning degrees of severity, patterns, risk factors and support after an experience of violence (Bundesministerium für Familien, Senioren, Frauen und Jugend 2012a). Main results of the mentioned survey including differentiations according to subgroups as well as main results of group discussions concerning support and services are reported in chapter 2.2.

A first Action Plan of the Federal Government of Germany to combat violence against women from 1999 (Bundesregierung 1999; in English: Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 2005) – accompanied by various actions to implement this plan in general (Bundesministerium für Familien, Senioren, Frauen und Jugend 2004) as well as evaluation research on intervention projects against domestic violence (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 2004b) – was followed by a Second Action Plan mainly on the base of the above mentioned representative study as well as the evaluation research and structured according to the first action plan (Bundesministerium für Familien, Senioren, Frauen und Jugend 2012b). Main issues of this current action plan are described in chapter 2.3.

In addition, models of good practice regarding administrative and legal issues in the process of public support of women affected by domestic violence in women´s shelters in particular have been collected (Bundesministerium für Familien, Senioren, Frauen und Jugend 2007) and a comprehensive report of the federal government concerning women´s shelters, specialised information centers as well as further offers to support women affected by violence and their children was published (Bundesministerium für Familien, Senioren, Frauen und Jugend 2013b). Moreover, a new study investigates the living situation and contentment of women living in autonomous women´s shelters in the largest “Land” of Germany, i.e. North-Rhine Westphalia (Becker 2013). Finally, the feminist network WAVE (WOMEN AGAINST VIOLENCE EUROPE) provides on its website country reports on Germany (http://www.wave-network.org/country/germany) with updated information, statistics and data on violence against women in general and women´s shelters in particular (WAVE 2010, 2011, 2012). Main outcomes concerning women´s shelters are summarised in chapter 2.4.

2.2 Violence against women in Germany – main results of a representative survey, differentiations according to subgroups and women´s views on help and support requirements

2.2.1 Overview on the prevalence of violence in Germany

In a large representative study from February 2003 to October 2003 – "Health, Well-Being and Personal Safety of Women in Germany – A Representative Study of Violence against Women in Germany" – 10.264 women from 16 to 85 were interviewed extensively regarding their experiences of physical violence, sexual violence, sexual harassment, and psychological abuse since the age of 16. Compared to physical violence, sexual violence was more narrowly defined, i.e. based exclusively on explicitly criminal forms of violence such as rape, attempted rape, and various forms of sexual coercion involving the use of physical force or threat (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 2004a).

While an **overview on the prevalence of violence in Germany** indicate – all in all – a medium to high range of women affected compared to other European studies[1] the authors assess the figures as to be seen as conservative minimum estimates. The findings on extent and range of physical and sexual violence against women in Germany confirm previous and current estimations of grey areas and research results. In detail, the data show that:

[1] Results from the new EU-wide survey on „Violence against women"(European Union Agency for Fundamental Rights 2014a) show the position of Germany mainly close to the EU-average: According to this source, 22 % of the German women have experienced physical and/ or sexual violence by a current and/ or previous partner, 24 % by any other person and 35 % by any partner and/ or non-partner. The respective figures for the EU-average are 22, 22, and 33 %. 15% of the German women indicate sexual harassment in the last 12 months when answering a short set of items and 22% when answering a full set of items. The EU-averages are 13 and 21 %. Asked on childhood experiences of any violence before the age of 15 by adult perpetrators 37% indicate physical violence, 13% sexual violence, 42% any physical or sexual violence, 13% psychological violence by a family member and 44% any physical, sexual or psychological violence. With the exception of a higher value concerning physical violence which influences two other variables the EU-average is again comparable: 27, 12, 33, 10 and 35%. But the perception of the frequency of violence against women is some lower in Germany than in the EU as a whole: while 19% of the German women see violence as very common, 53% as fairly common and 24% as not very common the respective EU-average is 27, 51 and 16% (European Union Agency for Fundamental Rights 2014b, p 18-19, 29, 31-32, 35).

37% of the respondents have experienced at least one form of **physical attack or violence**.

13%, that is, almost 1 woman in 7, had experienced some form of **sexual violence** since the age of 16 (based on a narrow definition of criminally forced sexual acts).

40% of the women have experienced **either physical or sexual abuse or both –** independent of the victim-perpetrator context – after the age of 16.

58% of the women interviewed report various forms of **sexual harassment**.

42% of all interviewees report forms of **psychological violence**, beginning with intimidation and aggressive yelling, on to slander, threats and humiliation, and up to psycho-terror.

Around 25% have experienced forms of physical or sexual abuse, or both, from **current or previous male or female partners**.

99% named male partners as using violence, and only 1% female partners as perpetrators.[2]

2.2.2 Main findings of the survey

Violence against women takes place predominantly in domestic situations and with the partner as perpetrator.

Violent acts frequently took place in the women's own dwellings and are predominantly carried out by the current or former relationship partner, usually male, concerning *sexual violence*, 99% of women affected named exclusively male assailants.

[2] Regarding ***national crime statistics (police)*** domestic violence in Germany is covered indirectly under various sections of Germany's Criminal Code. An annual report details the number of criminal offenses under each section. This data is gender and age disaggregated, but does not show the relationship between victim and perpetrator. Statistics on domestic violence – i.e. crimes committed by relatives – are presented as gender disaggregated for victims in another part of the report and show a family relationship between victim and perpetrator. According to the report on crimes committed in a domestic context, 75% of victims of domestic violence are female. In 2011 137.600 female victims of domestic violence (gender of perpetrator not specified) are recorded. Regarding ***national criminal justice statistics (court)*** there is no information on the availability statistics on domestic violence in Germany (WAVE 2012).

All forms of violence can contribute extensively to psychological, psycho-social and health problems for those women affected.

There is a consistently more serious level of violence when the abuse was carried out by the male relationship partner. While all forms of violence and harassment can have significant *psychological after-effects* there is an extraordinarily high psychological burden of *sexual* violence and a great extent and underestimated burden of *psychological violence* is also evident.

There is a great need for support for women suffering from psychological and sexual violence, frequently connected with other forms of physical violence, to which the existing aid and support systems are not equipped to respond.

All types of violence – not only sexual and physical but especially psychological violence – can result in long-term social and psycho-social effects. Violence can also have a decisive effect on the general state of women's health.

Early help, intervention and prevention are necessary.

While 62% of all respondents are aware of assistance facilities available for women after physical, sexual or psychological abuse, only 11% of women who had indeed experienced physical or sexual violence mentioned seeking help at such facilities.

Physicians are of central importance as the first point of contact with potential support and can play a key role in the further biographies of battered and abused women. While the second contacts are usually in the areas of women's shelters, therapists or social workers, the police are the third most frequent contact.

Since women affected by violence turn first to persons in their immediate social circles, such as girlfriends, parents and colleagues, educational and public relations efforts should be more strongly targeted on the social environments of women suffering from violent incidents.

Length of the history of violent acts and their frequency, severity and level of threat in couple relationships are significantly correlated. Thus, early intervention and easily accessible offers of aid and assistance could help to prevent more serious forms of violence from developing.

Improvements above all in the areas of police intervention have been seen, however, at this time, not in the areas of the legal system or court interventions.

The threshold for women living in violent couple relationships to turn to legal intervention or social assistance systems is often rather high, especially when it comes to informing the police. If they do so, their level of satisfaction with the response is quite high in cases of physical violence, but sinks when they report sexual assault. While women are overwhelmingly disappointed with courtroom experiences, there is a positive trend regarding police intervention: success of training and reorientation efforts can be seen, especially as to domestic violence. Further measures are needed, especially concerning victim protection, to help avoid secondary victimization.

Measures for help and prevention should be more strictly oriented on risk factors.

Women living in separation, legal separation or divorce are particularly endangered; amount and intensity of violent incidents are markedly higher for divorced women. The intention of separating was very often the point where the partners' violent acts began.

In addition to traditional gender-specific roles and dependencies and increased risk after announcing intentions of separation or divorce, further risk factors make violence more likely:

Psychological abuse seems to be relevant in further violence in couple relationships.

While there is a significant role played by the use of alcohol and by unemployment, especially considering violence in couple relationships, these factors should not be overrated by any means.

There is no connection between educational status/ social class, and violent tendencies, apart from a slightly higher quota amongst those without any school completion degree, thus, abuse and violence in couple relationships is not a phenomenon related to class.

A central risk factor is abuse in one's own family, or during childhood and adolescence. Women who have experienced physical or sexual violence were subject to extremely high rates of exposure to violence, as witnesses of parental violence or through corporal punishment by their parents, and were also significantly often subject to sexual abuse in childhood or adolescence. Thus, protection of children is a central measure for prevention of violence against adult women.

2.2.3 Central results of the supplemental sub-group population interviews

In addition to the main study, some sub-surveys were conducted to reach groups which are difficult to access: 250 supplementary interviews with Turkish and East-European immigrant woman using an

identical instrument as well as interviews with modified questionnaires with prostitutes, asylum seekers and women in prisons.

Turkish and East-European immigrants

Immigrants experienced sexual harassment and psychological violence about as often as the women in the main survey; but the incidence of physical violence was greater. Turkish immigrant women experienced more physical but less sexual violence, while East European women reported more sexual violence. It emerged that Turkish immigrants are not only more frequently affected by physical violence; but also reported more severe and extreme forms.

Both groups have suffered more frequently from the injuries as a consequence of physical violence than the women in the main study. Moreover, Turkish migrants report massive forms of sexual violence such as completed rape more frequently, resulting more often in injuries.

While women from Eastern Europe seem to suffer more often from sexual violence from unknown assailants or casual acquaintances, for example, at the workplace, Turkish women experienced an especially high rate of physical and sexual violence occurring in partnerships and in families. The level of Turkish women reporting violence in couple relationships – far above the average for the German female population – is notable. However, the data did not confirm that the rate of abuse by partners was higher among women with arranged marriages.

Immigrants in general report *psychological violence* by unknown persons or those known only by sight or superficially, but Turkish women do so even more frequently than East-European women. This indicates a type of psychological abuse accented by racist or xenophobic tendencies.

Women in prostitution, women in prison and refugee women

“Prostitutes”, “prisoners” and “refugee women” were affected by violence, physical, sexual, psychological, as well as sexual harassment, to a markedly greater degree.

Women working as ***prostitutes*** have experienced a high measure of violence at the hands of current or previous partners; furthermore, their work identity and situations are frequently related to physical as well as sexual violence. Prostitutes are at high risk of experiencing violence, feel a great degree of insecurity and have suffered much from abuse in childhood and adolescence.

The physical and mental health of many prostitutes is extremely difficult, including higher occurrence of health problems. Very high psychological and physical health risks are clearly reflected in a high level of drug consumption and increased tobacco consumption. Poor physical health and mental states and lacking reliable and stable contact persons, often coupled with multiple traumas and psychological damage because of violence experienced in childhood, can reduce their force to protect themselves and increase the risk of violence and assault in adult live.

Women in prison also suffered sexual abuse and sexual violence in childhood and in adulthood to a much greater degree than the women in the main study, and a strikingly higher percentage were completely or partially homeless before prison – or had been living in temporary housing facilities – and were lacking social contacts and contexts.[3] There is a grave problem that women in prison continue to be exposed to further psychological and physical violence.[4]

Quantitative findings concerning violence against ***refugee women*** are limited and the actual extent of violence in their situations was most likely understated, but an extremely high level in all forms and contexts was made visible, indicating the very great extent of violence. Assailants are not only relationship partners; there are also acts of violence and racist attacks from strangers or casual acquaintances, male and female residents as well as staff in temporary living accommodations, and in the context of psycho-social counselling and assistance for refugees.

As generally, violence seems to be most often experienced at the hands of a relationship partner. Due to special living and dependency situations, and against the background of frequently traditional gender role expectations, the problem is most probably intensified for refugee women. As a particular problem psychological, physical and sexual infringements and violation of personal limits apparently are not rarely carried out by professional helpers and counsellors – male and female – in temporary living situations, refugee centres, government agencies, bureaus, and welfare offices, i.e. persons from whom the women are seeking aid and assistance.

2.2.4 Central results of the group discussions on the topics of help and support requirements of women affected by violence

Finally, qualitative data were collected in group discussions with women who have been victims with the intention to identify concrete needs for assistance and support from the point of view of abused women.

Results in the context of domestic violence

Psychological and sexualised violence are relevant aspects of domestic violence:

Women have experienced massive forms of sexualised abuse in couple relationships as well as more subtle forms. Physical, psychological and sexual violence are tightly interwoven, and the

[3] Experiences of violence and abuse – which are significantly higher among female prisoners than among women in general – can have “grave impact on women´s pathway to criminal activity” (Grimm 2011a, p 9 et sqq.; Grimm 2011b, p 9-10 for Germany in particular). Therefore, “many female offenders have a background of physical violence and/ or sexual abuse and the share of victims of violence in imprisoned women is very high” (Grimm 2011b, p 9.).

[4] However, many studies on gender-based violence in female prisons deal with structural violence in prisons or refer to biographical analysis only and regarding Germany in particular data on sexual abuse, prostitution and violence in female prisons is scarce or is based on extremely small samples, respectively (Grimm 2011a, p 11-12; Grimm 2011b, p 12).

point where each type really began seems to be vague and fluid, hard to define precisely, and psychological abuse often is not perceived as violence at the beginning.

There are internal and external barriers to seeking support:

Traditional patterns of relationship contribute to maintaining and stabilising violent situations as well as avoidance behaviour, i.e. denying suffering from violence for a long time. Other hindrances to seeking support and assistance can be the man's very threatening behaviour, his extreme control of the woman, and her social isolation. Moreover, identifying with the perpetrator occurs: afraid of leaving the partner, some women do not turn to the support services on offer.

Children need special support in situations of domestic violence:

There is a considerable impact on children who witness domestic violence against their mothers and have been or are victims of abuse themselves.

Ending the violence and separation are major challenges:

It is essential for many women to show the partner from the beginning what is acceptable and what is not to prevent violence from the outset. Ending violence is mostly considered impossible within the relationship situation.

The social environment is an important factor for help and prevention:

There is a need of supportive intervention by third parties – the social environment plays a major role in the support of women affected by violence, in a positive as well as in a negative sense.

Physicians can play a central role in supporting these women:

While physicians are, in many cases, decisive contact persons for abused women, they do not always seem to recognise the relevance of the problem of violence behind the symptoms.

Police intervention, in spite of its potential, is felt to be a high threshold measure:

Police interventions can be perceived as a relatively high threshold measure. All-in-all, go-orders and protection orders are seen as helpful, but scepticism regarding actual enforcement is high.

The system of aid and assistance is challenged:

Women who had sought refuge in women's shelters are quite definite that, in some cases, there is no alternative to accommodation in a *women's refuge.* Generally, support and assistance of such shelters are rated positively. Some women claim more intensive psychological counselling for women and children, and more comprehensive practical measures of assistance. Low-level, accessible assistance, like a *national German emergency hotline*, with a well-known number and 24 hours service, was seen as quite valuable and pro-active assistance as very helpful.

Results within the context of sexualised violence from known or unknown perpetrators

Special reluctance thresholds exist in the search for support by victims of sexualised violence:

Women who had suffered sexual violence from strangers or acquaintances often were not aware of assistance available, like emergency hotlines or other counselling centres. A further threshold of reluctance to seeking support are experiences and expectations of victims not be believed, or to face mistrust and lack of understanding.

Police intervention must be further improved:

Contrary to positive developments in responses to domestic violence, there are no positive effects as regards satisfactory experiences with police officers – including female officers – concerning sexualised violence. To reduce the impact of sexual violence the actual availability of specially-trained female police officers and female health care workers for medical examinations is needed as well as support and company of a person they know and trust if desired.

Social environments and help systems are challenged:

Contact persons in their social circle in search for support are crucial for victims. They see emergency support through counselling as most unsatisfactory and full of gaps, due to very limited opening hours: A wide-ranging public information campaign for clarification and definition of sexualised violence is claimed.

2.3 Action Plan of the Federal Government of Germany to combat violence against women – central issues

While the first Action Plan of the Federal Government of Germany to combat violence against women from 1999 was followed by a range of practical projects the Second Action Plan (Bundesministerium für Familien, Senioren, Frauen und Jugend, 2012b) is based on the results of the survey "Health, Well-Being and Personal Safety of Women in Germany – A Representative Study of Violence against Women in Germany" (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 2004a), further scientific studies as well as evidence from practical experience. Against this background, the Second Action plan defines ***new questions and challenges:***

Stronger protection of female migrants affected by violence

Migrants are in special need of easy accessible support offers and can be better addressed by proactive or "calling on" measures considering the language issue.

Migrants also are affected by an additional form of violence: forced marriages. There are no reliable data in Germany on extent and characters of the phenomenon. Mainly affected are girls and young women from migrant families, but the problem is neither restricted to the Islamic culture nor to female migrants alone.

Focusing more on handicapped women

Male and female perpetrators mainly belong to the close social environment, often persons in charge of care who frequently exploit the dependency of the victims. Lacking self-confidence or failing demarcation by the women encourages violence.

Data on the actual extent of violence against handicapped women within their close social environment is lacking so far as well as information targeted for this group in particular.

Regarding children in time – prevention as early as possible

Physical and sexual violence experienced in childhood and youth of women and in their family of origin – both as witness of violence between their parents as well as victim of physical violence by parents or of sexual violence before the age of 16 – are central risk factors to become a victim later on in adult life clearly increasing the frequency of respective physical and/ or sexual violence.

Thus, there is a need of prevention in an early stage, i.e. effective and as soon as possible starting protection of girls and boys against violence is indispensable, and special efforts in this area are necessary[5].

Considering specific risks – Women in situations of separation

Women who live in a situation of separation or divorce or who have the intention to do so are vulnerable in particular and in danger to become victim of (increasing) violence in their relationship.

While police as well as counselling facilities are considering these circumstances, more evidence to better assess risks and support adequate interventions of different professional groups is needed.

Bringing the health sector into action to protect affected women

Since professionals in the health system – especially physicians –are frequently the crucial (first) contact person for affected women, who often suffer from partly considerable – physical or psychological – injuries, health services have to be developed in a way that adequate care and support for women affected by violence can be offered.[6]

Addressing further contact persons for women affected by violence: Justice system and persons from the close social environment

According to experiences in counselling women affected by violence still ask for higher competences of professional groups within the justice system concerning matters of domestic violence.[7]

Affected women often contact related persons at first before addressing institutions, but these persons frequently are overstrained and helpless. Thus, further measures of awareness raising are needed.

Enabling low-threshold and easy access to the help-system for affected women

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[5] Working with male youth including alternative role concepts for men is a central approach in preventing violence (Hagemann-White 2014).

[6] There is no information on whether national data on medical interventions related to domestic violence or intimate partner violence is collected in the healthcare system, but a systematic data collection "on contacts made with health care services identified as due to violence inflicted to women" exists. National level healthcare protocols for dealing with domestic violence or intimate partner violence are lacking in Germany and no information is available on whether hospitals are set up to provide emergency accommodation for women survivors of domestic violence (WAVE 2012).

[7] Providing legal counselling or supporting women survivors of violence during court proceedings can be regarded as an aspect of successfully implementing laws on domestic violence or articles in the Criminal Code. There is no free legal advice offered in Germany to women survivors of intimate partner violence (WAVE 2012). Under the German law on protective measures for women, the Violence Protection Act (2002), the police can bar the perpetrator for 7-14 days in cases of physical violence, threats of violence and stalking. Orders can cover the victims dwelling and the surrounding area. Civil protection orders are available in cases of physical and psychological violence, threats of violence and stalking, for up to 6 months covering the victim's house and other places such as workplace and schools the victim's children attend as well as general contact probation. Criminal law protection orders are available in cases of physical violence, threats of violence and stalking and are also imposed in connection with parole or probation cases. These protective measures can apply to the victim's dwelling and surrounding areas and workplace and children's schools and prohibit general contact (WAVE 2011).

Many victims of domestic violence suffer from their violent partners for long periods of time and victims of sexual violence in particular but also women affected by other forms of violence do not address either the police and justice or existing counselling facilities. Therefore, low-threshold offers are necessary which are easily accessible and which also include anonymous counselling.[8]

Holding perpetrators responsible and working towards behaviour changes

Approaches addressing perpetrators currently exist only in a few "Laender" (federal states in Germany) and only in basic manner. New tasks and questions in this respect comprise the development of standards of quality as well as the inclusion of new elements with regards to content, e.g. addressing violent men in their role as fathers or addressing men with a background of migration.

Extending the proven forms of cooperation between Federal State, "Laender" and non-governmental organisations

Cooperation between Federal State and Laender including non-governmental organisations to integrate their practical experiences as professional counselling facilities in the planning of national policies and measures was successful and benefited from nationwide networking of support facilities.

This comprehensive and interdisciplinary cooperation of Federal State, Laender and non-governmental organisations is to be continued and developed.[9]

The ***main objectives*** of the Second Action Plan are to improve the efficiency of combatting violence against women and to improve the protection of the affected women. The ***structure*** of the plan focusses on the measures of the Federal Government against all forms of violence in the areas:

- Prevention
- Federal legislation
- Help-system for supporting and counselling of affected women
- Nationwide networking within the help-system
- Cooperation between public institutions and non-governmental support offers
- Work with male and female perpetrators
- Qualification and awareness raising
- Research

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[8] Since March 2013 the German Ministry of Family and Social Affairs runs a national women's helpline – operating 24/7 and free of charge. The helpline covers all forms of violence, including domestic violence, cyber violence or sexual harassment in the workplace. Multilingual support is provided. In this respect, Germany meets the Council of Europe Taskforce Recommendations (WAVE 2012).

[9] Germany has a national strategy to combat violence against women covering rape and sexual violence, domestic violence, sexual harassment, genital mutilation, forced marriages, so called "honor crimes" and violence in conflict and postconflict situation. An inter-ministerial governmental coordinating body – with independent women´s NGOs as members – is responsible for implementing and coordinating the policies regarding violence against women and serves as policy advisor without decision making competences. Representatives of anti-violence projects are involved in working groups on domestic violence (WAVE 2011).

- European and further international cooperation
- (European Union, Council of Europe, further European cooperation, United Nations)
- Support measures for women abroad

2.4 Structural issues of support for women with the experience of domestic violence and the commitment of women living in shelters

In 2011/2012 there were 353 women´s shelters and at least 41 shelter and refugee apartments in Germany with more than 6000 places for women and their children. According to the Council of Europe Taskforce Recommendations approximately 8,200 shelter places are needed, thus, Germany fails to meet the Recommendations (WAVE 2012). However, women who have experienced domestic violence might also address themselves to other facilities which are not necessarily specialized in violence against women only but offer help to support – for example – drug addicts, mental ill persons or homeless people in general (including male clients). Actually, the sample of women interviewed in this study – addressing women with *multiple needs* – mainly comprise women which did not receive help from a women´s shelter since their problems on the way "from street to home" included domestic violence only as *one* aspect within a wider range of difficulties in their biography (see 3.2 below).

Regarding the existing women´s shelters in Germany 15.000 – 17.000 women with their children (altogether 30.000 – 40.000 persons) per year can find protection and support (extrapolation). Moreover, there are 750 specialised information centers regarding violence against women, i.e. 310 general centers (concerning any violence), 183 centers on sexual violence, 67 centers for women, who were sexually abused as child or in their youth, 130 intervention facilities offering pro-active counselling after police intervention due to domestic violence, 40 centers specialised in female victims of human trafficking, 12 centers specialized in girls and women threatened by forced marriages, 2 centers specialized in stalking, 1 center specialized in genital mutilation, 3 nationwide and 1 local hotline regarding domestic violence, 1 supra-regional hotline concerning forced marriages (Bundesministerium für Familien, Senioren, Frauen und Jugend 2013b, p. 13).

In most of the Laender there is a mixed financing of women´s shelters by daily rates and funding from the federal state and/ or the local community. Daily rates can be covered on the basis of individual claims of the women according to different laws on social welfare funding (SGB II, SGB XII or AsylbLG). Otherwise, the women have to pay partly or completely for the shelter. In some Laender, shelters are nearly completely funded by the federal state or local communities. Another source are in all Laender donations or own contributions of the organisations which run the shelter. All in all funding is very heterogenous (Bundesministerium für Familien, Senioren, Frauen und Jugend 2013b, p. 17-18) and often insufficient.[10]

[10] The typical accommodation period is between three to six months. The majority of shelters have no limit, but due to funding they need to report to authorities if women stay longer then a certain period (WAVE 2011, 2012). Most shelters receive government funding from different political levels but additionally do

The perspectives of female victims of violence (VoV) living in autonomous women´s shelters have been the objective of a new study in the largest of the German Laender (Becker 2013). In the following, its main results are summarised in an overview.

Living conditions in women´s shelters and client satisfaction with their offers

- Study conducted by Prof. Dr. Ruth Becker (2013)
- Semi-standardised anonymous questionnaire, women who stayed at one of the autonomous VoV shelter in North-Rhine-Westphalia
- Participation rate 30% -35 %, N = 906

Clients

- The autonomous women's shelters are mainly refuge for women threatened by violence who have no income and have one or more minor children, mostly at school age which they bring with them to the shelter. The majority of women have a migration background and are 21-35 years old.

Access to the autonomous women's shelters

- Very important is support from relatives or acquaintances.
- Counseling centers and other women´s shelters are on the second position.
- Other public institutions have only a limited importance.
- The continuous telephone availability is ensured. Only in a very few cases, there was no one reached on the first call.
- The vast majority of women come to a meeting place (77%). Only 23% go directly to the women's shelter or are been brought there.

Security and location of the Autonomous Women's Refuges

- The vast majority of respondents feel safe in the autonomous women's shelters. From the comments it appears that the confidentiality of the address is considered very important.

Key findings of the survey on satisfaction

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fundraising activities such as participating in international projects and donations. Only 3 Laender have allocated specific funds. In the 13 remaining federal states the financing is covered by different shares of state grants from federal states, municipalities and “day’s rate financing”. Since funding is often insufficient women’s organisations supporting women survivors of domestic violence are heavily dependent on donations and other fundraising activities (WAVE 2010).Existing funding programmes are not sufficient. Moreover, they are optional and cannot ensure planning dependability for women shelters. Since not all inhabitants of women´s shelters have the possibility to claim financial support according to SGB II, SGB XII or AsylbLG and not all cost of a women´s shelter can be covered within the framework of these claims financing problems of women´s shelters remain. Thus, the organization “Frauenhauskoordinierung (coordination of women´s shelters) campaigns for the implementation of a nation-wide obligatory legal basis ensuring a way of funding that is independent of single cases, cost covering and reliable (Frauenhauskoordinierung 2014).

- The questions on satisfaction with the different aspects of life in the autonomous women's shelters reveal *a very high level of satisfaction* in particular with the various forms of support from the staff.
- Somewhat lower, but still high is the satisfaction with the various offers.
- Also the obligation to take on tasks is perceived predominantly positive.
- Overall, three out of four respondents are very satisfied or satisfied with their stay in the autonomous women's shelter, only 9% are more likely to be very dissatisfied.

Key factors for success

- Ensuring a sufficiently long length of stay in the shelter
- Sufficient human (and material) resources for the professional support of this process
- Sufficient human resources for the care and support of children
- Appropriate structural and spatial features, which are also suitable for a longer stay

Conclusions

However, it must be concluded from numerous comments of the residents that these conditions are only inadequately met.

- Understaffed facilities complicate the fast and non-bureaucratic access to protection and assistance of the VoV and their children, and inevitably affect the success of the only effective long-term performance of the autonomous women's shelters.
- Autonomous women's shelters are far more than shelter for abused women.
- A central feature of the autonomous women's shelters is the support of the residents on the road to an independent, non-violent liberated life.
- This path is difficult and tedious and can only lead to success if the parties have adequate time in a safe and supportive environment in order to develop a new perspective on life.
- High professionalism, lot of time and energy of the staff for the support process are key factors to success.

3 Field work: stakeholder´s and women´s perspective

This main empirical chapter presents the results of the fieldwork, i.e. basically qualitative interviews with stakeholders (3.1) and with women involved (3.2). Both subchapters are connected two times: while the perspective of stakeholders on their clients and their needs as well as existing offers and perceived problems provides a form of "objective" background the view of women involved on their problems and experiences with existing support structures as well as expected but still missing offers shows their "subjective" perspective. Moreover, the contacts to the women were made consciously with the help of some of the previously interviewed professionals, thus, they are currently or have been in the past clients of these stakeholders.

3.1 Stakeholders

3.1.1Sample and methodology

Data and information from stakeholders were collected using ***semi-structured expert interviews with professionals working in support structures for women***, all-in-all twelve interviews. The expert interviews were conducted between September 2013 and March 2014 and include extensive face-to-face interviews – around ¾ to 1,5 hours – with the stakeholders which made the contacts to their current or former clients and further face-to-face as well as some (shorter) telephone interviews with experts in the field to get more and supplemental data. Additionally, documents of the single organisations (mainly leaflets and web-sites)[11] were used. Notes of the interviews were made during the interviews which were also recorded in order to save data for later corrections or complements. Interview guidelines were based on the respective FSTH-templates and the analyses are structured according to the key issues as they emerged from the data.

The stakeholders in the sample comprise a range of organisations with different focuses. They include secular as well as religious based organisations and some experts – like a streetworker (interview 1) and an advisor within a shelter (interview 5) – or organisations (interview 4) which are involved in social support or counselling only – without accommodation. Most of the stakeholders

[11] Die Pauke Bonn GmbH (o.J.): http://www1.wdr.de/mediathek/video/sendungen/lokalzeit/lokalzeit-aus-bonn/videodiepaukealslebensretter100.html (assessed 17.06.2014)

Frauenhaus Bonn, Frauenberatungsstelle – Frauen helfen Frauen e.V. (0.J.): http://www.frauenhaus-bonn.de/index.php?page=testseite (assessed 17.06.2014)

Johannesbund (o.J.): Haus Maria Königin – Wohnheim für alleinstehende Frauen und Mütter mit Kindern in Not. http://www.johannesbund.de/index.php?ID1=400& (assessed 17.06.2014)

Verein für Gefährdetenhilfe e.V. (VFG)(o.J.): Haus Sebastian. Notunterkunft für die Stadt Bonn. Informationen für Bewohner und Bewohnerinnen, information flyer, Bonn Verein für Gefährdetenhilfe e.V.

(VFG)(o.J.): helfen statt wegsehen. Hilfeangebote des Verein für Gefährdetenhilfe, information brochure, Bonn

Verein für Gefährdetenhilfe e.V. (VFG)(o.J.): Sozialberatung, Gemeinwesensarbeit, Betreutes Wohnen, Stadtteilcafé Am Nippenkreuz, information flyer, Bonn

are exclusively concerned with domestic violence against women and accommodation and social support for women involved – (autonomous) women´s shelters or respective overarching associations (interviews 6-12). A religious based charity (interview 3) provides support and accommodation for a broader group of women with various problems and offers different forms of accommodation for women and their children: low threshold emergency accommodation, permanent accommodation for old women, mother-child-facility, assisted accommodation – all forms of accommodation including social support of different intensity, i.e. every woman is related to a social worker for assistance. A secular charity (interview 2) deals with women with multiple needs as a part of its clients including also male clients at risk: this organisation supports vulnerable persons running a homeless shelter – assisted accommodation including social support and counselling – for homeless adults assigned by the local authorities. The homeless shelter is part of a wider network of the organisation with various services on a range of needs or problems like health issues including mental health, drug addiction or prostitution.

List of interview partners FSTH Germany: Stakeholders

Interview	Organisation	Affiliation
1	Association to support vulnerable persons (Verein für Gefährdetenhilfe)	Streetworker
2	Association to support vulnerable persons (Verein für Gefährdetenhilfe)	Supervisor and social worker working in the homeless shelter
3	„John Union“ (Johannesbund)	Director of women´s shelter
4	Social service of catholic women	Leading technical officer female offender
5	Counselling centre of an autonomous women´s shelter	Women´s advisor
6	Working group North-Rhine-Westphalia on women´s shelters	Coordinator of the women´s shelters in North-Rhine-Westphalia
7	Working group North-Rhine-Westphalia on women´s shelters	Former Professor for Social work, coordinator of a study on women´s shelters
8	Intervention Network supporting VoDV	Managing Director of the Network
9	Intervention Network supporting VoDV	Leading team member
10	Shelter for VoDV	Director/team leader
11	Shelter for VoDV	Team member
12	Shelter for VoDV	Director/team leader

3.1.2 Stakeholder´s perspectives: structural and comprehensive analysis

Funding of the facilities for women – mainly women´s shelters of different forms – basically depends on public resources, i.e. regional or local authorities – community – and social benefits for jobless persons – job centre (according to SGB II/ XII) – in case the women are eligible to get their stay paid for. Problems can result due to the rule, that the local community where the

women come from is responsible, or in case of migrants without non–permanent resident permit or for young women who are students, in education or training which do not meet conditions of public funding.

Moreover, women with own income have to pay for their stay but according to considerably different rules. While there are shelters with relatively high daily rates up to 40€ one stakeholder decided intentionally to take only 7€ (interview 5) in order not to exclude women with no or low income like students or migrants or women without access to their money due to behaviour of their (former) partner. In a further shelter (interview 2) only a minority is concerned by the rule to pay as far as they have income above a minimum level.

Additional funding – which can be used to finance the stay of clients which is not covered by the mentioned sources – are donations and monetary fines, but both are unreliable.

While in just one case the facility is described as “well provided in terms of resources and staff” (interview 2) funding is precarious and difficult in general and even if it is secured (interview 3) it remains on a too low level – restricting the provision of further services which might be desirable.

Since the organisations and experts in the sample of stakeholders represent a wide range of offers and support their **clients** vary considerably – also because of different criteria of exclusion and specific problematic subgroups. Besides the shelters for women affected by violence there are stakeholders providing offers for broader groups of women as well as help and support for specific vulnerable people in general with female clients as a part of them. Experiences of violence, drug addiction, psychic illness or prison characterise all these clients to different degrees.

As a matter of course the women´s shelters put their focus on temporary accommodation and support or counselling for women affected by – domestic – violence and their children including some limited special refuge available for minors in North-Rhine-Westphalia (interviews 5-12). An expert working in the counselling centre of a shelter (interview 5) observes “women with different stories, but all with experience of violence”.

The religious based charity (interview 3) provides a broader range of offers for “single women and mothers with children being in affliction” comprising stationary re-socialisation for (young) women with psychosocial problems, ambulant assisted accommodation with after care, permanent residential home for single homeless people with chronic alcohol addiction or psychic illness, short term accommodation and measures to support the day structure. Physical and psychical violence is not in the focus: the shelter is not anonymous and does not host threatened women since they cannot be protected. There are a lot of addicts in methadone programmes or substitution as well as psychic ill persons and most of the women have experienced violence from early childhood on.

The clients of the secular charity (interview 2) running a homeless shelter within a wider network of the organisation with various services tackling a range of needs or problems comprise in this shelter for homeless adults – not for children – a female subgroup of around 25% women within about 70 persons: while there are 3 mixed floors 1 floor is reserved for women only and couples

are accommodated in the same room (generally: two-bed-rooms). Most of the female clients are drug dependent and drug users in general within the clients are mostly polytoxicoman. The expert observes a growing share of younger people – 20-35 years of age – which do not "fit" anywhere and which are unemployable as well as a generally sharp increase of homeless people.

And also the street worker from the same organisation (interview 1) deals with the local drug scene in general – again restricted on adults – which includes released former prisoners. Female clients are described as often hardened and blunted due to past including their childhood and experiences of prison, violence and power struggles.

Exclusion criteria for the different forms of shelters vary considerably. In autonomous women´s shelters (interview 6-12) women with acute drug and/or alcohol use are not accepted in principle and need to be referred to specific facilities with limited places. And also the religious charity (interview 3) excludes acute addicts. Contrary, acute drug problems are no criterion for exclusion in the secular homeless shelter (interview 2) but drug or alcohol consumption is restricted to specific limits within the private room to respect intimacy. As the case may be referral to other facilities is possible but these are difficult decisions for the assigning local authorities in cold winters since the home is "the last resort". Since the assigning authority is decisive there is no exclusion if there is no violation of rules.

While in the homeless shelter transmittable diseases are a criterion of exclusion the religious shelter exclude acute psychotic persons and persons showing physical as well as verbal aggression (interview 2 and 3).

Foreign citizenship can hinder the access to shelters regarding necessary residence permit or lacking social benefit claims. The homeless shelter excludes foreigners without social benefit claims while in the religious shelter migrants need a 1 year residence permit (interview 2 and 3). And the autonomous women´s shelters regard women who´s resident permit depends on the resident permit of their husband as a problematic subgroup: the responsible authority (Ausländerbehörde) can grant an exception, but they are not obliged to do so (interview 6-12).

Since the sample of stakeholders comprise experts from different organisations with different focuses and tasks – homeless shelter, shelter for women in general, women´s shelter for victims of domestic violence, street worker, consultants – the statements on **key needs of the clients** can be summarised only partly. Some general features emerge: Stabilisation of the clients and providing a social framework is in the focus of experts from all shelters and also support in daily life and regarding basic needs is of concern for all kind of experts – varying in form and degree according to clients. Transfers to other agencies or professionals if necessary regarding particular needs are in some way also in the focus of all kind of experts. Again, the focuses of support in legal, administrative or financial issues ("paper work") or in front of authorities vary according to clients. Additionally, specific offers and supports depend on the focus of the shelters or professionals stakeholders and the kind of clients and their multiple needs.

Regarding ***stabilisation of the clients and providing a social framework*** all experts from shelters put a focus on this point. "All clients have their problems" observes the expert from a homeless shelter

"but they are not alone in the home" (interview 2). The expert from a religious based shelter declares "firstly: just stabilisation – the women feel secure here and have social contacts – nobody wants to live alone: 80% need a stationary frame" (interview 3). And the expert from an autonomous women´s shelter explains: "Going to the shelter does not only mean leaving the partner but also leaving dwelling, friends, work – thus women need stabilisation, a stable base" (interview 5).

Also ***support in daily life and regarding basic needs*** is of concern for all kind of experts even if form and degree might vary according to the clients. "Support of all kind" sees the expert from the homeless shelter as main task with the objective "independent living as fast as possible". This includes "self-provision by clients: cooking with food from a respective charity engaged in alimentation" (interview 2). The expert working as street worker puts the focus on "securing existence" and "transfer to home community or stabilisation of integration in new community" (interview 1). The expert from the religious based shelter offering differing forms of support and accommodation also points on basic needs: "20% just need accommodation with after care in order to avoid new homelessness" and adds: "firstly: accommodation/ contact persons/ shower/ clothing – Then actual social work starts". Again, daily life can be of special concern: "assistance in domestic home affairs is also helpful". The expert summarises: "They need general guidance, starting a new life is difficult, but there are also success stories – every individual story is different" (interview 3). And also experts from autonomous shelters (interviews 6-12) are focusing on group dynamics and the organisation of daily living and add a specific basic need for migrants: the need to start language courses.

Transfers to other agencies or professionals if necessary regarding particular needs are in some way also in the focus of all kind of experts. The expert from the homeless shelter sees "transfer to agencies" as main task: "First interview to identify needs – then transfer to respective agencies or support" and adds "especially transfer to substitution – the clients are mostly already in substitution" (interview 2). The street worker from the same secular charity reports "transfer to further support" – e.g. in case of psychic illness – or "transfer to contact persons" and summarise the approach as just cited above: "transfer to home community or stabilisation of integration in new community" (interview 1). The expert from an autonomous shelter characterise the counselling provided by the shelter as follows: "Establishing of all necessary contacts – more procurement than cooperation" (interview 5) and experts from further autonomous shelters mention external support like psychosocial counselling and/or trauma therapy as an additional offer (interviews 6-12).

Again, the focuses of ***support in legal, administrative or financial issues ("paper work") or in front of authorities*** vary according to clients. The expert from a homeless shelter observes "security problems" as rare – regarding the ex-partners of women: "in case of violence women have to press charges – support is possible if there are witnesses" (interview 2) and the expert from a religious based shelter states as task: "firstly: just support in financial issues like social welfare and child allowance" (interview 3). The expert from an autonomous shelter specifies the issues of counselling provided by the shelter as following: "separation and divorce; violence protection law: police send women on demand for implementation; problems with authorities; stalking – with respect to violence protection law (provisional injunction)". Moreover, the association running the shelter includes two experts in family law to offer "provision of legal counselling once a month" (interview 5). And further experts from autonomous shelters summarise a range of issues: applications,

requests, claims need to be organised, regarding children the clarification of visiting rights of the father is necessary and youth welfare offices and family offices need to be informed (interview 6-12).

Finally, ***specific offers and supports*** depend on the focus of the shelters or professionals and the kind of clients and their multiple needs. The secular homeless shelter offers "assisted accommodation including social support and counselling for homeless adults" with the general objective that "the stay should be pleasant but not too pleasant". But actually, "some clients are staying for years due to often double diagnosis: drugs and psychic problems". There is a "growing share of this group". Moreover, "many clients refuse medical provision causing a kind of vicious circle: refusing psychic drugs – exclusion – stay in psychiatry as an inpatient – coming back". There is a "difficult job for employees working at the gate (but no physical attacks) without respective training – two social workers are engaged to maintain house rules" (interview 2).

The expert from the same organisation working as street worker provides "low threshold help – searching outdoor in the street" including transfer to further support or contact persons with the general objective of "securing existence". Special offers are e.g. a "women´s evening – a beauty day with make-up and hair decoration as a way of "self care"" or a "women´s breakfast related to a working team on help for homeless people and drug dependants" (interview 1).

Regarding clients for stationary re-socialisation the expert from the religious based shelter states "a wide range including family structure, school education, psychic illness, illness in general" as tasks. Actual social work – after having satisfied basic needs (as described above) – includes e.g. counselling – "many women are heavily indebted" – as well as "working on personal relationships". For young or minor women of 18 – 25 years schooling is provided if they have no graduation or training "due to frequently changes of accommodation – including nationwide shelter "hopping" (with their mothers)" resulting in "lacking basic skills like reading and writing". The shelter does not necessarily provide therapies: "there is a large network on psychotherapy in the city and many clients come from hospital and have their physicians" (interview 3).

Issues of counselling in an autonomous shelter are already mentioned above: separation/divorce; violence protection law; stalking. Moreover, "meetings of former residents on a regular base, a mixture of café and counselling" are provided. The general objective of the shelter itself is "protection and security – thus: strict anonymity". Contact to other women is organised with the help of "meeting points where women are picked up by other residents". This approach "works very well". After entering the shelter, a first talk follows, i.e. "a: broad anamnesis" (interview 5).

Moreover, the experts from further autonomous shelters mention group therapies and discussions: "Women get support to talk about their situation, the issues around living in a refuge and their individual violence experiences" as well as issues like "creativity, painting, relaxation, leisure activities". Finally, the shelters support "women in finding a safe and stable living environment" (interview 6-12).

Partnership working aims at better and more comprehensive provision of clients by the stakeholders as well as at better and more satisfying work conditions of the professionals. In this sense stakeholders report "good network that makes work faster" and exchange with working teams on a regular base "in order to avoid double work and in order to not resign" (interview 1). And another

expert mentions that “women come via connections to other authorities or agencies in the social support field – a developed structure – or via personal relationships in the family and social surrounding” (interview 3).

The statements on networking generally show the stakeholders integrated in large networks which can include exchange with facilities providing the same or similar offers or cooperation with stakeholders providing supplemental or complementary offers for their clients out of their own focus or their professional competence – including facilities of the same as well as different concepts, e.g. religious based or secular.

Regarding the first point, the expert from the homeless shelter describes “cooperation with other facilities providing different forms of accommodation; i.e. longer stay for re-integration, assisted accommodation or emergency accommodation for clean clients” but also “referral to other accommodation facilities as the case may be” regarding drug problems (interview 2). Likewise the street worker from the same organisation reports “a range of different social agencies and facilities involved in support for homeless people – emergency accommodation as well as assisted accommodation – and drug dependants” (interview 1). And while an expert from an autonomous shelter explains that “there is a good network with other shelters and facilities – including shelters with different concepts – providing assisted accommodation or different forms of counselling” (interview 5) an expert from a religious based shelter reports “good networking with women´s shelters and a large network of different agencies and facilities in the field: “religious based or secular” (interview 3).

Concerning partnership working with organisations providing supplemental offers the forms of cooperation vary – as a matter of course – according to the organisations own clients and competences. The expert from a homeless shelter sees a main task of the facility in “transfer to agencies and support of all kind” and reports basically cooperation with the health sector, especially concerning drug dependence and mental health problems, i.e. “medical ambulatory – physicians and nurses – for people without health insurance coverage” and a “specialised hospital for drug treatment and therapy” (interview 2). Similar, the street worker of the same organisation mentions “associations engaged in the field of psychic illness” as well as drug dependants (interview 1). Also the religious based shelter reports partnership working with the “health sector, hospitals, therapists, physicians” (interview 3).

Moreover, the expert reports networking with various organisations offering supplemental and complementary counselling and support in specific fields. While the homeless shelter cooperates with a charity engaged in alimentation (interview 2) the religious based charity reports “different agencies and facilities in the field of social work, counselling, accommodation, counselling in debt affairs, work groups on “early help” or care for children outside families”. There is also “good networking with women´s shelters” since “physical and psychical violence is not our focus”. The shelter is not anonymous and does not host threatened women: “we cannot protect them” (interview 3). Contrary, the expert from an autonomous shelter reports “a good network with other shelters and facilities providing different forms of counselling, e.g. counselling on family issues or counselling against sexualised violence” since “the latter is not our concern, but domestic violence” (interview 5).

Finally, there can be made a distinction between partners within the social and health sector, basically non-profit organisations positioned in the civil society on the one hand – as described above –, and public or local authorities in the area of social control and policy on the other hand which might be problematic.

While the expert from the religious charity reports "youth welfare office, job office, regulatory authority, police, layers" as part of the large network of the shelter (interview 3) the expert from the homeless shelter puts one focus on the "assigning local authority" since the facility is "the last resort" for homeless people (interview 2, see above). The street worker from the same organisation reports "regarding foreigners a very difficult or even lacking cooperation with local authorities and the "job centre" on legal issues – right of residence and work permit" (interview 1).

Regarding the **impact of current policy and legislation** a main political issue reported by the stakeholders is lacking or ***insufficient funding*** in general or respective legislation to assure such funding resulting in time and resource consuming work to get more money. Experts running shelters for women or involved in this issue generally observe a funding problem (interview 5 and 6-12), e.g. "too less money from local authority" resulting in "a few denials every day" (interview 3). High costs are "a challenge for women without own income" and the stay of women which are not eligible for public funding depends on donations (interview 6-12). This is seen as a political problem or a problem of lacking political support (interview 3). "A better form would be a cost-covering funding by the national government" declares the expert from an autonomous shelter. Secured funding is necessary since the funding issue "takes too much energy" (interview 5). According to experts from autonomous shelters regular and stable funding is needed for all VoV refuges: The staff is very busy finding additional funding sources in order to keep their institutions running and for the time these efforts take, they are not available for therapeutic interventions for their clients (interview 6-12).

An immediate consequence of this situation is lacking or ***insufficient accommodation*** in general resulting in denials – and for specific groups of women in particular. Experts report "every day a few denials" because "the shelter is always occupied" (interview 3 and 5) and observe a political problem. An expert from a religious based shelter sees "no problems for mothers with children with the local housing office" but it is "very difficult for unmarried and homeless mothers" (interview 3). An expert from an autonomous shelter states "a regional problem: some women prefer to go to other cities" (interview 5). This stakeholder is looking for political support to build a new house with more space. "The house is too small: rooms, kitchens, bath rooms, all are very narrow and not barrier-free. A new house – barrier-free – is planned. There are ongoing talks with the local authority" (interview 5). Further experts from autonomous shelters observe a general lack of refuge places, in particular in some regions. If a woman does not find a place in a refuge, the police are supposed to offer police protection which is ridiculously expensive! Moreover, women shelters have to be rebuild according to the specific needs of handicapped women and new forms of living together need to be explored (interview 6-12).

Experts working in VoV refugees observe an ***inadequate public awareness*** and discussion of the issue "violence against women" including the assessment of specific laws as problematic. "The issue – violence against women – is not enough part of the

public discussions. The view on women – the perception and the female role model – is not adequate" states an expert from an autonomous shelter and concludes: "there should be a campaign that it is not "okay" to beat women, this is not a trivial offense" (interview 5). And also the further experts from autonomous shelters state that problems around violence against women need to be stronger emphasised in society in general. Moreover, prevention efforts with a main focus on safety of the children should be increased (interview 6-12). A new law regarding children – rights of custody – is also seen as problematic by an expert: "it is more a law on rights for fathers" (interview 5).

Considerations and proposals to increase effectiveness of interventions put the focus mainly on ***cooperation of players working on different aspects of the field as well as more overarching and holistic approaches***. Experts from autonomous shelters generally suggest to support and increase networking – policy, research and practice – in order to increase the effectiveness of interventions. In their view, a stronger coordination is needed, i.e. strategies of different players need to be better coordinated and there is a need for overarching concepts. In particular there is a strong need for more coordination between organisations who work with victims and those who work with offenders and perpetrators. Moreover, the refuges do not only want to offer crisis intervention but to work more holistically: there is a need to develop and implement stable and safe perspectives for the women. The question "how to measure success?" remains (interview 6-12).

3.2 Women

3.2.1 Sample and methodology

Compared to the expert interviews more ***narrative interviews*** were conducted between 24/02/2014 and 07/05/2014 to gather the ***life stories and experiences of women with multiple needs*** including domestic violence in particular, i.e. altogether nine interviews – seven extensive face-to-face interviews of around 45 minutes to 1,5 hours, one short telephone interview (15 minutes) due to the family situation of the woman and one relatively shorter face-to-face interview (30 minutes) due to the health situation of the woman. After having introduced the woman to the project, the consent form (covering anonymity, permission to take notes and record the interview and to quote anonymously) was explained and signed. Notes were taken during the interviews, which were recorded as well for later corrections or complements. And again interview guidelines were based on the respective FSTH template and the analysis was structured according to the key issues as they emerged from the data – which where necessarily more heterogeneous than the information from the experts due to the narrative character of the interviews.

Demographic and main features of the sample

Name of respondent	*Experience of DV/abuse*	*Mental Health Problems*	*Experience of CJS*	*Drug and or alcohol addiction*	*No. of children*	*Benefits On welfare*	*Ethnicity*	*Age*
1. AA	20 years of DV by husband	Depression Anxiety disorders PTSD	4 years and 8 months at a stretch (drug related: stepped in for her husband)	Methadone substitution; Earlier: heroin	3	Social welfare	German	37
2. BB	Abused as a child by father; 1,5 years of DV by husband	Depression Panic attacks and anxiety disorders	In total 6 years in prison (drug related)	Methadone substitution with concomitant use of codeine; Earlier: heroin; then alcohol in addition	0	Invalidity pension	German	ca. 50
3. CC	Ca. 3 years of DV by partner	Not mentioned	Several drug related sentences: first time with 19; max. 3 years at a stretch; now for the first time not on probation	Methadone substitution with concomitant use of pills and alcohol; Earlier: cocaine, heroin, LSD, codeine, powder drugs	0	Social welfare Small job	German	43
4. DD	18 years of DV by partner; Beaten up once by another man	Sleeping and anxiety disorders; Suicide attempt; Depression	-	Methadone substitution Earlier: Pills (benzodiazepine); then hash; then heroine	0	Invalidity pension	German	48
5. EE	beaten as a child (but not abused)	Not mentioned	8 months	25 years of drug addiction (heroin, cocaine) but has been completely clean for 6 years (even without substitution)	3	Invalidity pension Small job	German	52
6. FF	DV by husband	Not mentioned	-	-	3	Unemployment benefits Child benefit Child maintenance advance	German	29
7. GG	Abused as a child (by her elder brother and cousin between the age of 9 and 12 years)	Borderline and co-morbidities: depression; bulimia; sleeping disorders; voices; suicide attempt	-	-	0	Invalidity pension	German	52
8. HH	Beaten up three times by partner; beaten up once by another man	Not mentioned	Several prison sentences	methadone substitution Earlier: Hash, heroine and alcohol	0	Invalidity pension Small job	German	53
9. II	Beaten up once by husband	Anankasm; Anxiety disorders;	-	-	0	Social welfare	German	61

		Depression						

Contact and access: Difficult and time-consuming

All interviewed women (9) were accessed through social workers of the respective accommodation or day care centre they are in or used to be in. First it was difficult to motivate the staff to help us find interviewees probably due to work overload and lack of staff. We had to be very insistent and contact repeatedly many organisations by email and by phone. To gain their confidence and motivate them, we sometimes first scheduled face-to-face interviews with the social workers to introduce the FSTH project, answer their questions and asked about their work. This was time-consuming but it helped us finally access more women.

It was very difficult to find women (1, interviewed by phone) directly from the autonomous women shelters since women living in such a shelter have just escaped domestic violence and are still threatened and under shock. Many women there are foreigners and cannot understand und speak enough German (neither English nor French) to be interviewed. Moreover, most all-women shelters don't accept drug users who are victims of DV, who then turn to homeless shelters or services addressing drug addiction and multiple needs instead, who receive more funding and have more staff. The users (and social workers) of such services or shelters were easier to access and to motivate for an interview.

All women except one (who preferred to be interviewed by phone due to her three young children) were interviewed face-to-face in a place of their choice, mostly in a common room of the shelter or of the assisted accommodation there lived in, put to our disposal for the interview.

State of mind: Motivated interviewees

Most of the interviewed women (7) seemed motivated and smart, happy to tell about their life and were quite talkative (most interviews lasted more than an hour: between 15 and 90 minutes with an average of one hour) even if a few of them (3) seemed a bit worried at first and needed some courage. One woman was under drugs when we met her for the scheduled interview. She understood the questions and gave clear answers but after approx. 30 minutes she broke up because she didn't feel well enough to continue. She was neatly dressed and this was very important to her, as well as for about half of the women, who seemed to have dressed up for the interview (two of them in a punk fashion), which can be considered as a kind of coping strategy.

Structural and comprehensive analyses of the data are presented firstly (**3.3.2**) followed by summaries of the single biographies to document their base (**3.3.3**).

3.2.2 Women's perspectives: Structural and comprehensive analysis of the data

Demographic and social structure of interviewed women

Ethnicity and age

All women interviewed were German. As mentioned above, this can be explained by language barriers and by the fact that there are far less foreign women using services for drug users - where it was much easier to find interviewees - than all-women services addressing specifically DV.

More than half (5) of the interviewed women were around 50 years old. The youngest was 29 and the oldest 61. The average age was 47. Through their stories, it seemed that they would not have been able or ready for such an interview some years earlier since they would still have been in the midst of their difficulties. This explains perhaps why we couldn't find younger women to interview.

School education and vocational training

Most interviewees (7) completed a vocational training after finishing school and were able to work some time (6). Two were very good at school (trained then as foreign language correspondence clerk and as geriatric nurse's aide) but for most of the interviewed women, the circumstances of their life (abused as child; early drug addiction; early pregnancy) became soon obstacles to their school, training and job career.

Income and resources

Unemployment benefits, invalidity pension and social welfare

Most of the interviewed women get some kind of state benefits and no additional informal financial support (from parents or partner). In one case, the parents have been helping financially, for example to pay the rent of the flat in order to keep it. One of the women has never worked and has lived 20 years in total dependency on her violent husband.

Five women are receiving an invalidity pension ("volle Erwerbsminderungsrente") since they have worked and are not able anymore. Three of the interviewed women have not worked (enough) to get a pension (state pension fund) or unemployment benefits (by job centre) and are receiving social welfare by the local (city) administration/treasury, one of them sickness benefit in addition. The younger of the interviewees has three young children. The rent of her flat is covered directly by the job centre and she gets unemployment benefit (so-called "Arbeitslosengeld ALGII"), child maintenance advance as well as child benefits which she finds enough to cover the expenses for her and her children.

Small jobs

Today, half of them are not able to work anymore and the other half has a small job like cleaning lady or selling a street newspaper. But even such a “small” job or any day occupation in a day centre is very important to all of them (the ones without job would like to work again) to give them a certain day structure, stability and independence.

Family of origin (childhood and youth)

All interviewed women except one had a rather unhappy childhood (two of them were even abused as a child, one by her father, the other by her brother) and they partly escaped in a very early marriage or partnership. About half of the women were only child, the other had two siblings. Four of the nine women had a good relationship to both parents or to one of their parents and six of the interviewees have been helped by one or both parents: the mothers of two women took their (grand) children in care; the fathers of four women gave support of some kind in their later life.

Marital status, partnership, children

Most interviewed women experienced early partnerships, early pregnancies or/and a feeling of “failing” motherhood. Five of eight women who have had partnerships moved in with their partner or got married before the age of 20, two of these started the partnership at 14. Seven women have been married (partly for more than 20 years) but five of these are now divorced. Four of the interviewees have had new partnerships after their divorce or breaking up. Seven of the nine women have been abused by their husband or partner, two of these for about 20 years. One woman never had a partnership (abused as a child by her brother then diagnosed with Borderline much later).

Only three out of the nine women have children and all three had relatively early pregnancies (with 14, 19 and 20) and gave birth to three children. Only one of these three (the youngest) mothers has been able to keep her children and bring them up. The other children were given in care to their maternal grandmother or to foster parents. Two of the other women had miscarriages.

Experience of domestic violence and abuse

Two of the nine women were abused as children: one by her father (beaten up and raped) and one by her older brother and cousin between the age of 9 and 12. A third one was beaten up as a child but not abused. She didn’t mention this by herself and didn’t consider this as violence. Seven women experienced domestic violence by their husband or partner and two in addition by acquaintances.

From these seven women, two experienced DV over a period of approx. 20 years (one of them with 3 children, one of them with none), three over a period of 3 to 6 years and two for shorter periods. One was abused both as a child and later by her husband who were fathers as well for about a year but then divorced due to DV.

Perpetrators

The perpetrators who were violent to their wife or female partner over a period of approx. 20 years had both been abused as children. They were also both drug addicts as well as two other perpetrators (total of 4). One perpetrator was alcoholic. The perpetrators as husband who were father as well were both non-violent to their children.

The perpetrator violent to his sister was 4 years older than her (the cousin, 5 years older than her). She was told that sometime after her birth, her older brother was given in the care of their maternal grandmother since their mother had to undergo several surgeries. The maternal uncle also lived at the grandmother's. The doctor who diagnosed her borderline disease thought that the brother had some difficulties accepting the situation at the time and took revenge on her[12].

Two one-time perpetrators where some male acquaintances who had taken the keys to the flat of the women and refused to give them back and beat the women up when they insisted.

Acts, intensity and effects of abuse and domestic violence

In all cases, the acts of abuse and domestic violence were massive but the intensity varied: One woman was three time in coma (once up to three months), was cut with a knife from chest to stomach and lost several teeth; another one was three times in hospital due to the beatings and kept locked in the flat. One woman was hit only on hidden parts of her body over approx. 20 years so that no one would notice at work but then was pushed down the stairs where she broke her shoulder. One woman was slapped many times until unbearable.

Three women started using drugs as coping strategy to DV (age 14, 16 and 17) and for one woman, the addiction worsened due to DV. The woman abused as a child by her brother became massive psychic problems: She deeply repressed what had happened for 25 years until she was finally diagnosed with borderline but had collapsed many times starting in her teenage years and suffers many co-morbidities (depression, massive sleeping disorders, massive bulimia, hearing voices). All women also suffered psychic violence more or less destructive of their self-esteem.

No charges due to fatal dependencies and lack of formal support

Fatal dependencies

None of the women have pressed charges against their main perpetrator. One woman (with 20 years DV) is afraid it would be even worse if she did: Her husband is now for the first time in prison (since about one year ago) and will be out soon; he has paid some guys to look her out and they have already been at the shelter and asked for her. One other woman explained: "At the hospital, I lied to protect the man who had pushed me: he could have been sentenced to 8 or 9 years of prison for attempt of murder; the lies were part of my life." The women who suffered DV over the longest periods felt guilty and thought it was partly their fault if they were beaten up. The separation from their perpetrator made their life even worse *at first*. "At that point, I fell deep down: It was as if a

[12] Due to the fact that the brother has always repressed what happened, some questions cannot be answered, i.e.: Was the brother perhaps even abused himself, by his uncle for example?

crutch was taken away from me!" She was depressive and consumed many drugs. When the violent husband of the second women left for prison, she felt completely helpless. She had to leave their flat since she couldn't pay for it so lived on the street and had no money for drugs.

In the case of the woman abused as a child by her brother, it is out of the question for her to press charges against her brother since, on the one hand, her parents are still repressing and ignoring what happened, but on the other hand, they have been an enormous help to her all her life. For their sake she still has to see her perpetrator. In one case, the father filed charges against the violent partner of his daughter and the perpetrator had to go three weeks in prison. In another case of massive and frequent violence, the police came twice to three times a week called by neighbours so they had to change place often, but no action was taken against the perpetrator.

Inadequate responses from police and legal authorities and lack of social support

Obviously, the interviewed women have been disappointed by the police and legal authorities and didn't expect any support or protection from them. Two women filed charges against their one-time perpetrator (who had taken the keys to their flat in both cases) with the help of a social worker at the social hangout near their (assisted) accommodation/flat. They both said that the police wouldn't have taken them seriously and wouldn't have even come if they hadn't had the support of the social worker. The police would have said "testimony against testimony" and left. Even so, in one of the two cases at court, the perpetrator told the judge that his door had fallen on the woman and so injured her. A neighbour was invited as witness and was asked if the attacked women had been "provocative". "She answered with "yes" although she of course didn't know what the word meant! The perpetrator ended up with only 300 working hours as sentence. This was not fair!"

So the grounds for not pressing charges and even lying are: fear, guilt, shame, protection of perpetrator, fatal dependencies (to partners/family), lack of self-esteem, lack of support and inadequate responses from police and legal authorities. To be able to press charges, women victims of DV need some formal social support and adapted police and court interventions.

Health problems

Somatic health

Five women of nine have problems of underweight due to current or past drug use and other drug related health problems. The woman with borderline suffers from several co-morbidities, like bulimia with massive overweight (179 kg). She had two surgeries due to her overweight and the second helped. One woman needs some help to cope with the health examinations because she is afraid of the results due to diseases of her parents. Two women need to become new teeth due to DV.

Mental health

Most women interviewed (5) have significant mental health problems: sleeping and anxiety disorders (5), sometimes massive; depressions (4); thoughts of suicide and suicide attempts (3); low

self-esteem (at least 2); PTSD (at least 1); Borderline (1) with co-morbidities like hearing voices, phobias, panic attacks, helper syndrome.

Experience with institutions of social control

CJS

Five of the interviewed women spent some time in prisons, always due to drug-related infringements. One of these five women actually stepped in for her violent husband (sentence of 4 years and 8 months) who was dealing with drugs and who had hidden drugs in the flat. One sixth drug user felt very lucky that she was never sentenced. The shorter total time in prison was 8 months but the total prison time was mostly at least 5 years, an addition of short sentences with probation periods or "therapy instead of detention" in between. In the past, there was no substitution for drug addicts in German prisons (still the case in Bavaria), but now most prisons in most German federal states offer it rather than cold detox.

In one case, the prison stay was seen as positive since it helped the woman to leave her violent partner and not to return to him after release. One of the women is even looking forward to her coming prison stay: "The advantage of prison is that I can save some money during that time (my invalidity pension) and I get regular meals which keep my stomach full. And the prison services help with finding a place to live and a therapy at the end of the sentence."

Compulsory public measures

Two of the three women interviewed who have children could not keep them and bring them up due to their drug addiction. The three children of one woman were brought up by her own mother. In the other case, two children were taken away from her and given in the care of her mother (older daughter at 4) and foster parents (younger daughter at 7) due to the drug addiction of both parents (the middle child died as a baby). They had to take part in a methadone substitution program during five years in order to be able to keep their third child but they both relapsed and had to give the child away.

One woman had to make a socialization therapy and there was a collective relapse and she was thrown out, put on the street and landed up in a homeless shelter. One other woman had one week to leave the flat until the bailiff came. "I lost everything since it was not possible to move my things."

Other closed institutions

Four of the women had to stay in closed psychiatric clinics which they didn't find helpful and thought it even worsened their situation. One of the women took pills during her first detox (she was 14 or 15) which made her flip out so she was committed to treatment in a psychiatric institution and was put under tutelage (but her capacity was restored after her first therapy at 17). After the first suicide attempt of another woman (she was 20), she was sent for 8 weeks in a closed mental hospital. At the time, psychological problems and their treatment were taboo and stigmatised. Her family was ashamed. At the mental hospital, she didn't receive psychotherapy but just pills and there was no

through care after release. “Psychotherapy as they exist today could have changed the course of my life at this point”.

The woman with borderline spent a lot of time in closed psychiatric clinics since her early twenties. After her first collapse, she spent three weeks in a psychiatric hospital but there was no aftercare. She then made a suicide attempt during a clinic stay where she got mainly strong medication and no aftercare. During the one year she spent in the psychiatric clinic at age 35, she had to stay in the closed section for her own safety whenever her physician was on holiday or not on duty. She was on strong medication and never left alone. She hates closed institutions and is very happy to be able to live in her own flat rather than in such an institution.

One woman lived in a children’s home between 13 and 16 because her father was single parent and working. She escaped several times.

Addictions and therapies

Alcohol

From the six women using (or having used) drugs, three were not alcoholic and three had become alcoholic *later on* (vodka, beer, etc.), in addition to their drug consume. Two women managed to reduce the other drugs and are substituting but still have a problematic alcohol consume. One of them now wants to stop with alcohol. That's why she is at the hospital for a detoxification treatment. "Regarding my alcohol addiction, it has not clicked in my mind yet". She is afraid she will relapse. But she wants to get rid of these nasty circles under her eyes. There were no women who were "just" alcoholic.

Drugs

Six of the nine women interviewed are drug users or former drug users: heroin (6), cocaine (2), hash (2), pills (2), codeine (2), LSD (1). Five of the six women addicted to drugs had an early partner or husband who was taking drugs before they started themselves. Five of the six women addicted to drug started consuming drugs very early (between 13 and 16). One of them was first addicted to pills (13) and later to drugs. Her mother was depressive, alcoholic and addicted to pills. "Drug addiction comes from my mother's family: My maternal grandmother was already an addict!" She had some difficulties to sleep and anxiety disorders and her mother would give her pills (Praxiten Forte, similar to Valium: Benzodiazepine), more and more until she became addicted to them, without realising it. It was in the seventies and people were not as critical of pills and aware of their side effects as they are nowadays.

Out of the six women with drug addictions, four were big victims of domestic violence and for them, domestic violence was the cause of their starting with drugs or in the case of the women addicted to pills, the cause of enlarging and worsening her addiction to other drugs. One fifth woman taking drugs started with 14 due to her clique of friends. She did experience DV later on but for a short time only thanks to her father's help and DV didn't seem to influence her drug addiction. The woman who didn't experience DV started much later (21) with drug use: She took her first drug injection out of curiosity (her husband was an IVDU and she wanted to know what he was experiencing). She is also the only one who was able to completely overcome her addiction and has been completely clean (without even substituting) for the last 6 years. The other five women addicted to drugs are all substituting now but two of them still have a problematic alcohol and/or pills use and one takes codeine additionally. Early starting age and experience of DV seem to worsen the healing prospects.

From the six women taking drugs, two never prostituted to be able to buy drugs. One used to beg for money on the street instead. At the end of the nineties, drugs were very expensive. They were two couples and shared everything. All the money they would get as beggars would go on drugs and for the food for their dog. They couldn't afford to buy drinks or food. She was down to 42 kg at the time. It was a very harsh time, which lasted about 3 years. The other woman earned enough money to buy drugs by working. Earlier, she got the pills from her mother, from the doctor and from the

pharmacist – far too easily, even without prescription. Two women didn't mention having to prostitute. Two women prostituted if they were not able to get drugs through other ways (husband/partner, work, begging). One woman, once her husband was in jail and she had to live in the street, slept at "friends" places but often had to make sex in exchange. She prostituted to get some money for drugs, the "easiest but worse way of getting money".

Detoxification, drug therapy and substitution

The six women have all had several detoxifications, partly cold detox, for example in some prisons. Some of them also had one or more long-term drug therapies including aftercare and rehabilitation measures (10 months and more) – which seem to be quite helpful and successful -, some also as "therapy instead of prison". Most of them had many relapses. Out of the six women with a (present or past) drug addiction, only one has been completely clean (without substituting) for the last 6 years after a successful long-term drug therapy. The other five women addicted to drugs are all substituting now but two of them still have a problematic alcohol use and/or pills and one takes codeine additionally. "I am substituting but it's not enough, I need to take some drugs additionally to be able to function. I am not supposed to but my doctor is quite lax. I need the drugs. I couldn't cope in this homeless shelter without."

But all the other substituted women have finally succeeded in reducing their concomitant drug use and some are even trying to reduce their substitution dosage. This represents a big achievement for them. Since her last therapy, one woman doesn't take cocaine, heroin or powder drugs anymore but she still takes pills and alcohol. She substitutes with Polamydon. She used to be on the dose "20", now she is on dose "16" and she aims at dose "12" but she knows she cannot reduce this dosage further without risking awakening her addictions to other drugs. One woman has started a methadone substitution therapy at the medical day centre and has been clean (no additional drug use) for about a year and hopes she will manage to stay so because she feels good without drugs. She is followed by a doctor from the medical day centre. She says some days she feels she "is falling in a deep hole and she is afraid to relapse on heroin". Her doctor says "a relapse is just an incident".

One other woman was in a substitution programme but consumed pills and cocaine in parallel. "The doctors aren't as strict as they used to be". She finally succeeded in completely reducing any additional drug use to substitution. After the last prison sentence of yet another woman, she did a long-term drug therapy. She trusted this establishment and finished the therapy which was effective. Now she is on a methadone programme. She is trying to reduce the dosage because of the side effects. She has been clean for a while, without concomitant use, just some beers and mixed drinks. But she has to breathalyse when getting her methadone, so it's under control.

Therapies (other than for drug addiction)

Three of the nine interviewed women have had psychotherapy which they found helpful but feel they still need further sessions. All three complain that they would have needed psychotherapy at an earlier stage but in the seventies and eighties, psychic problems like anxiety disorders, suicide attempts, etc. were only treated with pills and medical drugs, many times in stigmatised closed

institutions which rather worsened the situation for the patient: “After my suicide attempt (age: 21) at the closed mental hospital where I was sent for 8 weeks, I didn’t receive psychotherapy but just pills and there was no through-care after release. My family was ashamed. Psychotherapy as it exists today could have changed the course of my life at this point”. Due to the supposed second suicide attempt approximately 20 years later, she was prescribed psychotherapy as an in-patient and later as day-care and this was very helpful: It gave her the strength to leave her violent partner after 18 years of DV.

Two women made couple therapies with their husband. In the one case where therapy was prescribed due to domestic violence, the violent husband broke off the therapy. For the other couple, where both were drug users as well, there was no domestic violence but one of the children had been given in charge to the maternal grandmother and the second child had died of sudden child death. After the couple therapy, they got their third child, which they could raise until it was seven.

Two women with psychic disease visit a day centre with occupations and activities to structure their day which is very helpful to them. Only one woman (victim of DV over 20 years) made a trauma therapy as an inpatient in a specialized clinic, which she first broke up because it was so hard but then joined again and finished the therapy. The trauma therapy helped a lot. Without it, she would not be able to talk to us like this. One woman made a socialization therapy which is a rehabilitation measure for drug users.

Loss of home and homelessness

Eight of the nine women lost their home for various reasons and six of them were homeless for some time. One woman had to leave her flat due to her psychic disease and had to stay four years in psychiatric institutions and in a rehabilitation home. For her, it was most important not to lose her flat during all these years: “You can take everything from me but my flat!” so her parents paid for it and maintained it during the four years of absence. One woman had to leave her flat because her husband was beating her up and she fled twice in a women shelter with her three young children and had many difficulties finding a flat to rent for her and her three children. One other woman was making a socialisation therapy and she was thrown out after a collective relapse and put on the street.

Five women had to leave their flat because they couldn’t pay the rent anymore due to drug consumption or relapse, so they lost their job and home. Two of these had to live on the street because their husband left: one in prison, one broke up. Two other women lived on the street with their partner which was safer. “My ex-husband and I, we had to live on the street for a while. As a woman, it was better to be with a man on the street. If you are alone and spend the night at somebody, you have to sleep with them in return.” One woman slept at the train station and was too weak to prostitute herself for drugs, even to walk. Another lived one month on the street, eating out of dustbins and taking only 2 showers in 4 weeks. Of the six women who had lived on the street, four first found a provisory home in a homeless shelter and two in a drug therapy centre.

From street to home: Past and current housing since homelessness

Homeless shelter and then assisted accommodation

Life in a homeless shelter is seen quite differently by the interviewed women: two women are very positive about it and two quite negative: For one woman, the homeless shelter has been a saving and safe haven to her. She feels secure here. There is a floor for women only with video cameras to check the door of this floor. The shelter has double rooms but she has been alone in a room since she arrived. Alcohol and drugs are forbidden in the shelter (except cigarettes). At first, she was ashamed to be homeless and to have to live in such a shelter. But now, for the first time in her life, she feels she is in charge, independent. She has her room, her things. She now wants to find a place to live for herself, but not at her mother's with 37 years old. She wants to be independent.

A second woman explains that after a relapse, she often slept in a mixed homeless shelter, only open for the night (from 8 p.m. to 8 a.m.). It was not really home since it was closed during the day. It was just a bed and some food, but she missed the human support there: Nobody from the shelter took the initiative and offered her any support. At the time she really needed such support and was not able to take the initiative to get it. She needed to be approached, like the street workers did later for her. After 3 years on the street, she was taken by street workers to a homeless shelter which was open 24 hours a day. She had a room there with her friend and it felt a bit like home. There were five floors in the house which was protected by a wall, with one floor for women only. Three times a week residents had to work for an hour and help with house chores, which was fair enough. She stayed approx. 5 months in a homeless shelter and they helped her to find her own flat (as assisted accommodation[13]), for the first time in her life. An association cooperates with a real estate company who rents affordable flats and it offers social support for the independent residents in a local hangout. She has been living in a flat there for 4 years. At the moment, she is renovating it. At first she was afraid to live on her own and needed time to get used to it, but now she really enjoys having her own place without being constantly under control like in a shelter.

This is a rather negative description by another woman: "I spent some time in a homeless shelter but it was not good for me because even if you aren't supposed to, there is too much drug use there and I wanted to reduce my consumption parallel to substitution." Then she spent five months in an all-women shelter but she didn't want to stay there: She was shocked by a woman there who had spent the last 20 years in this place, completely dependent. She then had the possibility to rent a small affordable flat (45 m²) with social assistance and a meeting place (open five days a week, with activities) in the neighbourhood (assisted accommodation, refer footnote [13]). She has now lived there for one year. "I got the help I needed here. And I can be myself here; I don't need to maintain a façade." She needn't be afraid to lose her flat since she could still afford it even if she would only get social welfare (the minimum). A social worker helps her renovate the flat and is available for any social assistance, paperwork, appointments with doctors, etc. And it helps her to feel safe in her flat

[13] Assisted accommodation, so-called „Betreutes Wohnen" in Germany: Flat with affordable rent (even for recipients of social welfare) and with provision of social support on-site, for ex. in a nearby meeting place with social assistance and activities to structure the day

(refer to above story of the visitor who hit her and she got help from the social worker to call the police and press charges).

The other woman who was not happy about life in the homeless shelter explained: “I have to pay 150 € monthly for the shelter and from next month even 200 € monthly. I have to share a room with another woman. I have no radio or television in the room, which I really miss. And there was this 18-year-old woman with me in the room, she was so dirty. There’s one thing I cannot stand, this is dirt. I keep myself and my place clean and neat and hate to live in a dirty place. And this place is dirty and full of dirty people.” She is looking forward to prison: “I’m fed up with this homeless shelter. I can’t wait to get in prison and out of this hole! The advantage of prison is that I can save some money during that time (my invalidity pension) and I get regular meals which keep my stomach full.” At the homeless shelter where she lives, residents may use the common kitchen but have to buy food and cook for themselves, which can also be challenging and difficult for some women with multiple needs.

Drug therapy centre

Two women went from the street in a drug therapy centre where they both completed a successful long-term drug therapy. There, they shared a room with another woman and, during follow-up care ("Adaption"), they shared a flat and cooked for themselves. But once the aftercare was over they had to find a place to live. One of them had a friend with an assisted accommodation and she was also able to get an affordable flat with social assistance on-site (assisted accommodation, refer footnote [13]). The intensive on-site assistance provided at first is limited to 2 to maximum 3 years but she can keep the flat which she can pay with unemployment benefits or social welfare. The other woman has been renting her own flat for the last two years and is very happy and proud about it.

Women shelter

One woman fled with her three young children in a women shelter due to her violent husband. First they said she would have to go to another city but finally, after two days, she could get a room for the four of them in a women shelter closer to her home. The address of such an autonomous women shelter is kept secret: She was given a meeting time and place. From there, she and her three children were escorted to the women shelter by a women living there. She felt she was in good hands and safe there, even if the living conditions were partly difficult: The shelter was cramped and there were many different women and children from different countries and cultures. The day rate for the shelter (approx. 7 euro per person in this shelter) was paid directly by the job centre (unemployment benefit) in her case. Some administrative and legal assistance was given by the social workers of the shelter, who accompanied her to the respective administrative offices and family court hearings and helped with paperwork. She also had the possibility to talk about all her problems with the social workers. "However, I didn't get any help to find a flat and it was very difficult to find one in my situation with three children." She now lives in a rented flat with her three children and feels fine and safe.

Psychiatric clinic

The one woman who had to leave her flat to stay in a psychiatric clinic then spent several years in a rehabilitation establishment for persons with a psychic disease also offering group and psychotherapy. She was not able to go out or do anything by herself partly due to the strong medication. So her parents enrolled a student to help her additionally and they visited her on week-ends since there was no night or week-end permanence at the time. For her, it was most important not to lose her flat during all these years: "You can take everything from me but my flat!" so her parents paid for it and maintained it during these four years of absence. She then became a new carer who was a former colleague of her with whom she had had difficulties and she started to hear voices (two, both nasty). So she left the establishment with 41 years and went back to live in her flat where she still lives today.

Social relationships

Partner partly as fatal dependency

Most women interviewed have not many friends or supportive family and feel much or quite alone. All nine women interviewed are not living with a partner currently. Two women are still married to their violent husband: One intends to file for divorce. The other woman's husband is now for the first time in prison (since about one year) and will be out soon; he has paid some guys to look her out and they have already been at the shelter and asked for her: She is afraid!

For the two women who suffered of domestic violence over the longest periods, the separation from their perpetrator made their life even worse *at first*. "At that point, I fell deep down: It was as if a crutch was taken away from me!" She was depressive and consumed many drugs. When the violent husband of the second women left for prison, she felt completely helpless. She had to leave their flat since she couldn't pay for it so lived on the street and had no money for drugs.

Most of the women interviewed are divorced, not always due to domestic violence. Some ex-husbands died (2), some left (2) or were left by their wife (2). Some women had or still have contacts to their ex: One woman made herself a tattoo to honor her dead ex who committed suicide one year ago. One ex comes from time to time and helps his ex-wife with her computer.

Parents

The most supportive relationships of most of the interviewed women have been both or one of their parents. In one case, the father helped her drug addicted daughter a lot from the beginning (took her to a drug counselling centre as soon as he realized) and didn't let her down later. He also helped her out of a violent relationship by calling the police and filing charges against the perpetrator. Unfortunately, he died quite early and she still fights against tears today when she tells about his death. For another woman, although her parents are repressing the fact that her brother abused her and they are expecting her to keep seeing her perpetrator occasionally, they have always been an immense support to her: "Without their help I wouldn't have been able to keep my flat and would have to live in a closed establishment which would be terrible for me! And I would need a legal guardian." Instead, she asked her father to take care of all her paper work and financial matters and to have her car under his name for instance. In two cases, the parents or the mother of the interviewed women helped out in taking one or all children in care due to drug addiction. In two other cases, the women were helped in some way by their father to avoid domestic violence: One was able to live at her father's after a prison stay to avoid going back to her violent partner; another asked her father to live with them for a while to avoid being alone with the violent partner.

Children

From the three women having children, all three find some raison d'être and motivation in their children. One mother is taking care of her three children aged 6, 7 and 10 with some professional help. The two other mothers had to give their children in care to their own parents or to foster parents due to their drug addiction. This was very difficult for them. One of them is now able to see her younger daughter (14) every 2 weeks and during the school holidays. The other woman sees her children on week-ends: "They are doing fine"; her older son is now grown up and lives with his

girlfriend in a flat. The thought of her children helps her, although she feels guilty for not taking care of them most of the time.

Friends

Five women have received support from their friends. One woman always found support among her punk mates, in good and bad times. One woman is happy to live again close to her circle of friends. For another woman, stable relationships are very important and she has a few good friends. One other enjoys contacts to her colleagues at her former drug therapy centre where she is now working a few hours. Another woman likes the company at the homeless shelter. She has close contacts with two women in the shelter who had similar experiences. Such contacts help a lot. She never had friends to talk to before.

One experienced negative influence from her environment (wrong clique of friends as teenager; with 18 she wanted to get out of the drug scene so she left for another city: unfortunately she met the wrong people there and moved to yet another city).

Pets

Two women had a dog which meant a lot of comfort to them. One woman had her dog for 15 years before he died one year ago, which was very hard for her. The other woman's dog also died recently that's why she was wearing its collar at the interview (part of her punk outfit). She also has a tattoo dedicated to her ex-husband who died one year ago and to her dog.

One woman found an additional coping strategy in writing a journal: She writes it to help herself see the positive and less positive of each day.

Decisive situation making life worse

Unhappy childhood

Eight of the nine women didn't have a happy childhood: Two were even abused as a child; five women became addicted to drug as girls (13 to 17) partly due to DV; one woman was pregnant with 14. One woman expressed the feeling she couldn't be a teenager but had to be grown-up with 13 and take care of her younger sister since her parents didn't. One girl fled from the children home to end up in the arms of a violent partner. One girl was left alone a lot and sometimes beaten up. One girl had a very strict catholic education and suffered from this and she was already sick as a child (anankastic and anxiety disorders).

Experience low-point or even hit rock-bottom

Eight women suffered from domestic violence. Six women became addicted to drugs. Seven women experienced a low-point or even hit rock bottom through a separation or a massive change: For the two women who suffered of domestic violence over the longest periods, the separation from their perpetrator made their life even worse *at first*. "At that point, I fell deep down: It was as if a crutch was taken away from me!" She was depressive and consumed many drugs. When the violent husband of the second women left for prison, she felt completely helpless. She had to leave their flat since she couldn't pay for it so lived on the street and had no money for drugs. One woman suffered a lot when her third child was taken from her at seven and given in the care of foster parents. Her husband broke up shortly after and a girlfriend let her down as well so she had to live one month on the street, eating out of dustbins and taking only two showers in four weeks. She had reached the bottom. For one woman who was hit by her husband, it was not finding a flat after her first stay at the women shelter that worsened her situation again: after nine months looking for a flat without success, she finally left the region. She lived with a man there for a while but he became somewhat violent as well and threw her out.

"Any change is hard for me. I need a stable home, a stable occupation and stable relationships."

One woman was very sad at the (early) death of her father who had always helped her a lot. She still had tears during the interview, 25 years later. One woman was thrown out of socialisation therapy and landed on the street and then in a "dirty" homeless shelter where she is very unhappy. One woman's psychic disease worsened as her husband left her. She feels alone, especially on week-ends. Two women explained that any changes to their life, but especially change of accommodation and social relationships are bad: "Any change is hard for me. I need a stable home, a stable occupation and stable relationships."

Disease

For four women, disease (not including drug addiction) made their life worse: One woman was diagnosed with cancer at 36 and things started getting worse. For the three other women, it was the

worsening of their psychic disease (anxiety disorders, suicide attempt, blackouts due to borderline) and the subsequent stay (partly) in a closed psychiatric establishment with strong medication but without psychotherapy or after-care, as well as the reaction of their environment to this (shame; repression).

Decisive situation making life better

Safe accommodation

For all nine women interviewed, living in a safe accommodation was an essential condition for making their life better. For all of them, a safe accommodation ought to be and was indeed linked to the concomitant provision of social assistance in different types of housing: women and homeless shelters, drug therapy centres, flat with social assistance (assisted accommodation, refer footnote [13]).

One woman even mentioned a prison stay as safe haven: “My saving was that with 19, I was convicted to prison: Once there, I decided I wouldn’t get back to this (violent) guy. In this case, I have to say that the prison freed me from him!”

Supportive social relationships

For all of them, the existence of some kind of supportive social relationships was an essential condition for making their life better as well: For some, it was the family (supportive parents or husband, children as motivation); for others, friends or street workers or even a homeless alcoholic man who brought one woman to a reception centre where she got some help.

Day structure and food supply

An important factor for making life better for all interviewed women is having a day structure through some activity in the shelter or in a day centre or even having a job. One woman summarized as follows: “I need an accommodation, social support and a job to be able to stay stable and clean.” Another woman put it: “I need a stable accommodation, stable and trustful relationships and a day structure.”

Another woman mentioned a prison stay as structuring factor: “I’m fed up with this homeless shelter. I can’t wait to get in prison and out of this hole! The advantage of prison is that I can save some money during that time (my invalidity pension) and I get regular meals which keep my stomach full.” At the homeless shelter where she lives, residents may use the common kitchen but have to buy food and cook for themselves, which can also be challenging and difficult for some women with multiple needs.

Successful therapies

For the two women who suffered domestic violence over the longest period, different therapies (in-patient psychotherapy with after-care and in-patient trauma therapy) played a primordial role in

making their life better. One woman found an additional coping strategy in writing a journal: She writes it to help herself see the positive and less positive of each day.

For six women (of six using drugs), a successful drug therapy (3) and a substitution program (5) helped their life getting better.

Experiencing low-point as beginning of upturn

For four women interviewed, experiencing a low-point or even hitting rock bottom (through homelessness, separation of violent partner) was the beginning of an upturn and life improvement: “I had to get down to the very bottom to start looking up and to find the strength to face life again.”

Prospects

Eight of the nine women interviewed have prospects or goals, some of them quite detailed. The woman with borderline didn’t really mention any prospect, except that her brain keeps finding some new way and she wonders what it will be next. For most women, there is a general desire to make a new start and rebuild their life and most of them are already trying even if they are not sure to succeed. One woman concludes: “I didn’t have a nice life so far but things are looking up now”.

For all nine women, an appropriate accommodation is essential today and in the future: Those who have found one want to keep it and those who haven’t found a long-term accommodation yet would like to.

For eight of nine women, having an occupation or a job to structure their day or their week and help them get out is essential today and in the future: those having an occupation or a job want to keep it and those who don’t have one, would like to find one once it is possible (health stable; children older): “I would like to find a working place for a few hours to escape boredom and negative thoughts and to break the vicious circle “no work, no home; no home, no work”.

For all women it is essential to continue getting social support from organisations and from relatives and friends. One woman feeling alone on week-ends wants to try starting a get-together on Sundays for lonely people.

All six drug addicted women or former drug users want to stay “clean” (meaning for most of them: no additional drug consume concomitant to substitution; just one has made it to become “1000% clean”, i.e. without even needing to substitute) or to get clean with the help of the right substitution dosage. Several women substituting without additional consume would like to reduce their substitution dosage as far as possible. Those women who are taking medical drugs to be able to sleep would like to manage with less or without.

Most of the women would like to improve their health: Two women would like to get new teeth (damaged due to DV); four women would like to make either a (further) psychotherapy or an out-patient trauma therapy; three women would like to gain more weight (lost due to drug addiction) and manage to take care of their daily supply and cooking; one woman wants to make early detection examinations despite her fear of the results.

Effective formal support by organisations

Support within the framework of accommodation

All women interviewed have become support *within* the framework of their different types of accommodation: Assisted accommodations (refer footnote [13]) for 5 women; homeless shelter (2 current and 2 former residents) and autonomous women shelter (1); room or flat at drug therapy centre (3 former residents); prison services helping find a place to live and for therapy after release (3 former prisoners); home-based family support for 1 woman with three young children ("sozialpädagogische Familienhilfe"); one woman was helped by street workers who repeatedly took the initiative, went out to seek her in the streets where she used to live and took her by the hand.

Support from organisations not directly linked to accommodation

Additionally, they have received support from organisations not directly linked to their accommodation: 5 women have received psycho-social assistance (PSB) accompanying the substitution programme; 4 women have received psychotherapy; 2 women have received support from day care centre for persons with psychic diseases; 1 homeless drug addicted woman was helped by a reception centre run by the municipality and the police close to the train station and they sent her to a homeless shelter; 1 woman asked to get a legal guardian who would take care of her mail, bills and all financial matters since she was overstrained by such matters.

Type of assistance

The assistance provided covers various areas: psycho-social support and stabilization in general, helping with very practical and essential matters like financial (filling the right forms correctly for claiming benefits), administrative and legal issues (file a divorce, call the police, press charges, hearings at family court), so-called "paperwork", offer activities (cooking, gardening, office work) to meet other people, to structure the day and the week, get-together for former residents, helping renovate a flat, offering an "open ear" and helping to cope with daily problems as well as emergencies (in 2 cases of domestic violence, the social worker linked to the assisted accommodation called the police and helped file a claim), and simply encouraging, motivating. Those services are also a referring platform helping find the needed specialized medical and psychological support, the right therapy, helping find a long-term place to live, an occupation, a job.

What helped most

Most women with multiple needs found the assistance provided very helpful and effective, especially within the framework of a safe and stable home like an assisted accommodation (refer footnote [13]), which allows independence linked with non-invasive all-round assistance.

Many interviewed women were able to start improving their life with the help of effective long-term therapies as psychotherapy, drug therapies and couple therapies, including aftercare and rehabilitation measures if necessary. Services offering a day structure and occupations are primordial as well.

Women with drug addiction in addition to DV seemed to be better helped than women with DV "only": Women with drug addiction and DV may not stay in an autonomous women shelter but have many other possibilities addressing drug users: homeless shelter, drug therapy centre and especially assisted accommodations. Women victims of DV but without drug addiction may go to an autonomous women shelter but that's it. The women shelter are not as well financed as the homeless shelters and don't have as much staff. Consequently, they cannot offer as much help, for example helping to find a flat after the stay at the women shelter.

3.2.3Summaries of the single biographies

Summary of interview AA on 24.02.2014

AA is a 37 years old German woman. She has 3 children, aged 23, 17 and 14. She had an early pregnancy (aged 14) and got married very young (aged 17). Since then, she has experienced domestic violence by her husband (who was abused as a child) and has become a heroin addict like her husband (her first injection made by him). She had trained to be a salesperson specialized in pastry and bakery shop but has never worked. For 20 years she lived in complete dependency of her violent husband who procured heroin partly as a dealer. He kept saying "You are dumb and fit for nothing". Once, drug was found at their home and she stepped in for her husband and was sentenced to 4 years and 8 months prison for violation of the German narcotics law. She was three times in coma due to DV, once up to three months. She was cut by her husband with a knife from breast down to stomach. She lost several teeth due to DV. The police came twice to three times a week called by neighbours so they often had to change place. The couple did a partner therapy due to DV but he quitted the therapy.

In the time when she was in prison and when she was not able to take care of her children due to the drug addiction and DV, AA's mother took care of AA's children. The two younger children live permanently there. AA's mother has been a great help. The older son is now grown up and lives with his girlfriend in a flat. AA sees her children regularly, on week-ends. AA's husband, the father, was not violent to the children and the children still have contact with him. The children are fine. The father was not allowed to come to AA's mother's house but once beat her up as well. AA's husband is now for the first time in prison (since a bit less than one year) and will be out in 2 months. She has not pressed charges against him yet. She is afraid that it will get even worse if she does so. He has sent some guys who he pays to look her out and they have already been at the shelter and asked for her.

When he left for prison, she felt completely helpless. She had to leave their apartment since she couldn't pay for it. She slept at "friends" places but often had to make sex in exchange. She prostituted to get some money for drugs, the "easiest but worse way of getting money". Then she got weaker and weaker (weighed only 38 kg when she entered the shelter, five months ago), slept at the train station and was too weak to prostitute for drugs. "I had to get down to the very bottom to start looking up". Actually, an alcoholic man also sleeping at the train station almost carried her (she was almost too weak to walk) to a reception centre run by the municipality and the police close to

the train station and they sent her to a homeless shelter where she now lives. “If it hadn’t been for him, the reception centre and the homeless shelter and other services (medical day centre, psychosocial counselling), I would probably have died of an overdose by now”.

She has started a methadone substitution therapy at the medical day centre and has been clean for about a year and hopes she will manage to stay so because she feels good without drugs. She had a detoxification therapy and also a trauma therapy as an inpatient in a specialized clinic, which she first broke up because it was so hard but then joined again and finished the therapy. The trauma therapy helped. Without it, she would not be able to talk to us like this. She suffers of depression, PTSD and sometimes thinks of suicide. She gets medication against depression but they still need to be adapted since she has strong anxiety disorders. She is followed by a doctor from the medical day centre for this and for the methadone substitution. She says some days she feels she “is falling in a deep hole and she is afraid to relapse on heroin”. Her doctor says “a relapse is just an incident”. But she found the courage and strength to face life and to look up. The thought of her children helps her, although she feels guilty for not taking care of them most of the time. She feels lucky not to have Hepatitis C or HIV.

The homeless shelter has been a saving and safe haven to her. She feels secure here. There is a floor for women only with video cameras to check the door of this floor. The shelter has double rooms but she has been alone in a room since she arrived. Alcohol and drugs are forbidden in the shelter (except cigarettes). At first, she was ashamed to be homeless and to have to live in such a shelter. But now, for the first time in her life, she feels she is in charge, independent. She has her room, her things. She now wants to find a place to live for herself, but not at her mother’s with 37 years old. She wants to be independent. She would like to find a working place for a few hours as well to escape boredom and negative thoughts. She wants to break the vicious circle “no work, no home; no home, no work”. But she is afraid of being alone. She likes the company at the homeless shelter. She has close contacts with two women in the shelter who had similar experiences. Such contacts help a lot. She never had friends to talk to before. She writes a journal to help herself see the positive and less positive of each day.

She also talks to the two social workers at the homeless shelter and at the psychosocial counselling centre for drug users/substituted at least twice a week and that’s a big help. She needs it. She has to take the initiative but the homeless shelter supports her in many areas like administrative paperwork and finding a place to live, at first an assisted accommodation* with other women and psychosocial counselling support (“Betreutes Wohnen”), before being on her own. She has been on sick-leave for 6 months and gets social welfare: 259 EUR a month but asked the social worker at the counselling centre to give her weekly rather than monthly instalments until she learns to better deal with the money. She pays 30 EUR a month to the shelter for electricity and charges. (People who have a job have to pay more for the shelter). The social workers at the shelter can also help finding a job. They can help find medical and psychological support. She will get new teeth next week paid by her health insurance and is proud of taking care of this on her own. She wants to join a “clean group” meeting once a week to help her not to relapse. She would also like to meet a

psychologist/psychotherapist once a week. The talking and crying are liberating. She concludes: “I didn’t have a nice life so far but things are looking up now”.

Summary of interview BB on 25.02.2014

BB is under drugs when we meet her for the scheduled interview. She can hardly open her eyes. She understands the questions and gives clear answers but after approx. 20 minutes she breaks up because she doesn’t feel well enough to continue. She is neatly dressed and this is very important to her.

BB is a (approx.) 50 years old German woman. She was abused as a child by her father (beaten up and raped). She became a drug addict at 14 years old. Later she became alcoholic as well but hasn’t drunk for the last ten years. She was married for one and a half year but divorced due to domestic violence. She then lived with a partner for many years but he died in 2005. She doesn’t have children. She used to work in a security agency. At the age of 36, she was diagnosed with cancer. Then things started getting worse. She was sick, the drug and alcohol addictions got worse. She lost her job and her partner. She was in pre-trial custody.

She already made many detoxification therapies but had many relapses. “The prisons in Bavaria are terrible: They don’t substitute drug users; it’s cold detox!” She spent all-together 6 years in prison, due to drug-related crimes. But in-between, when leaving prison, the prison services helped her find a place to live: She has always had her own flat or room or lived in a shared flat or in assisted accommodations*. That was fine. She had a job as maid/cleaning lady for an organisation helping drug users (“Drogenhilfe”) for a while. But then she had to make a socialisation therapy and there was a collective relapse and she was thrown out, put on the street and landed up in this homeless shelter, for the first time in her life, six months ago.

She receives a disability pension so she has to pay 150 EUR monthly for the shelter and from next month even 200 EUR monthly. She has to share a room with another woman. She has no radio or television in the room, which she really misses. “There was this 18-year-old woman with me in the room, she was so dirty. There’s one thing I cannot stand, it’s dirt. I keep myself and my place clean and neat and hate to live in a dirty place. And this place is dirty and full of dirty people.” She is alone: Her partner died; her father died; her mother died. “I cannot stand it much longer here. My psychic health is getting worse since I am here. I have panic attacks and anxiety disorders. I need a certain medication (Codeine syrup) but I have to pay 5 Euro for it and I don’t have the money. I also lost too much weight in too short a time. That’s not good. There’s no support here. You have to help yourself!”

She is not looking for another home anyway since she is waiting for her prison sentence of about 9 months (she is convicted but is waiting for the warrant of arrest). “What should I do? I don’t have the money and I am an addict. I am substituting but it’s not enough, I need to take some drugs additionally to be able to function. I am not supposed to but my doctor is quite lax. I need the drugs. I couldn’t cope here without. Perhaps after my sentence in prison, I might try again to get clean, if I am substituted in prison and afterwards, and find the right dosage. But first I would need to find a

room for myself with a television, perhaps a shared flat or assisted accommodation. Then I would make a psychosomatic therapy. This will be organised by the prison before I will be leaving there. The advantage of prison is that I can save some money during that time (my disability pension) and I get regular meals which keep my stomach full." „I'm fed up with this place! I can't wait to get in prison and out of this hole!"

Summary of interview CC on 06.03.2014

CC is a 43 years old German woman. She is a punk. Her dog died 16 days ago, that's why she is wearing its collar. She also has a tattoo dedicated to her ex-husband who died one year ago and to her dog. From the age of 13 to 17 years, she lived in a children's home since her father was working and didn't have time to take care of her. She used to be good at school, even qualified for the "Gymnasium" (grammar school). Then things started to look down, but she managed to get her O-Levels ("Realschulabschluss") and she finished her training as a geriatric nurse's aide. With 14 years she had met a cool guy, a rocker aged 21. She was in love with him. She often fled from the home to sleep at his place and with 16 years old, she moved to his place. She worked as a model for advertising photos which was well paid.

First things were fine but after a while, he didn't want her to be a model anymore. He also wanted "to fight the punk out of her", didn't like how she dressed. He started to hit her in the face, so she could not work as a model anymore. And he hit more and more. "Three times he made me fit for hospital through his beatings". She had already tried some drugs but was not an addict yet. With the beatings she became a drug user. He was a drug user as well. He also locked her up in the attic flat. She would let down a basket on a rope and her punk mates would deliver her some drugs. At the time she thought it was her own fault that he would beat her up. Her punk mates would say: "Hell no! You're nuts!" "My saving was that with 19, I was convicted to prison: Once there, I decided I wouldn't get back to this guy. In this case, I have to say that the prison freed myself from him!" When she came out, she went to live with her father.

She has no children. "I had two miscarriages unfortunately. I wish I would have children." With 19, out of prison, she was consuming drugs and was also anorexic. Her father was worried and she tried to hide it all. Her weight was down to 33 kg at the time (now she weighs 54 kg and still looks slim). Then, there was a period of about 20 years during which CC tried to live with and overcome her addiction: She made a total of five therapies with after-care, was then clean for a while (longest period at a time: 3 years completely clean) and able to live in assisted accommodations* and work, but then relapsed again and again (5 to 6 times). She was several times in prison. Now they do substitute, but in the past, they didn't. Her longer prison stay was 3 years at a time.

After her first violent partner she never had a violent relationship anymore. Once, she had a friend with whom the relationship seemed to develop in a similar direction so she decided to quit him right away. She was five years with another punk together. They met in therapy, were one year clean together but then both relapsed and lost their job and home. It was autumn and getting colder. They needed sleeping bags. They tried to sleep at friends' places (other punks) but most of them were homeless as well. So they often slept in a mixed homeless shelter, only open for the night (from 8

p.m. to 8 a.m.). It was not really home since it was closed during the day. It was just a bed and some food, but she missed the human support there: Nobody from the shelter took the initiative and offered her any support. At the time she really needed such support and was not able to take the initiative to get it. She needed to be approached, like the street workers did later for her. They were a great help because they repeatedly took the initiative, went out to seek her and took her by the hand.

But at that time, she was on drugs non-stop and on all drugs (cocaine, heroin, pills, codeine syrup, LSD – but not so much alcohol). It was at the end of the nineties. Drugs were very expensive. They had to beg for money on the street. She never worked as a prostitute to be able to buy drugs. They were two couples and shared everything. All the money they would get as beggars would go on drugs and for the food for their dog. They couldn't afford to buy drinks or food. She was down to 42 kg at the time. It was a very harsh time, which lasted about 3 years. After this phase, she was taken by street workers to a homeless shelter which was open 24 hours a day. She had a room there with her friend and it felt a bit like home. There were five floors in the house which was protected by a wall, with one floor for women only. Three times a week residents had to work for an hour and help with house chores, which was fair enough. A friend of hers, also a punk, took her to a compact drug therapy with after-care, but then, she eventually relapsed. She used to be married (to a non-violent man). One year ago, her ex-husband (for whom she still cared) committed suicide by jumping in front of a train.

After her last prison sentence, she started directly a programme "Therapy instead of prison", but this time she didn't have the power to go through the after-care at the end. She stayed approx. 5 months in a homeless shelter and they helped her to find her own flat, for the first time in her life. An association cooperates with a real estate company who rents affordable flats and it offers social support for the independent residents in a local hangout. She has been living in a flat there for 4 years. At the moment, she is renovating it. At first she was afraid to live on her own and needed time to get used to it, but now she really enjoys having her own place without being constantly under control like in a shelter. The assistance offered in the hangout is very pleasant: They are a great help with paperwork for example, without being too invasive. She is on social welfare: approx. 240 EUR are left per month after having paid electricity, bus monthly ticket, etc. Since about 30 years, it's the first time she isn't on probation anymore. She sells a street newspaper. She will never be allowed to work as a geriatric nurse's aide again, due to her drug addiction.

She substitutes with Polamydon. She used to be on the dose "20", now she is on dose "16" and she aims at dose "12" but she knows she cannot reduce this dosage further without risking awakening her addictions to other drugs. Since the last therapy, she doesn't take cocaine, heroin or powder drugs anymore but she still takes pills and a lot of alcohol (vodka, beer, etc.). Now she wants to stop with alcohol. That's why she is at the hospital for a detoxification treatment. In order to be able to stay longer there, she intently took more pills than usual. So she is treated for this as well. "Regarding my alcohol addiction, it has not clicked in my mind yet". She is afraid she will relapse. But she wants to get rid of these nasty circles under her eyes. After the detox at the hospital, she will

ride a bus home and will try to go drink a coffee rather than a beer. Her current boyfriend said he would be there and help her. “I don’t know if it will work, but I will try!”

Summary of interview DD on 20.03.2014

DD is a 48 years old German woman. She was not abused as a child but her addiction to pills started when she was 13. Her father was not much home and her mother was depressive, alcoholic and addicted to pills. “Drug addiction comes from my mother’s family: My maternal grandmother was already an addict!” DD liked going to school, was very good at it and found it easy. But she had some difficulties to sleep or anxiety disorders and her mother would give her pills (Praxiten Forte, similar to Valium: Benzodiazepine), more and more until she became addicted to them, without realising it. It was in the seventies and people were not as critical of pills and aware of their side effects as they are nowadays. She got the pills from her mother, from the doctor and from the pharmacist – far too easily, even without prescription! She could not really be a teenager; she had to grow up very early since her mother couldn’t take care of her and of her younger sister and older brother due to her addictions. It would have been much easier if her father had taken care of her mother and siblings. DD was like a mother to her younger sister. Her older brother was 4 years older than her and was sentenced to prison at the time (with 17). Nonetheless, DD successfully passed her A levels and wanted to study but finally completed a vocational education as foreign language correspondence clerk. DD has no children. She had one miscarriage.

At the age of 21, DD made a suicide attempt. After the attempt, she was sent for 8 weeks in a closed mental hospital. At the time, psychological problems and their treatment were taboo and stigmatised. Her family was ashamed. At the mental hospital, she didn’t receive psychotherapy but just pills and there was no through care after release. “Psychotherapy as they exist today could have changed the course of my life at this point”.

The year after her suicide attempt she met a Dutch man. They first lived together in Germany then moved to Holland. They were both drug users. She worked at the time and earned enough money to buy drugs (pills, hashish and later heroin – but she never had an addiction to alcohol). They didn’t get married since they didn’t have children and she was financially independent. “From the outside, everything seemed fine: I had work, a house, a car, a dog but behind the front, there was violence, addiction and low self-esteem!” The violent relationship developed “like a spiral”. Her drug addictions got worse (heroin use was added) and she was depressive. “I felt it was my fault; my self-esteem was very low.” “I worked part time in a hotel so he hit me on hidden parts of my body so no one would notice. If someone would ask, I would lie. But after 18 years together he pushed me down the stairs and I broke my shoulder; at the hospital, I lied and said I had taken some pills for suicide and then fell in the stairway; I lied to protect the man who had pushed me: he could have been sentenced to 8 or 9 years of prison for attempt of murder; the lies were part of my life.” The deliverance of this long violent relationship was that, due to the supposed second suicide attempt, she was prescribed psychotherapy (with no methadone but many pills) as an in-patient and later as day-care where she lived in Holland which really helped her and helped her take the decision to leave her violent partner and go back to Germany. When asked, she added that, in contrast to her, her violent partner had been abused as a child.

She left Holland and went back to Germany. Her violent partner followed her and lived with her at first but she asked her father to live with them to avoid being alone with the violent partner. Finally, they separated completely. “At that point, I fell deep down: It was as if a crutch was taken away from me!” She was depressive and consumed many drugs. She had already been in many detoxification therapies. At the time she started a detox therapy with “Le Patriarche” from Engelmajer, some kind of work therapy in France then Portugal, but she broke off after two months. She was then in a substitution programme but consumed pills and cocaine in parallel. The doctors aren’t as strict as they used to be. One year later, she met a man whom she married. He was also a drug user. He was not violent to her. They had a flat. They got divorced after 7 years but they kept the flat together because it would have been very difficult to find an affordable flat as a single. Then they couldn’t pay the rent anymore due to drug consumption. They had one week to leave the flat until the bailiff came. “I lost everything since it was not possible to move my things.” “My ex-husband and I, we had to live on the street for a while. As a woman, it was better to be with a man on the street. If you are alone and spend the night at somebody, you have to sleep with them in return.”

“Two years ago, my ex-husband left town and went back to his wealthy relatives. I spent some time in a homeless shelter but it was not good for me because even if you aren’t supposed to, there is too much drug use there and I wanted to reduce my consumption parallel to substitution.” Then she spent five months in a women shelter but she didn’t want to stay there: She was shocked by a woman there who had spent the last 20 years in this place, completely dependent. Even if it was not easy for her in her late forties to start afresh, she wanted to try. She asked to get a legal guardian who would take care of her mail, bills and all financial matters since she was overstrained by such matters. First she had a professional male legal guardian and it didn’t work out well but after that a women solicitor with whom she gets along well. She finally succeeded in completely reducing any additional drug use to substitution. Her dog that she had had for 15 years died. It was hard. She then had the possibility to rent a small affordable flat (45 m²) with social assistance and a meeting place (open five days a week, with activities) in the neighbourhood (assisted accommodation*).

DD has now lived there for one year. “I got the help I needed here. And I can be myself here; I don’t need to maintain a façade.” She needn’t be afraid to lose her flat since she could still afford it even if she would only get social welfare (the minimum). A social worker helps her renovate the flat and is available for any social assistance, paperwork, appointments with doctors, etc. And it helps her to feel safe in her flat. Once she had a visitor. He hit her on the head and she asked him to leave her flat. He did so but took her keys to the flat. She went to the doctor due to her head injury and when she came back, she was afraid he would be in the flat waiting to beat her up. So she went to the meeting place and the social worker called the police. She filed charges against him. The man was waiting in front of her flat and the police arrested him. He is now in prison. “If I had called the police, they wouldn’t have come or if I had filed charges against him without the support of the social worker, they would have said testimony against testimony and I wouldn’t have been taken seriously!” She manages to take care of her daily supply and cooking. She is proud to have gained 7 kilos since she’s lived here (she weighed 45 kg one year ago and now 52 kg). She would like to continue gaining weight and to manage to sleep better without pills. It would help to make an

ambulant behaviour and trauma therapy in a psychiatric hospital (as an out-patient). She wants to get her teeth fixed but needs general anaesthesia for this. And when everything gets more stable, she would like to work again for a few hours.

DD has worked as a foreign language correspondence clerk and later in a hotel and made good money. She was never in prison and feels she was lucky not to. But then, due to her drug addiction, there were more and more absence periods in her CV and it became difficult finding a job. She worked as a cleaning lady on night shift for a while. She has not worked anymore for more than ten years and she has received an invalidity pension (reduced earning capacity of 100%) since 2005 (from age 40): one third from the German state pension fund and two thirds from the Dutch state pension fund. She also gets unemployment benefit (ALGII/"Hartz IV"). Every three years, she undergoes an examination linked to the invalidity pension.

Summary of interview EE on 27.03.2014

EE is a 53 years old German woman. She was beaten as a child – but apparently not abused, since she didn't consider this worth mentioning as experience of domestic violence. As a child and teenager, she was a lot on her own. She has a 2-year older brother and a 2-year younger sister with whom she is starting to get in contact again, as well as with her mother (she explains: "my father died unfortunately approx. 10 years ago") after many years with very little contact. At 16 she started a vocational training in home economics (housekeeping) but broke off. She got married and lived about 30 years with her husband who was never violent to her. With 20 years she gave birth to her eldest daughter. With 21, she took her first drug injection. She did it out of curiosity: Her husband was an IVDU and she wanted to know what he was experiencing (and it became a 25-year drug addiction to heroin and cocaine with a total of 8 detoxifications and 4 relapses). Three years later, the 4-year-old daughter was given in the care of the maternal grandparents due to the drug addiction of both her parents. With 24, EE gave birth to her second child but the boy died with 4 months from sudden infant death. In the nineties she did a detoxification and then a couple therapy with her husband. Two years later (EE was then 38), EE gave birth to her third child, a daughter (who will turn 15 this year). For a period of five years, EE was in a substitution programme (Methadone) to be able to keep their daughter with them. In this time, she had a car accident because she had driven under drugs and without driving license and was sentenced to 8 months of prison. Then her 7-year-old daughter was given in the care of foster parents. This was very hard for EE; she cried a lot. Shortly after her husband broke up and she lived with a girlfriend in another town for a while until she was kicked out of her flat. In this summer, she had to live one month in the street, eating out of dustbins and taking only 2 showers in 4 weeks. She had reached the bottom. Fortunately, she had applied for a further therapy in order to get her daughter back and the assumption of costs was accepted so she could start her therapy. This time, it "made click" in her head, the therapy was successful and she has managed to stay clean since then, "1000% clean", without even having to substitute. Since summer 2012, she has her own flat. She is now able to see her younger daughter (14) every 2 weeks and during the school holidays. EE gets an invalidity pension. The 25-year drug addiction took its toll and she has some health problems. But she works 15 hours a month for an association supporting drug users. She gets the support she needs there. Her psychic health is good,

according to her. She made it from the bottom, from the street to her own home, and overcame her addiction and rebuilt a new life, with social contacts to her younger daughter and her colleagues.

Summary of interview FF on 01.04.2014

FF is a 29 years old German woman. She has three children aged 6, 7 and 10. She prefers to be interviewed by phone because it's easier with the children. She has heard of our project through an autonomous women shelter where she spent nine months two years ago and again a shorter time last year.

Her husband is alcoholic. He wasn't violent to the children but he slapped and hit her again and again. "At some point, it became unbearable and I moved to a women shelter". First they said she would have to go to another city but finally, after two days, she could get a room for the four of them in a women shelter closer to her home. She felt she was in good hands and safe there, even if the living conditions were partly difficult: The shelter was cramped and there were many different women and children from different countries and cultures. The day rate for the shelter (approx. 7 euro per person in this shelter) was paid directly by the job centre (unemployment benefit) in her case. Some administrative and legal assistance was given by the social workers of the shelter, who accompanied her to the respective administrative offices and family court hearings and helped with paperwork. She also had the possibility to talk about all her problems with the social workers. "However, I didn't get any help to find a flat and it was very difficult to find one in my situation with three children." She couldn't find a flat so after nine months she finally left the region. She lived with a man there for a while but he became somewhat violent as well and threw her out. So last year, she came back to the same women shelter until she could finally find a flat in the area this time, closer to her circle of friends.

She now lives in a rented flat with her three children and feels fine (health and wellbeing) and safe. The rent is covered directly by the job centre and she gets unemployment benefit (ALGII / Hartz IV), child maintenance advance as well as child benefits which she finds enough to cover the expenses for her and her children. On the legal side, things are getting sorted out now: She has not filed charges against her husband but she intends to file the divorce. Once the children are a bit older, she would like to work again. She is also getting home-based family support ("sozialpädagogische Familienhilfe") and keeps in touch with the social workers of the women shelter who organise a get-together for former residents.

Summary of interview GG on 07.04.2014

GG is a 52 years old German woman. Her father was civil servant. She has two brothers, a four-year older one and a younger one. She doesn't have children and never had a partnership. Both her brothers have children. She was told that sometime after her birth, her older brother was given in the care of their maternal grandmother since their mother had to undergo several surgeries. The maternal uncle also lived at the grandmother's. Between the age of 9 and 12, she was abused mostly by her older brother and by her cousin (5 years older than herself). But she repressed these events

for approx. 25 years. She was finally diagnosed with borderline in her mid-thirties but the first blackout incidents started much earlier, in her teenage years (approx. 16-17 years).

With approx. 16 years, she passed her Certificate of Secondary Education. She had first prepared for the O-levels but she was dyslexic so had to change school. She wanted to become a nurse or train in a social profession but she would have needed the O-levels for this. Her father wanted her to become a secretary so she started secretarial training but quitted with 17. Instead, she trained in housekeeping and domestic economy and worked in the household of several families. She also helped in youth centres and homes for handicapped persons. She practiced a lot of sport, especially swimming. In her early twenties, she started working for an organisation helping disabled persons and worked there almost 10 years. She lived in a flat-sharing community and liked it very much.

This living community dispersed so she had to move out. This was the first time she collapsed and spent three weeks in a psychiatric hospital but there was no aftercare. She found another living community. At that time she was working very intensively with handicapped persons also in her free time (organised a sports and a dance group). She organised many holiday camps for disabled persons in Germany, Holland and even Mallorca. She also took care of and housed handicapped persons when the parents were away. The organisation she was working for asked her to become a group leader so she took part in a further training on special needs education. But there were some problems at work with colleagues and she also had to find a new flat. She was depressed and got shots once a week from a psychologist but no therapy.

She was advised to make a psychosomatic cure during 6 weeks. She sensed that something was wrong with her but she didn't have anything to talk about; she couldn't; it was too deeply buried and repressed. She attempted suicide during the cure and finally stayed a total of 10 weeks there but couldn't explain her own problems. But she wanted to help the others there. It's very difficult for her to set boundaries, to maintain a certain distance to others and their problems. She wants to help everyone. She was suggested by the mother of a handicapped person to a foundation giving awards for outstanding social commitment and she received an award at the age of 30. The award was 10,000 DM and she bought a van to be able to pick-up more handicapped persons for activities she organised in her own free time. At that time she moved in the flat in which she still lives today after more than 20 years.

Then she got another award and bought a new bus with the money. Then she collapsed again. She went to the psychiatric hospital. She told her parents and friends that she went there to lose weight since she was in fact very overweight (179 kg). She didn't know what was wrong with her but she sensed that something was wrong. The doctor who took care of her there – and still does – suspected that she was repressing traumatic abuse in childhood but it took GG one more year to be able to realize what she had suppressed for such a long time and to write (not talk!) about it to her physician who finally diagnosed Borderline. The physician talked to GG's mother so she knows about it but she is repressing what happened and GG still has to meet her older brother now and then for her parents' sake. He does as if nothing had happened. He as well as his girlfriends and children even visits her in her flat if he is in town which is particularly hard for her. During this year in the psychiatric clinic, she had to stay in the closed section for her own safety whenever her physician

was on holiday or not on duty. She was on strong medication and never left alone. She tried to start working again based on a model of professional reintegration funded by the sickness fund (Hamburger Modell) but collapsed again. “Each change is hard for me. I need a stable home, a stable occupation and stable relationships.”

After her clinic stay, GG stayed several years in a rehabilitation establishment for persons with a psychic disease also offering group and psychotherapy. She was not able to go out or do anything by herself partly due to the strong medication. So her parents enrolled a student to help her additionally and they visited her on week-ends since there was no night or week-end permanence at the time. For her, it was most important not to lose her flat during all these years: “You can take everything from me but my flat!” so her parents paid for it and maintained it during these four years of absence. She then became a new carer who was a former colleague of her with whom she had had difficulties and she started to hear voices (two, both nasty). So she left the establishment with 41 years and went back to live in her flat and has been visiting a day care centre for persons with psychic diseases five days a week for more than 10 years now. It gives her a day structure, which is primordial to her and some occupation like cooking, gardening, office work, etc. as well as free time activities. She does a lot of sports like aqua jogging. She also took part in skills groups for borderliners. She had two surgeries due to her overweight and the second helped.

Today, she has much less overweight and takes less medication but this makes her more aware of her problems: She has serious sleep disorders (manages to sleep only 2 hours a night due to constantly hearing the voices) and she also “woke up” several times on a highway bridge about 3 km from her flat, in the middle of the night, in night gown and slippers or bare foot without remembering how and why she got there. Suddenly she was not able to take a shower or to swim anymore for a while. Recently, she was suddenly not able anymore to open her eyes. The neurologist gave her a drug which helped. “My brain keeps finding some new way. I wonder what it will be next!” But she never had a drug addiction: neither tobacco, nor alcohol or any other drugs.

She has learned to trust three persons beside her parents: her female physician who diagnosed her borderline disease about 15 years ago and who is discussing everything with her and is taking some risk to let her live in her flat versus a closed establishment; her female social carer who is visiting her in her flat once a week and her male psychologist to whom she has been going for the last year. Although her parents are repressing the fact that her brother abused her and they are expecting her to keep seeing her perpetrator they have always been an immense support to her: “Without their help I wouldn’t have been able to keep my flat and would have to live in a closed establishment which would be terrible for me! And I would have a legal guardian.” Instead, GG asked her father to take care of all her paper work and financial matters or to have her car under his name.

Summary of interview HH on 15.04.2014

HH is a 53 years old German woman. She has no child and was herself only child. Both parents died quite young: her father when she was 27 and her mother with only 59 from lung cancer four years later. HH started consuming drugs with 14 years due her clique of friends: first hash then heroine and later alcohol in addition. She always had a good relationship to her parents, especially to her

father. He was working at the Red Cross. As soon as he noticed that she was consuming, he accompanied her to a drug counselling centre then to a detoxification centre, where she took pills which made her flip out so she was committed to treatment in a psychiatric institution and was put under tutelage (but her capacity was restored after her first therapy at 17). She started an apprenticeship as painter and varnisher but broke off and then trained as advertising technician, which she liked.

With 18 she wanted to get out of the drug scene so she left for another city. Unfortunately she met the wrong people there and moved to yet another city where she had relatives. She prostituted on the street and a suitor drove her back home to her parents who had tried to find her. She did a detox again. She worked as advertising technician but she once had convulsions at work due to the medication of the cold detox. Her colleague didn't help her. It could be dangerous to have convulsions while on a scaffold so she had to stop working in this sector. So later, she worked occasionally as assistant in tanning salons and in hairdresser's shops.

The first partner HH lived with beat her up three times. Her father helped her to defend herself in alarming the police. The perpetrator had to leave their flat. HH's father had filed charges against him and he had to go three weeks in prison. On his return, he called and threatened HH but she answered back and he left her alone. HH was then married for seven years. Her husband was in the ship sector. He was not consuming drugs at first. He took care of her. But then he started consuming and lost his job. She left him because she had a clean phase and didn't want to have a relapse.

HH had mostly cold detox but she also did three therapies but had relapses. She was several times homeless. She also spent some time in prison. After her last prison sentence, she did a therapy. She trusted this establishment and finished the therapy which was effective. During therapy she shared a room with another woman and during follow-up care ("Adaption") she had a flat and cooked for herself. But once the aftercare was over she had to find a place to live.

Now she is on a methadone programme. She is trying to reduce the dosage because of the side effects. She has been clean for a while, without concomitant use, just some beers and mixed drinks. But she has to breathalyse when getting her methadone, so it's under control. She had a friend with an assisted accommodation and she was also able to get an affordable flat with assisted accommodation. She was once victim of violence in the area: a cocaine addict had the keys to her flat and she wanted to get them back so she rang at his door. He refused to give her the keys and beat her up. At court, the perpetrator told the judge that his door had fallen on her and so injured her. A neighbour was invited as witness and was asked if HH had been "provocative". "She answered with yes although she of course didn't know what the word meant! The perpetrator ended up with only 300 working hours as sentence. This was not fair!"

The intensive assistance is limited to 2 to maximum 3 years but HH can keep the flat which she can pay with unemployment benefits. She still has the psycho-social assistance (PSB) accompanying the substitution programme, which is not much. She needs some help to cope with the health examinations because she is afraid of the results due to diseases of her parents. "I try to think positive but negative experiences can also help on!" She sells a monthly street newspaper. She also

volunteered (first as “one-euro job”) to help designing the stage for a theatre company and really enjoyed it.

“I need an accommodation, social support and especially a job to be able to stay stable and clean!”

Summary of interview II on 07.05.2014

II heard of the project through a social worker of the day centre for persons with psychic diseases she is visiting. She wanted to come to the WIAD office for the interview which took her almost an hour by bus. She had dressed up and seemed at ease, motivated and smart. The interview lasted approx. 30 minutes.

II is a 61 year old German woman. She said she had an unhappy childhood with a very strict catholic education. She suffered from this and was already sick as a child (anankastic and anxiety disorders diagnosed when she was about 6). She had a hard time at school and didn’t make friends because of her illness. After completing school, she started several vocational trainings without success. She worked for just a short time. In her twenties, she was finally able to complete training as office clerk. Although she didn’t get along with her parents, she was dependent on them and lived with them until she was 29 when she got married. She was married for 25 years and doesn’t have children.

With 29, she moved with her husband in the countryside where she never felt at ease. She would have rather lived in a city. She didn’t work and felt isolated. She suffered of depressions in addition to her anxiety disorders. But she did enjoy reading and going to lectures on physics and astronomy with her husband and especially travelling abroad with him, although her anxiety disorders worsened when not at home. But the depressions got worse and were straining their relationship. Her husband beat her once until she had bruises in the face but she didn’t mention this by herself and didn’t seem to consider this as domestic violence. They finally separated after 25 years of marriage.

She moved in a flat in a city but felt too depressed and lonely there. “My flat was like a prison to me!” After a stay in a psychiatric clinic she lived in a foster family for a while but it didn’t work out well. Now she is living in an elderly home and visits a day care centre for persons with psychic diseases which gives her a day structure during the week but she still feels very lonely on week-ends. So she wants to try starting a get-together on Sundays for all kind of lonely people in the city. She stayed several times in a psychiatric clinic and underwent psychotherapy which helped but she feels she would need further psychotherapy sessions. She doesn’t have friends (never had) or contact to family but her ex-husband visits her from time to time and helps her out with her computer.

4 Conclusions and recommendations

A large representative **survey** showed the significance of **violence against women** in Germany:

- violence against women takes place predominantly in domestic situations and with the partner as perpetrator
- all forms of violence can contribute extensively to psychological, psycho-social and health problems for those women affected
- early help, intervention and prevention are necessary
- improvements above all in the areas of police intervention have been seen, however, at this time, not in the areas of the legal system or court interventions
- measures for help and prevention should be more strictly oriented on risk factors

Group discussions with women revealed central **help and support requirements**: psychological and sexualised violence became apparent as relevant aspects concerning ***domestic violence,*** as well as internal and external barriers to seeking support. While children need special support, ending the violence and separation are major challenges. An important factor for help and prevention is the social environment and physicians can play a central role in supporting while police intervention, in spite of its potential, is felt to be a high threshold measure. Generally, the system of aid and assistance is challenged. Regarding ***sexualised violence from known or unknown perpetrators*** special reluctance thresholds exist in the search for support by victims. Police intervention must be further improved and social environments and help systems are challenged.

A current **Action Plan** summarise the **politics of the German Government:** stronger protection of female migrants, a focus on handicapped women, early as possible prevention for children and situations of separation as specific risks for women. Regarding protection the health sector is to be addressed as well as the justice system and persons from the close social environment and low-threshold and easy access to the help-system is to be enabled. Responsibility and behaviour changes of perpetrators are issues as well as the extension of cooperation between Federal State, “Laender” and non-governmental organisations.

A central feature of **women´s shelters** as a main kind of facility is the support on the road to an independent, non-violent liberated life, a process that needs adequate time in a safe and supportive environment in order to develop a new perspective on life as well as high professionalism, lot of time and energy of the staff. But literature as well as qualitative fieldwork reveals **funding** of shelters in Germany as very heterogeneous and often insufficient – stakeholders describe it as precarious, difficult and too low and as a main political issue since lacking or insufficient funding cause time and resource consuming work to get more money with the immediate consequence of lacking or insufficient accommodation resulting in denials. Thus, political measures to ensure stable and sufficient funding are a main recommendation.

Another conclusion results from the fact that the existing different shelters and facilities with various focuses and tasks according to different **clients** with multiple needs also show considerably varying **exclusion criteria.** Autonomous women´s shelters in particular exclude in principle acute drug or alcohol addicts. Moreover, the access of foreigners can be restricted in various ways. Thus, the recommendation of *different* offers necessary for *various* groups can be concluded.

Since the specific offers and supports depend on the kind of stakeholders and the kind of clients and their **multiple needs** the facilities generally are integrated in large and differentiated **partnership** networks complementing one another. Considerations and proposals of experts working in VoV refuges to increase effectiveness of interventions put the focus mainly on cooperation of players working on *different* aspects of the field as well as more overarching and holistic approaches. Moreover, cooperation with public or local authorities in the area of social control and policy might be problematic and thus are to be improved in particular.

Finally, the same group of experts observe an inadequate **public awareness and discussion** of the issue "violence against women" which – thus – is to be put more on the public and political agenda.

According to our **field study among women**, the provision of joined-up accommodation and social support for women with multiple needs not only already exists in Germany but seems also well-established. However, improvements are necessary according to the following recommendations.

- Many of the interviewed women had an unhappy childhood and were somehow neglected as child. Two of them as well as both worst adult perpetrators were abused as child. Consequently, we would recommend extending early prevention of sexual abuse against children and teenagers by supporting at an early stage parents and children in families at risk and developing social early-warning systems. In Germany, the interdisciplinary "National Centre on Early Prevention" has been working on such issues since May 2007.
- According to our field study, women with drug addiction in addition to being victim of DV seemed to be better helped than women being "solely" victim of DV. This should be improved: On the one hand, women suffering of DV - and their children - without further problems as drugs should be able to access and get social benefits when attending services provided for women with multiple needs. On the other hand, accommodations and services addressing specifically victims of DV – and their children - without the drug problematic should be given more public funding to be able to better assist their target group, since there are not enough all-women shelters and they are mostly overcrowded as well as under-staffed.
- Furthermore, many women with drug addictions are or have been victims of DV and vice-versa. Consequently, drug services should be able to address and assist victims of DV and services addressing specifically victims of DV should be able to address drug addictions as well. This could be achieved through more cooperation

between these different services and through more interdisciplinarity within these services, both being already partly applied but this should be extended.

- Since none of the women have pressed charges against their main perpetrator partly due to inadequate responses from police and court authorities, these should be improved. The police and legal authorities should be trained and sensibilised to the issues of DV: Victims of DV should be taken seriously, supported, protected and referred to adequate social services. There should be some cooperation between police, legal system and such social services.
- Many interviewed women were able to start improving their life with the help of effective long-term therapies as psychotherapy, drug therapies and couple therapies, including aftercare and rehabilitation measures if necessary. The existence and access at an earlier stage to such long-term therapies should be enlarged rather than be cut back by the pension and sickness funds as it is unfortunately the case at the moment. Services offering a day structure and occupations are primordial as well.
- After their stay in a provisory shelter, many women found a stable and safe home in an assisted accommodation, so-called „Betreutes Wohnen“ in Germany: Flat with affordable rent (even for recipients of social welfare) and with provision of social support on-site (for example in a nearby meeting place with social assistance and activities to structure the day), which allows independence linked with non-invasive psycho-social help. Since this approach offers effective support, the number of such assisted accommodations should be increased and the access to them be kept low-threshold.
- During our field study, we encountered an association (Verein für Gefährdetenhilfe, Bonn) which can be seen as best practice example since it offers a very broad range of low-threshold all-round services for different needs and at different stages. Such associations should be encouraged and get more public funding in order to increase their number.

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