Overview Guide

Illinois Imagines Project

May 2010

Overview Guide

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Acknowledgments

Thanks to the Illinois Imagines Team members, who worked creatively and collaboratively to envision and create a new way to serve women with disabilities who experience sexual violence. The Illinois Imagines team included:

- Self advocates
- Department of Human Services, Division of Community Health and Prevention
- Department of Human Services, Division of Rehabilitation Services
- Department of Human Services, Division of Mental Health
- Department of Human Services, Division of Developmental Disabilities
- Illinois Coalition Against Sexual Assault
- Illinois Family Violence Coordinating Councils
- Illinois Network of Centers for Independent Living
- Illinois VOICES
- The Blue Tower Training Center

Many thanks to the model site collaborations that pioneered this work at the local level:

- Chicago — Pilsen Collaborative
- Rockford Collaboration
- North Central Collaboration
- Coles County Collaboration
- Southern Illinois Collaboration

These sites drafted charters, built collaborations, developed networking agreements and strategic plans and patiently tested ideas and products for the Toolkit. Thanks for your commitment to the vision and mission and for paving the way for women with disabilities in Illinois to receive the best possible response if they experience sexual violence.

We owe a great debt to all of the women with disabilities who participated in this project. Many women with disabilities participated in focus groups during the needs assessment and planning phases, and starred in the DVDs that are included in this kit. Thanks to all of them. A smaller group of women with disabilities worked with their colleagues in the Illinois Imagines statewide model site collaborations. They contributed days of their time to this project. Along the way, they gave us invaluable insight into their world, sharing their thoughts, feelings, ideas and dreams. Without their guidance, we could not have done our job.

NOTES:

Victim/Survivor – The terms victim and survivor are often used interchangeably, though individuals who are sexually victimized may prefer one term over another. Both terms will be used throughout this toolkit. When working with a victim/survivor, ask her which term she prefers and use that term.

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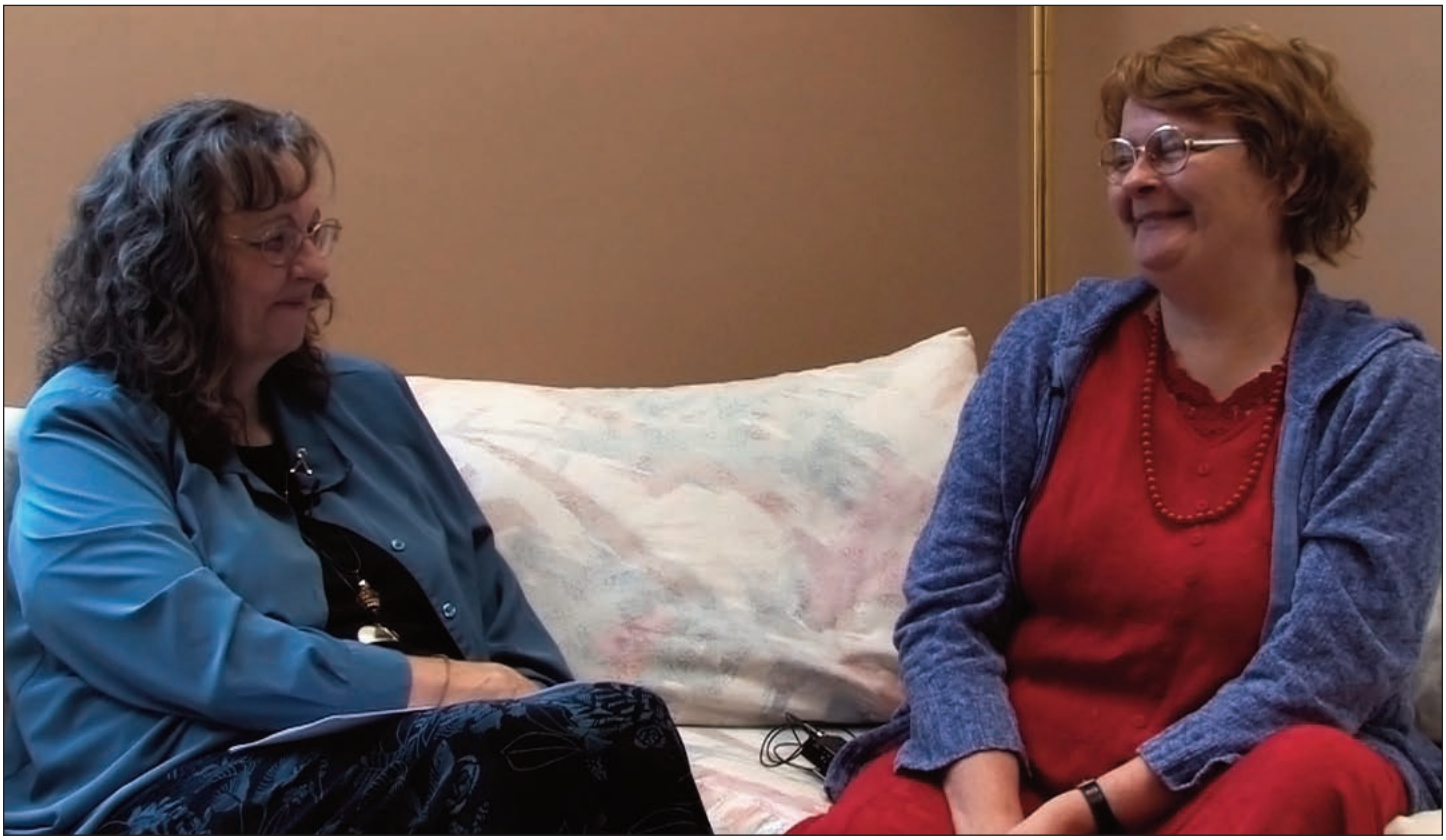


Special Thanks

Special thanks to Teresa Tudor for coordinating the Illinois Imagines project; Carol Corgan for writing, editing and overseeing the toolkit production; Shirley Pacely, Amy Walker and Susan Faupel for writing parts of this toolkit; Yvonne Bronke, Suzanne Knox and Libby Shawgo for editing; and Sean Black for writing, design and layout of the toolkit.

Section 1
Introduction

Introduction

What Is This Toolkit?

A collaboration team, called Illinois Imagines, created the Our Rights, Right Now Toolkit to guide disability service agencies and rape crisis centers as they respond to women with disabilities who experience sexual violence. The guide includes an introduction to the issue of sexual violence against women with disabilities, information specific to each discipline and tools for service provider agencies to share with women with disabilities.

This Toolkit is one key product of the strategic planning process. It contains the resources to: 1) foster local collaborations among disability service agencies and rape crisis centers, 2) train workers in disability service agencies and rape crisis centers to improve their response to women with disabilities who experience sexual violence, and 3) equip service providers with the tools to inform women with disabilities about their rights and options.

The Our Rights, Right Now Toolkit consists of five modules:

Module 1: **The Overview Guide** – This module provides the foundation information and guidance to assist a local collaboration to improve responses to women with disabilities who experience sexual violence.

Module 2: **Guide for Disability Service Agencies** – This module provides educational and training material on sexual violence and trauma response for disability service agency staff. It also guides agencies regarding how to create a safe environment for women with disabilities to discuss sexual violence.

Module 3: **Guide for Rape Crisis Centers** – This module provides education and training material on a victim-centered rape crisis center response to women with disabilities who experience sexual violence. It also guides rape crisis centers regarding how to enhance their ability to serve women with disabilities.

Module 4: **Women with Disabilities and Sexual Violence and Education Program** – This module provides a step-by-step training curriculum for the rape crisis center and/or disability agency staff to use to educate women with disabilities about sexual violence, their rights, healthy sexuality and how to get help.

Module 5: **Multi-media** – The materials in Module 5 are intended for both rape crisis centers and disability service agencies. This module contains training material for agency staff, including two education videos on working with women with disabilities who experience sexual violence. A third video is intended for use when conducting educational sessions with women with disabilities. The module also include a CD containing this toolkit material, including handouts, in PDF format. Also, a CD of "Who, What, Where, When: A symbol book for communicating with survivors of sexual abuse who use Augmentative and alternative communication" is in this module. Additional videos, posters and other material can help create an environment that welcomes women with disabilities to discuss sexual violence.

We hope this Toolkit is useful as you work to Achieve Change

What is Illinois Imagines?

Illinois Imagines is a project of the Illinois Department of Human Services (DHS) funded by the Office on Violence Against Women (OVW). In 2006, DHS received a three-year grant from OVW to examine and propose changes to the systems responding to women with disabilities who experience sexual violence. DHS' grant project, called Illinois Imagines, is designed to strengthen the service delivery systems so that women with disabilities who survive sexual violence will receive a proactive, individualized, compassionate response to their experience.

Illinois Imagines convened a project team including representatives of key agencies working in the fields of disability and sexual assault. While bringing together partners from various areas of study can be challenging, all project team members shared a common vision of justice, compassion, person-centered services, and the empowerment of all women with disabilities who have survived sexual violence.

What is this Project About?

The project focus is to change Illinois systems to better serve women with disabilities who experience sexual violence. The Illinois Imagines collaboration began its work by defining a vision, mission and goals to achieve change.

Vision

All women with disabilities will be guaranteed an environment free from sexual violence, where they are empowered to speak and act for themselves. Survivors of sexual violence will be assured a proactive, individualized, compassionate response to their experience.

Mission

The project's mission is to develop, implement, formalize, and sustain integrated systems in Illinois that will:

- Empower women with disabilities to actively shape those systems.
- Prohibit and interrupt sexual violence perpetrated against women with disabilities.
- Support and empower women to report sexual violence to any provider, agency or law enforcement official.
- Provide survivor-centered crisis response, advocacy and counseling for women with disabilities.
- Remove all obstacles faced by women with disabilities who are survivors of sexual violence.

Goals

- Reduce the incidence of sexual assault and the threat of sexual violence against women with disabilities.
- Create a supportive, accessible environment for women with disabilities who choose to disclose sexual assault or the threat of sexual violence.
- Ensure survivors receive timely, relevant, survivor-centered services.

Guiding Principles

This project has three core principles:

- people first
- victim-centered
- disability humility

These principles are the framework for all of our work and are central to the project vision.

People First

This concept has two primary tenets:

1. **"Nothing about us without us"** – This tenet states the obvious, though often overlooked, belief that no decisions about women with disabilities should be made without their input and participation. If we are changing policy or developing service models for women with disabilities, those women must be included in every meeting, from the first to the last. They are the experts. Without them, we are missing the most important voice.

2. **People first language** – The language of disability (as with language used to refer to race, ethnicity and sexual orientation and identity) is continually evolving. Some terms that were once in common use (e.g., retarded) have been or are gradually being replaced by terms that: a) more accurately describe the disability and; b) are positive rather than disparaging. Changes in language occur gradually and the process of replacing one term with another takes time, so continuous self-education is needed to remain current on best practice terminology.

Regardless of the language used to refer to a disability, the people-first concept always refers to the woman/women before the disability. Here is how it works:

Only refer to the disability if there is a reason to do so. Just as it is not necessary to reference race or ethnicity when speaking about someone, it is not necessary to refer to the disability, unless it is somehow relevant to the interaction. When referring to the disability, refer to the disability second. For example, she is a woman with a developmental disability, not a "developmentally disabled woman." She is a woman who uses a wheelchair rather than a "wheelchair-bound woman."

The chart below indicates preferred terms and terms not to use.

DO USE (always with person first)	DO NOT USE
❍ cognitive disability	❍ impaired, retarded
❍ developmental delay	❍ handicapped, lame, crippled
❍ uses a wheelchair	❍ spastic
❍ cerebral palsy	❍ crazy
❍ mental illness	

Victim-Centered

This is an approach to working with victims of sexual assault that focuses on restoring control to the victim, helping the victim identify and explore options, and supporting the victim's right to make decisions and guide her own recovery. Based on this model, the expressed needs of sexual assault victims are the focus of services.

When services are victim-centered, the victim directs her recovery process. She brings up the issues she wants to discuss and sets the goals for the recovery process. The worker supports the empowerment of the victim by sharing information and describing options available to her. The worker ensures the victim's right to make her choices and decisions about those options and the recovery process. Services that are victim-centered utilize the victim's support system and respect the role of extended family, informal networks, non-traditional healing, self-help groups and other forms of support as appropriate and desired by the victim.

Disability Humility

Disability humility is an adaptation of cultural and disability competence frameworks. The difference is that disability humility shifts the focus from the worker as the expert to the individual with a disability. Instead of trying to master all of the information available about disabilities, the worker focuses on developing an attitude of respect, non-judgment, acceptance and support. Rather than the support worker feeling obliged to be informed about every aspect of disabilities, she invites the woman with a disability to share information about herself and describe what she may need in relation to any disability. This approach of respectful inquiry and openness promotes equality and empowerment. This requires the worker to listen and learn and puts the woman with a disability in charge of defining and describing her experience on her own terms. See Tool #2 for more information.

Terminology

(See Section 5 Tool #1 for more definitions and terms)

Victim/Survivor – The terms victim and survivor are often used interchangeably, though individuals who are sexually victimized may prefer one term over another. Both terms will be used throughout this Toolkit. When working with a victim/survivor, ask her which term she prefers and use that term.

Women with Disabilities – This Toolkit focuses exclusively on women with disabilities, as this was the purpose and restriction of the funding. However, most of the material can be generalized to improve services to males and youth with disabilities who experience sexual violence.

She – This Toolkit focuses on women, the most common victims of rape. The sexual assault victim is referred to as “she” throughout this Toolkit. However, men can also be victims of sexual violence. The reactions, feelings and needs of sexual assault victims, whether male or female, are very similar. This information in this Toolkit is equally relevant and helpful to male sexual assault victims and their friends and family.

Sexual Violence – The term sexual violence is used throughout this Toolkit to refer to any act (verbal and/or physical), which is non-consensual and is sexual in nature. The term “sexual violence” includes sexual harassment, exposure, voyeurism, sexual abuse, sexual assault and other forms of sexual exploitation. Sexual violence may be perpetrated by a family member, partner, acquaintance, caregiver or stranger.

SECTION 2
PLANNING PROCESS

Illinois Imagines' Planning Process

Needs Assessment

Illinois Imagines began its work with a needs assessment. A summary of the needs assessment report follows. The findings are shared to create a backdrop to the Toolkit and provide information to local collaborations about common needs, issues and trends across the state. The insights, experiences and expertise of women with disabilities, rape crisis center staff, disability service agencies and state level administrative personnel captured in the needs assessment report can be used as a starting point for the work of a local collaboration team. We adapted the statewide needs assessment surveys and questionnaires for use by a local collaboration wishing to conduct its own needs assessment (see Tool #5).

I. Needs Assessment Process

Through needs assessment, the team sought information at the individual level (women with disabilities), the community level (rape crisis centers and disability service providers) and the state level (Illinois Coalition Against Sexual Assault and DHS staff). Additionally, we reached individuals from many different areas in Illinois to support our statewide change efforts.

The needs assessment process collected data from these stakeholders through focus groups, individual telephone or in-person interviews, and electronic surveys.

Women with Disabilities – Individual Level

The Needs Assessment process reached 133 women with disabilities through 20 focus groups, and three women through individual interviews. Individual interviews were conducted with women who were unable to attend a focus group or preferred an interview.

We recruited approximately equal numbers of women with mental illness, women with developmental disabilities and women who utilized vocational rehabilitation services and/or Centers for Independent Living (CILs).

Sexual Assault Service Providers – Community and Statewide Level

We collected information from rape crisis centers through three focus groups with 24 participants and electronic surveys completed by staff of 27 rape crisis centers. Individual interviews were conducted with four staff members at the Illinois Coalition Against Sexual Assault.

Disability Service Providers – Community and Statewide Level

The collaboration reached 88 staff in disability service agencies through eight focus groups, and 137 more of those staff through electronic surveys. Surveys were e-mailed to the network managers of the Division of Mental Health and Division of Developmental Disabilities within DHS. The network managers then e-mailed those surveys to community providers.

Within the Division of Rehabilitation Services, surveys were e-mailed to direct-line staff members. These counselors and case managers located in local offices across the state serve in a similar capacity as community-based providers.

To gain the state level perspective, individual interviews were conducted with 15 non-direct service staff in all three divisions of DHS. These staff included training coordinators, bureau chiefs and network managers.

II. Needs Assessment Measures

Survey and focus group questions varied depending on the target audience. The questions for women with disabilities focused on factors influencing disclosure of sexual violence, the desired response to that disclosure, and barriers that prevented the women from getting that desired response. Questions for rape crisis center staff and disability service providers focused on awareness of the issues, current response practices around sexual violence, obstacles they faced in improving their response to women with disabilities and barriers to collaboration with other key players in the response system.

In addition to themes covered in focus groups and surveys for disability service providers and rape crisis centers, the individual interviews for state system staff included questions about contractual requirements, monitoring services, and involvement of people with disabilities in policy making.

III. Needs Assessment Findings

Needs assessment findings center around four key areas across every target population:

- Disclosure
- Response,
- Connection to Services
- Policy/Rules

Common themes and recommendations emerged across groups and are central to our findings. Each group – women with disabilities, rape crisis centers and disability service providers – made recommendations to Illinois Imagines.

Women with Disabilities

Women with disabilities identified recommended strategies for improving the service delivery system for survivors. Their priorities, in order based on number of responses (most to least), follow.

1. Women with disabilities, their families and their service providers need to be aware of sexual violence.

2. Rape crisis centers and staff of disability service agencies should be aware of sexual violence and rape crisis centers.

3. Women with disabilities need to be able to identify sexual violence, to tell, to call a rape crisis center for help and to seek counseling.

4. Services need to reach women with disabilities where they are, i.e. groups held at disability provider agency.

5. Responders to women with disabilities who experience sexual violence should focus on the incident of sexual violence rather than the disability.

6. Responders should listen, make eye contact with the survivor and ask her what she needs.

7. Rape crisis centers should be trained regarding survivors with disabilities, and their services should be fully accessible.

Disability Service Providers

The following recommendations were given by disability service providers in multiple venues (surveys, focus groups, and individual interviews).

1. Provide tools for providers to aid in identification and response to women with disabilities who experience sexual violence.

2. Formalize collaboration between disability providers and rape crisis centers.

3. Develop referral protocols, training resources and options for sexual assault services to be provided on-site at disability service agencies.

4. Clarify definitions and guidelines to improve shared understanding regarding guardianship and confidentiality for both disability providers and rape crisis centers.

5. Provide tools for women with disabilities to promote awareness of sexual violence, their rights and how to access services.

6. Provide transportation for women with disabilities to rape crisis centers.

7. Ensure that local agencies have the resources to develop effective collaborative responses (training, communication, etc.).

8. Provide immediate access to resources/services when a woman with a disability experiences sexual violence.

9. Develop and conduct public awareness campaigns to make women with disabilities more aware of sexual violence and rape crisis services.

10. Provide information lines/hotlines/Internet, information about sexual violence and services for women with disabilities and disability providers.

11. Involve women with disabilities in decision-making and systemic changes.

12. Develop training and print material to increase workers' awareness of sexual violence.

Rape Crisis Centers

The following recommendations were given by sexual assault service providers in multiple venues (surveys, focus groups, and individual interviews).

1. Change policy so that a woman with a disability does not need a guardian's permission to access services.

2. Clear up confusion about how guardianship affects the survivor's confidentiality rights.

3. Hire women with disabilities to be on staff at rape crisis centers and ICASA.

4. Get the input of women with disabilities in developing trainings, policies, and resources.

5. Develop formal networking agreements and cross training plans between rape crisis centers and disability service providers.

6. Educate each other on what the various providers do and their respective responsibilities.

IV. Needs Assessment Conclusion

These recommendations from women with disabilities, rape crisis centers and the disability service systems have many commonalities, as do the responses at the individual, community and state levels. The areas of commonality between the two service systems point to the need for:

- **mutual awareness and understanding of services and roles;**
- **confidence and comfort in providing services;**
- **coordination of service systems; and**
- **models for collaboration, accompanied by policy and training guidelines.**

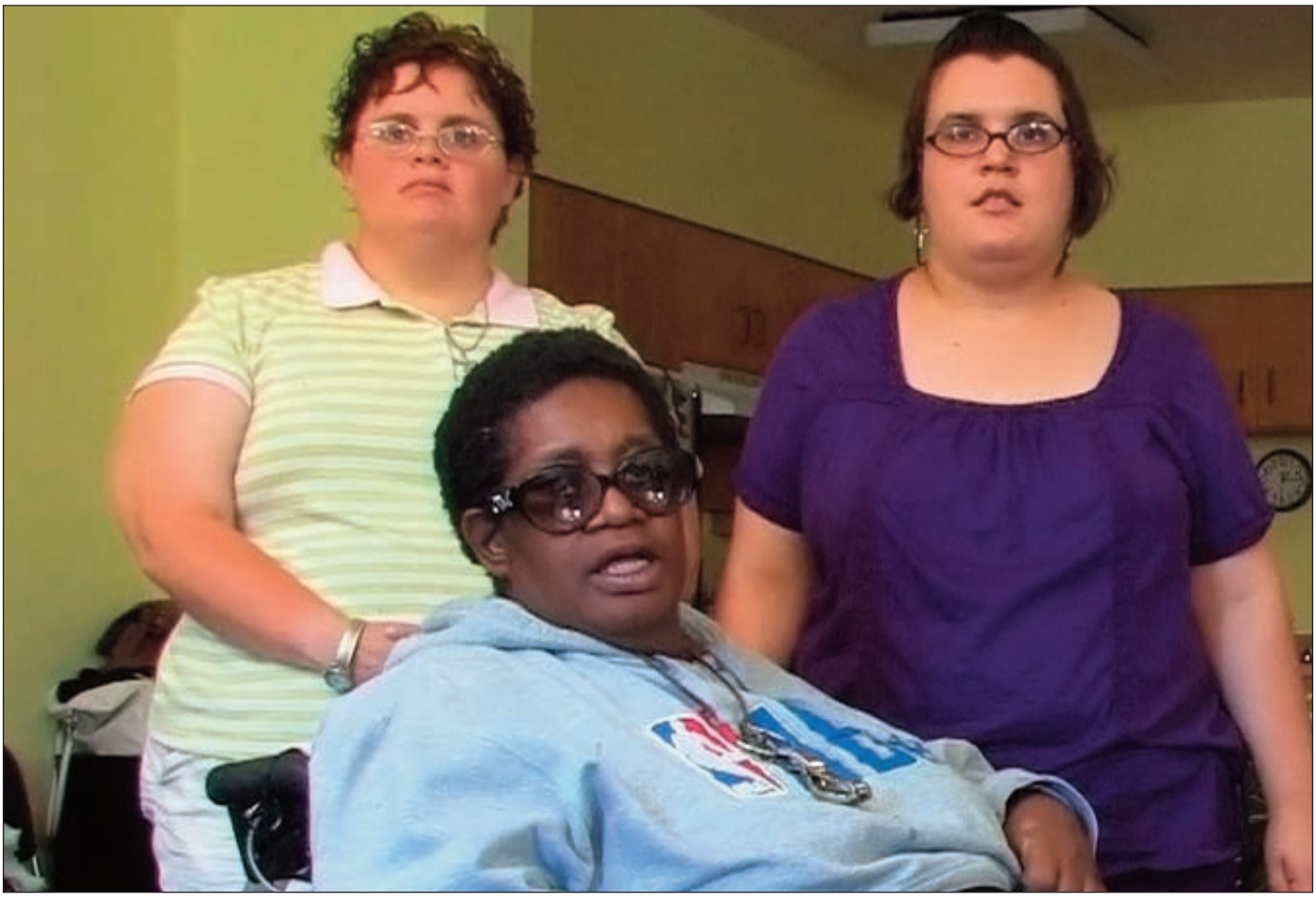
A key theme of the Needs Assessment relates to lack of connection:

1. women with disabilities are not connecting to rape crisis centers, and

2. disability service providers and rape crisis centers are not connecting with each other to serve women with disabilities.

Though both service systems provide a comprehensive menu of services for the people they serve, we learned that we must capitalize on the strengths of each system to create an integrated response to women with disabilities who experience sexual violence.

THE NEEDS ASSESSMENT HELPED US SEE THE NEED FOR COMMUNITY-LEVEL COLLABORATION MODELS TO ENSURE THAT RAPE CRISIS CENTERS AND DISABILITY PROVIDERS WORK TOGETHER TO SERVE WOMEN WITH DISABILITIES WHO EXPERIENCE SEXUAL VIOLENCE.



Strategic Planning

Based on the Needs Assessment, we approached the strategic planning process with a focus on several key outcomes.

- Build a survivor-centered, best practice, collaborative response system that engages both the disability provider and the rape crisis center in responding to a woman with a disability who reports sexual violence.

- Include and empower women with disabilities in every aspect of the systems' changes to be achieved through this project.

- Identify key elements of response protocol to women with disabilities who experience sexual violence, and develop models for implementation in local communities. Embed models within local collaborations via technical assistance and/or mandates/standards.

- Adopt training requirements and policies to build confidence and competence of rape crisis centers in responding to women with disabilities in partnership with a disability provider agency to meet the presenting needs of the survivor.

- Adopt training requirements and policies to build confidence and competence of disability service providers in recognizing sexual violence and responding in partnership with a rape crisis center to meet the presenting needs of the survivor.

- Promote universal access to rape crisis services via removal of barriers related to physical access, communication, attitude, and transportation.

Achieving these outcomes became the focus of our strategic planning process, and we developed goals and a work plan to achieve those outcomes.

GOAL 1: Foster collaboration among disability service agencies and rape crisis centers in Illinois communities.

Strategy – Develop collaboration teams in five test sites to: work collectively on local responses to women with disabilities who experience sexual violence, and to test/evaluate Illinois Imagines' products.

GOAL 2: Ensure best practice response to women with disabilities who experience sexual violence by ensuring: accessibility of rape crisis centers and trauma informed response by disability agencies.

Strategy – Conduct reviews of rape crisis centers and disabilities agencies.

Disability Responsiveness Reviews – Conduct accessibility reviews with rape crisis centers in five test sites and subsequently with all Illinois rape crisis centers.

We want rape crisis centers to improve their accessibility in relation to all aspects of disability services. This includes physical access, communication, attitude, comfort and competence of workers and geographic access.

Trauma-informed Responsiveness Reviews – Conduct trauma-informed reviews with disability service providers in five test sites and begin roll-out of statewide review with all disability service providers.

We want disability service agencies to develop a more trauma-informed response to women with disabilities. "Trauma-informed" refers to workers' awareness of sexual violence; indicators of sexual violence and impact on survivors; appropriate initial response to disclosure; positive relationships with rape crisis centers and willingness to make a referral.

GOAL 3: Make women with disabilities who experience sexual violence aware of their rights and options.

Strategy – Develop, distribute and promote outreach messages and strategies for service providers to use to make women with disabilities aware of their rights and options in the event of sexual violence.

GOAL 4: Develop public policy changes and initiatives to enhance safety and trauma recovery for women with disabilities who experience sexual violence.

Strategy – Research and review current policy (including statutes, rules, policies, standards and other guidelines). Identify areas to change and to develop new policy. The resulting blueprint will: recommend new and revised policy; build consensus and the momentum toward change; and establish a sustainable collaboration group(s) to continue policy review/change into the future.

Section 3
Women with Disabilities and Sexual Violence

Women with Disabilities and Sexual Violence

Women with Disabilties and Sexuality

When asked what they want everyone to know about them and their sexuality, women with disabilities made these statements.

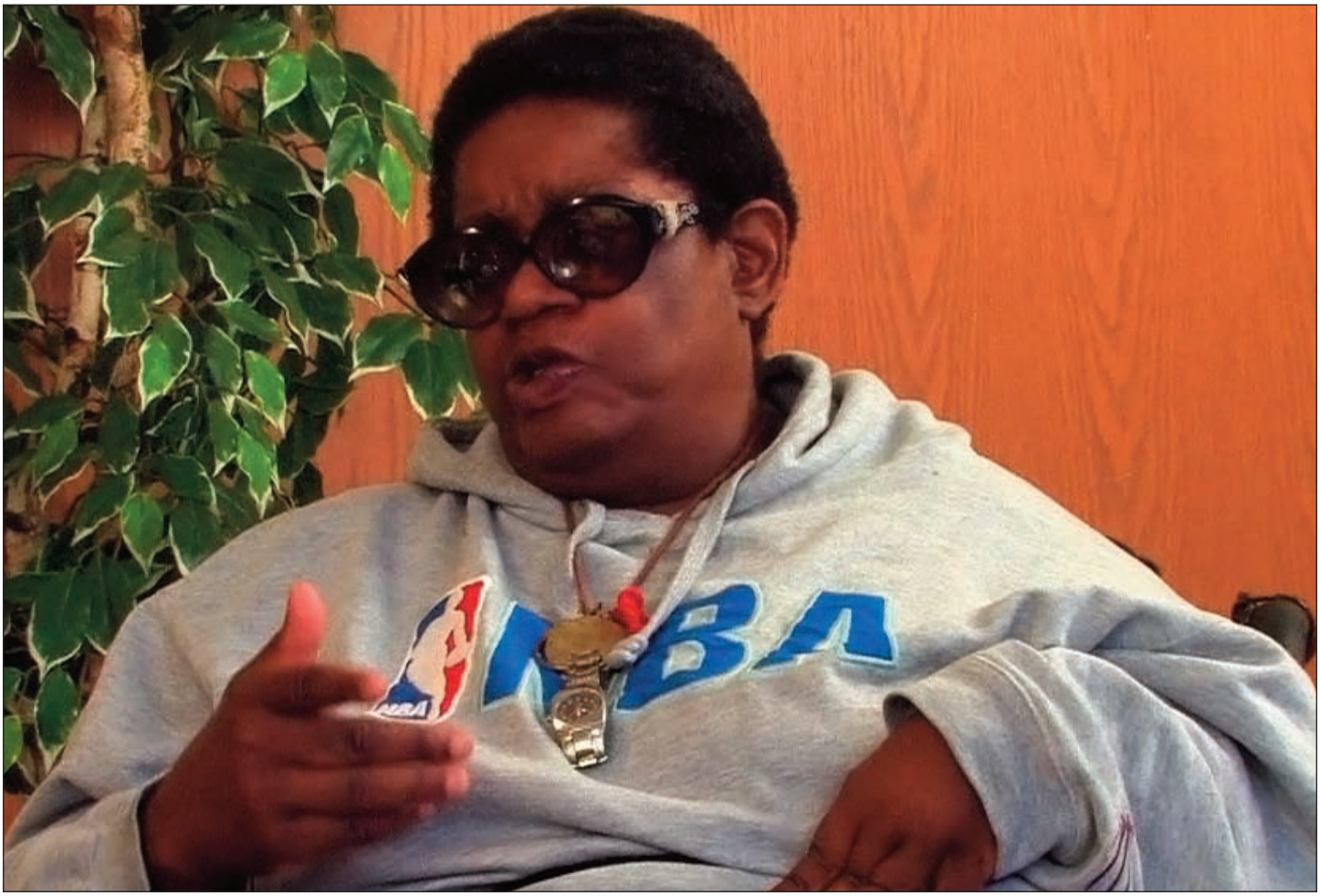
- **I am a human being, just like everyone else.**
- **I am a sexual being, just like everyone else.**
- **I am not a child, I am an adult.**
- **My sexuality is a human right, not a legal one.**
- **I have the right to information, community participation, private sexual expression, boundaries in personal care and relationships, and a full life.**

As advocates and providers of services and support, perhaps our greatest responsibility is to listen to the words of women with disabilities whose lives are affected by our actions. Including women with disabilities in setting policy and rules which affect their access to information and opportunities for full inclusion in a safe and meaningful life is essential to our work in supporting survivors of sexual violence. We must also be willing to look at our own values and assumptions about human sexuality and not place judgments on others just because they may look, think, or sound a little different than we do.

Sexuality is the totality of each person including: gender identity and orientation; how I feel about myself; what kind of person I am attracted to; what makes me laugh, cry, ponder; how I like to dress; my anatomy; how I feel about my body; how I relate to and with others; what I experience as sexual pleasure; what I have experienced as harmful sexual events in my life; my experiences as a daughter, sister and/or parent; and my current age. Human sexuality is as unique as each human being, depending on many social, physical, cultural and individual factors. For many people, coming to fully appreciate ourselves as a sexual being can be quite a journey. For women with disabilities, the journey can be treacherous.

In order to move toward healthy sexuality, a woman needs to understand her own personal power. She needs to be able to express her life experiences and the myriad feelings associated with her life story. Understanding that any feelings of shame or confusion about her sexuality are related to how she has been treated rather than who she is can be very life-changing.

Women with disabilities have often been denied critical information about human sexuality and even about relationships. This happens for many reasons. One reason is the segregation that still occurs in our schools. Special education students are often denied sex education and even violence prevention classes. This lack of critical information about human anatomy, sexuality, rights, and relationships leaves students vulnerable for abuse of all kinds. In addition, the myth that people with disabilities are asexual leads to a denial of appropriate education as well as lack of exposure to social opportunities. We all learn through experience so when those experiences are denied, we lack the information we need to understand who we are in relation to others and the world. Some women with disabilities have not even had preventive gynecological exams because of assumptions made by family members and medical professionals.



Sexual Violence Against Women with Disabilities

Since women with disabilities have been segregated from society at large, and denied traditional opportunities for education, employment and other social interactions they are at an increased risk for sexual assault. Their risk is increased because they may be physically vulnerable and isolated from information, services and support. Because of this, women with disabilities experience sexual violence at a disproportionate rate and are at a greater risk for repeat victimization and multiple perpetrators.

The term sexual violence refers to any act (verbal and/or physical), that is non-consensual and is sexual in nature. The term “sexual violence” includes sexual abuse or assault by a date, acquaintance, partner, caregiver, stranger or family member. It also includes sexual harassment, exposure, voyeurism and sexual exploitation. Sexual contact becomes abusive when a person is unable to consent to an activity, does not consent, and/or when a service provider engages in any sexual contact with a client. Victims/survivors of sexual violence can be forced, coerced, and/or manipulated into participating in sexual activity. Adults with disabilities who have been sexually assaulted may have experienced sexual victimization as an adult, may be adult survivors of childhood abuse, or may have experienced sexual abuse both in their childhood and as an adult.

Incidence of Sexual Violence

1. Within the past decade researchers have studied and published re: violence against people with disabilities. Most research underscores the problem of violence against people with disabilities and stress the vulnerability of people with disabilities to being abused and exploited:

2. Any type of disability appears to contribute to higher risk of victimization, but intellectual disabilities, communication disorders and behavioral disorders appear to contribute to very high levels of risk, and having multiple disabilities results in even higher risk levels (Sullivan and Knutson, 2000.)

3. Women with disabilities are at similar or increased risk for abuse compared to women without disabilities. (Brownridge, 2006; Martin et.al., 2006; Nosek et. al., 2001; Powers et. al., 2002).

4. Women with disabilities experience increased severity of violence (Brownridge, 2006; Nannini, 2006; Smith, 2008), multiple forms of violence, including disability-targeted violence (Curry, et. al. 2003; Martin, et. al., 2006), and experience the violence for longer periods of time (Nosek, et. al., 2001).

Dependence on the perpetrator for personal assistance adds to the cost and complexity of the survivor/perpetrator relationship (Copel, 2006).

Even when a report is attempted, people with disabilities face barriers when making statements to the police because they may not be viewed as credible due to having a disability (Keilty and Connelly, 2001).

Impact of Sexual Violence

Sexual violence can be a deep and life-altering event with broad impact, touching many life domains. When responding to survivors the importance of physical and emotional safety is paramount. The complaints, behaviors and symptoms that victims of sexual violence may exhibit may actually be coping mechanisms acquired to deal with the trauma. A program's readiness to meet the particular needs of women with disabilities can affect their engagement with services and influence treatment outcomes. With safety, support and resources, victims can learn to cope positively with their experience of sexual violence.

Responding to Sexual Violence Against Women with Disabilities

When we consider the denial of information, exposure, and experience and combine it with the high incidence of sexual violence against women with disabilities, it is obvious that the effects can be devastating. In providing a compassionate, proactive, person-centered response to women with disabilities who experience sexual violence, it is important to understand each woman's history of oppression, segregation, and denial of basic rights.

We want to support survivors to be fully whole in every aspect of their lives. This potential can be fulfilled with our support in:

- ❍ providing facts;
- ❍ creating a safe place for expression;
- ❍ accepting each person as a human being with rights and possibilities;
- ❍ empowering each person to make choices and use her voice on their own be half; and
- ❍ supporting each survivor in recognizing and totally embracing herselves as capable, strong, sexual, beautiful and worthy.

Sexual violence takes away a victim's sense of control and her connection to herself, others, and the world around her. Helping a victim regain a sense of control over her own life and re-connect with herself and others in a positive way is central to recovery. This is done through focusing on the victim's strengths, providing information,

exploring options and resources, supporting choices and empowering each survivor to help plan her own response and recovery.

This requires collaboration between the disability service provider and the rape crisis center. Disability workers are the most likely to observe indicators of sexual violence and/or receive a disclosure. The rape crisis center worker is the best prepared to provide a crisis response, advocacy counseling and other services related to sexual violence. In order to provide the best response, the disability service provider needs to be trauma responsive and the rape crisis worker needs to be disability responsive. This will be covered in greater detail in Modules 2 and 3. Following is a summary of the qualities of trauma responsiveness and disability responsiveness.

Disability Responsiveness

Rape crisis workers are trained to be trauma responsive. They may need additional training and experience to become disability responsive. The following actions are disability responsive:

- ❍ Recognize the high prevalence of sexual violence and the level of underreporting among women with disabilities.
- ❍ Assess and remove barriers that prevent women with disabilities from receiving rape crisis center services.
- ❍ Conduct outreach to women with disabilities and their support systems (family members, guardians, service providers).
- ❍ Identify and respond to communication needs.
- ❍ Collaborate with service agencies on protocols to provide prompt, victim-centered, supportive response.
- ❍ Train staff regarding disability humility and disability competence to build staff knowledge and comfort with women with disabilities.

Trauma Responsiveness

Disability agency workers are trained to be disability responsive. They may need additional training and experience to become trauma responsive. The following actions are trauma responsive:

- ❍ Recognize the high prevalence of sexual violence and the level of underreporting among women with disabilities.
- ❍ Assess and remove barriers that prevent women with disabilities from disclosing sexual violence.
- ❍ Conduct outreach to women with disabilities and their support systems (family members, guardians).
- ❍ Collaborate with rape crisis centers on protocols to provide prompt, victim-centered, supportive response.
- ❍ Train staff to believe women with disabilities who experience sexual violence and to respond with compassion.
- ❍ Train staff who work with women with disabilities to help a woman who discloses sexual violence to connect the with rape crisis center.
- ❍ Train staff who work with women with disabilities to incorporate healthy sexuality and healing from sexual violence into existing service plans.

Section 4
Creating a Local Collaboration

Creating a Local Collaboration

Why Collaborate?

At both the statewide and local levels, Illinois Imagines is grounded in collaboration. Though we may regard it as jargon or something we are required to do for funders, it is essential to achieve the vision of this project. In fact, a woman with a disability who experiences sexual violence will only receive a useful response if those who work with her most (disability service providers) and those who work with sexual assault victims (rape crisis centers) are in a collaborative partnership. If a community collaboration among all disability agencies and the local rape crisis center exists, everyone knows what to do and how to work together to provide the best possible response to the victim.

What is Needed to Create a Local Collaboration?

Collaboration requires a several key elements:

- Willing partners
- Mutual respect for partners' strengths and assets
- Mutual respect for partners' differences in mission and approach
- Commitment to develop a relationship among partners that is focused on the woman with disabilities as the first priority
- Willingness to resolve differences with solutions focused on women with disabilities

These elements may seem both obvious and impossible. Yet, if all parties come together with a primary focus on serving women with disabilities who experience sexual violence, collaboration will work.

Where Do We Start?

ASSEMBLE A TEAM

Bring together disability service agencies with the local rape crisis center and women with disabilities. Factors to consider when identifying potential team members include: areas of influence, level of staff, past history of working together collaboratively, areas of ability and stakeholders.

Send invitations and make follow-up telephone calls to get maximum participation. Ask that key policy makers or program managers from each agency — those in a position to support system change — attend collaboration meetings. Membership size should be conducive to the development of collaborative working relationships (8–15 members).

ESTABLISH THE FUNDAMENTALS

Begin with concrete tasks to establish the purpose and operations of the collaboration. This will create buy in. Some of the basic beginning tasks include:

Agree on Purpose

- ❍ Agree on a vision and mission.
- ❍ Identify values.
- ❍ Assess strengths and possible contributions of all partners.

Set Ground Rules

- ❍ Identify leadership.
- ❍ Decide where and when you will meet.
- ❍ Decide who will write and distribute notices, agendas and minutes.
- ❍ Decide on your decision-making process (e.g., consensus, Roberts Rules of Order).

Ensure Accessibility

- ❍ the meeting site(s) should be physically accessible,
- ❍ make meeting materials accessible,
- ❍ arrange for communication needs to be met (e.g., interpreter), and
- ❍ ensure people with wheelchairs can move around comfortably.

Provide Comfort

- ❍ Try to create a comfortable environment.
- ❍ Try to meet in a room with windows.
- ❍ Provide coffee or other refreshments or meet over lunch.
- ❍ Do whatever you can to set the scene for pleasant, enjoyable meetings.

ADOPT A CHARTER

Write a charter to guide your collaboration. The charter spells out your fundamentals so each current and prospective member knows what you are about and how you work (see Tool #4, Sample Charters).

BUILD RELATIONSHIPS

You can do a variety things to help build relationships among collaborative partners, ncluding:

- ❍ Visit each other's facilities (e.g., rotate meeting sites).
- ❍ Provide an opportunity for each member of the collaboration team to make a brief presentation about his/her agency, its primary issue area, its services and how it works.
- ❍ Engage in team building activities.
- ❍ Build understanding of and respect for each other's systems and the intersection between violence and disabilities.
- ❍ Anticipate that conflict will arise among team members at some point and stay committed to addressing conflict in a respectful manner. If there is agreement on everything, the team should consider whether difficult issues are being fully addressed.

We all know that getting any job done is about people and relationships. No matter what a grant or program plan or strategic plan says, the work will only get done if the people want to do the work. In the instance of collaboration, people only work together if they feel connected and invested in one another. Team building activities may initially feel forced or silly, but they help build bridges. Laughter, shared experience and compassion for one another can all build the connections that are essential to collaboration (see Tool #3, Sample Team Building Activities).

What Do We Do Now?

Needs assessment is the place to start.

You've probably already figured out a lot about needs just by being in a room talking together. Clarify what you know already and what you need to study further. Some key questions to answer at this stage include:

- **?** How do workers in disability agencies and rape crisis centers know what to do when a woman with a disability experiences sexual violence?
- **?** What happens in our community when a woman with a disability experiences sexual violence?
- **?** Who does she tell? Who reports to law enforcement, Office of Inspector General, and the rape crisis center?
- **?** How will she get rape crisis services?
- **?** How does she get to the police department, emergency department, rape crisis center, court? Who goes with her?

This is not an academic research project. Keep it simple. Ask local providers (e.g., collaboration members) and local women with disabilities. Write down what you find. Identify gaps and places where women fall through the cracks. Name the barriers to a holistic, victim-centered response.

> "If you raise up truth, it's magnetic. It has a way of drawing people."
>
> *Jesse Jackson*

What's Next?

Strategic planning is the next step. This is the heart of it. When you get this far, celebrate. Then, write a strategic plan. It does not have to be fancy. Just a clear, outcome-oriented guide to what you will do – individually and collectively – to make the system in your community work for women with disabilities who experience sexual violence.

The plan should bring you closer to your vision, and be manageable, measurable and sustainable. The plan should include benchmarks where you can stop and measure your progress. A good strategic plan will be anchored in steps that yield sustainable systems change. To achieve long-term success, change must not be contingent on today's individual champions (or collaborative team members), but instead be embedded in the community response. For example, integration of better practices into agency policies and procedures will have a wider reach and longer impact than one-time staff training.

This is where you identify which agency will do what by when to help women with disabilities who experience sexual violence. Your strategic plan should respond to your needs assessment by telling what you will do to address barriers you identified.

- ❍ What changes are needed to remove barriers faced by women with disabilities who experience sexual violence?
- ❍ What steps need to occur first? What is the best way to sequence the work so the each steps builds on each other?
- ❍ How will we promote organizational buy-in?
- ❍ Who has the capacity to achieve each change?
- ❍ What is a realistic timeline to achieve the changes?
- ❍ What resources (e.g., training, supplies, change agents, etc.) are needed to achieve the changes?
- ❍ How will you know if you were successful?
- ❍ Does the plan reflect the team's core values and mission?

- ❍ Will the plan make a difference in the lives of women with disabilities who experience sexual violence?

- ❍ Does the plan incorporate steps that will lead to sustainable change

Keep it simple and concrete. (See Tool #6 for a Sample strategic plan.)

Is the Collaboration Over?

No way! When you finish the strategic plan your collaboration is just beginning. Now you start to work together in addition to thinking together.

This is where you find out if your ideas and plans lead to change. Start to keep track of key information such as the following:

- ❍ Changes in agencies' policies to promote disability/trauma responsive services.
- ❍ Number of hours of cross-training among agencies.
- ❍ Number of women with disabilities referred to rape crisis centers by disability providers.
- ❍ Number of women with disabilities served by rape crisis centers.
- ❍ Feedback from women with disabilities regarding experience with both disability agencies and rape crisis centers.

Decide how often you need to meet to continue reviewing outcomes and identify solutions. Reach out to other agencies that could benefit from the collaboration.

How Do We Know This Will Work?

Illinois Imagines selected five model sites around the state to test the materials created for this kit. We chose these sites for geographic and demographic diversity. Each site created a collaboration and did every step we just described. Each of these model site teams has been working together since November 2008 and has committed to ongoing collaboration. And they are making a difference in the lives of women with disabilities! Remember the fundamentals:

❍ Assemble a team ❍ Establish the fundamentals
❍ Adopt a charter ❍ Build relationships
❍ Conduct a needs assessment ❍ Write a strategic plan
❍ Keep working together

SECTION 5
TOOLS

Overview Guide Tools

"We, the ones who are challenged, need to be heard. To be seen not as a disability, but as a person who has, and will continue to bloom. To be seen not only as a handicap, but as a well intact human being."

Robert M. Hensel

Tool 1: Definitions and Acronyms

Definitions

Advocacy – The act of directly representing or defending others; championing the rights of individuals or communities through direct intervention or through empowerment.

Access and Accessibility - Individuals with disabilities will be able to utilize the same services as individuals without disabilities. Full access means being able to obtain these services without physical barriers, cultural barriers, communication barriers, attitudinal barriers, and programmatic barriers.

Advocate – Person who helps someone else get what they need or want.

Caregiver – Individuals who provide support to another person who is ill, has a disability or needs some help. Caregivers provide assistance with daily living activities and support staying in the home.

Center for Independent Living (CIL) – CILs are non-residential, consumer-controlled, community-based, not-for-profit organizations that provide systems advocacy to create options and choices for independent living. CILs provide services to individuals to help them in increasing skills and abilities for independent living and provide public awareness. Core services provided by all CILs include advocacy, peer counseling, skills training, information and referral.

Civil No Contact Order (CNCO) – A protective order (stay away order) for sexual assault victims in Illinois who do not have a relationship with the perpetrator.

Community Integrated Living Arrangement (CILA) – A CILA is a combination of supports and services individually tailored for an adult with developmental disabilities. The CILA client may live in his or her own home, in a family home, or in a community setting with no more than seven other adults with disabilities. The primary goal of CILAs is to help the individual become more independent in daily living, more involved in his or her own community and more economically self-sufficient.

Cultural Humility – Practice of both being aware of cultural differences and developing partnership between service provider and client that permits respectful exploration of similarities, differences, particular needs of the client and provider capacity to respond to those needs.

deaf – This term refers to individuals with severe to profound hearing loss. The lowercase "d" reflects a physical or audiological perspective.

Deaf – The term "Deaf" is defined by the individuals who consider themselves a part of Deaf culture. The capital "D" reflects this socio-cultural point of view. Individuals who self identify as Deaf may or may not self identify as a person with a disability.

Department of Human Services Division of Developmental Disabilities – The Division of Developmental Disabilities is responsible for coordinating the State's response to the needs of all people with developmental disabilities in the state. Services include pre-admission screening, service linkage and coordination, in-home support services, residential services, day services and therapies.

Department of Human Services Division of Mental Health – The Division of Mental Health (DMH) is responsible for coordinating a comprehensive array of public and private mental health services for adults with mental illnesses and children and adolescents with serious emotional disturbances. The DMH coordinates and assures the provision of public funded mental health services through a network of community mental health centers/agencies, community hospitals with psychiatric units and state operated hospitals. Within this structure, the DMH funds services that include crisis intervention, psychiatric services, community-based case management, supported and supervised residential services and psychosocial rehabilitation programs.

Department of Human Services Division of Rehabilitation Services (formerly DORS) – The Division of Rehabilitation Services (DRS) operates offices in communities throughout the state, as well as three residential schools serving students with disabilities, and a residential training facility for adults who are blind or visually impaired. The major programs offered through DRS are the Vocational Rehabilitation (VR) program, and the Home Services program (HSP). DRS programs are designed to serve individuals who have disabilities that have a significant impact on their ability to work and to live independently in the community.

Developmental Disability (DD) – Developmental conditions must be in evidence before the age of 22, be expected to last indefinitely, and result in substantial functional limitations in three or more of six major life activity areas. Developmental disabilities include cerebral palsy, autism, epilepsy and cognitive disabilities.

Development Training (DT) – Work skills training for people with development disabilities, generally provided in a central location during weekdays.

Disability – The following definition of disability from the World Health Organization is consistent with the collaboration teams' belief system: "disability is not something that a person has but, instead, something that occurs outside of the person – the person has a functional limitation. Disability occurs in the interaction between a person, his or her functional ability, and the environment. A person's environment can be the physical environment, communication environment, information environment, and social and policy environment."

Disability Provider Agency – Local, community-based provider of direct services to people with disabilities, usually focused on developmental disabilities, physical disabilities or mental health.

Dual Diagnosis – A person who has two diagnoses, e.g. both a developmental disability and a mental illness or both a mental illness and physical disability.

Empowerment – Providing information and resources to help someone exercise more power and control about their own lives.

Guardian – A person appointed by the court when a person with disabilities cannot make or communicate responsible decisions regarding personal care and/or finances. A guardian makes decisions about medical treatment, residential placement, social services and other needs.

Guardian Ad Litem – An attorney or lay person appointed by the court to advocate for the best interest of a person with disabilities. The guardian ad litem may interview the person with disabilities, inform the person of his or her rights, and investigate the appropriateness of guardianship.

Hard of hearing – This term refers to individuals who experience hearing loss from a physical or audiological perspective. An individual who is hard of hearing may primarily use spoken language (their residual hearing and speech) to communicate.

Individual Program Plan (IPP) – A person-centered plan which outlines the services and supports for a person with a developmental disability. May also be called an ISP (Individual Service Plan) or an IHP (Individual Habitation Plan).

Individual Treatment Plan (ITP) – A plan that details the services and supports for a person with mental illness.

Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) – People with developmental disabilities who live in the community and have support staff 24 hours a day who help them stay safe while learning new skills.

Illinois Coalition Against Sexual Assault (ICASA) – Statewide non-profit association of local rape crisis and prevention centers. ICASA administers funds to and monitors local centers, conducts training, sets policy/standards.

Illinois Department of Human Services (DHS) – State agency responsible for:
1) administering funds, establishing standards, and monitoring services to women with developmental disabilities and mental illness through community based providers via the Division of Developmental Disabilities and the Division of Mental Health and
2) providing direct services to women with disabilities via the Division of Rehabilitative Services.

Leader (also referred to as consultant) – person with a developmental disability that takes part in Network and Statewide Advocacy Council meetings. A leader can also choose to show their skills by speaking in front of a bigger group.

Order of Protection (OP) – A protective order (stay away order) for domestic violence victims in Illinois who have a relationship with the perpetrator.

Personal Assistant – Services provided by individuals who are selected, employed and supervised by the person with a disability. These individuals may assist with or perform household tasks, personal care and, with the permission of a physician, certain health care procedures.

Psychosocial Rehabilitation (PSR) – A day program for persons with several mental illnesses.

Rape Crisis Center (RCC) – Community-based agency providing a specific set of services to sexual assault victims, their significant others and community. Services must include 24-hour hotline, 24-hour medical/criminal justice advocacy, counseling, public education, professional training, institutional advocacy and information and referral. Services are free and confidential and are protected via state statute specific to sexual assault survivors.

Required Reporters – Any individual who suspects, witnesses, or is informed of abuse or neglect and employed by any agency licensed, funded, monitored or otherwise under the authority of the Department of Human Services that provides services to individuals with developmental disabilities or mental illness

Respect – means to care about others and to treat them nicely.

Responsibility – means to be able to answer for your actions or decisions, to be able to choose between right and wrong.

Rule 50 – State law (commonly referred to as "Rule 50") authorizing the Office of the Inspector General to promulgate rules establishing minimum requirements for reporting and conducting investigations into alleged abuse/neglect.

Sexual Assault Nurse Examiner (SANE) – a registered nurse (R.N.) who has advanced education and clinical preparation in forensic examination of sexual assault victims.

Sexual Assault Survivors Response Team (SART) – specially trained professionals (typically includes the SANE, law enforcement, rape crisis center advocate or counselor, and emergency department medical personnel) who provide a community coordinated response to sexual assault.

Sexual Assault Emergency Treatment Act (SASETA) – Illinois law that governs the healthcare that hospitals are required to provide to sexual assault survivors, establishes a statewide forensic evidence collection system, and creates a reimbursement program for the cost of care and evidence collection for victims who are not covered by private insurance or Medicaid.

Self-Advocate – person who speaks up for himself or herself and may choose to speak up on behalf of others as well.

Sexual Violence – Any act (verbal and/or physical), which is non-consensual and is sexual in nature. The term "sexual violence" includes date, acquaintance, partner, caregiver, stranger, family member. It also includes sexual harassment, exposure, voyeurism and sexual exploitation.

State Operated Facility – Residential institution operated by the state for people with disabilities.

The System – The system of agencies responding to women with disabilities and survivors of sexual violence in Illinois.

Woman with Disabilities – woman who has a developmental disability, physical disability, mental illness and/or who is Deaf/hard of hearing.

Acronyms: What It Means

Agencies

AG	Attorney General
CIL	Center for Independent Living
DCFS	Illinois Department of Children and Family Services
DHS	Illinois Department of Human Services
DOJ	Department of Justice
ICASA	Illinois Coalition Against Sexual Assault
ICF/DD	Independent Care Facility for Persons with Developmental Disabilities
IDHS	Illinois Department of Human Services
IDPH	Illinois Department of Public Health
OIG	Office of Inspector General
OVW	Office on Violence Against Women
VAWA	Violence Against Women Act
VOCA	Victims of Crime Act

Others

CILA	Community Integrated Living Arrangement
CNCO	Civil No Contact Order
DD	Developmental Disability
DT	Developmental Training
GAL	Guardian Ad Litem
IPP	Individual Program Plan
ITP	Individual Treatment Plan
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning
OP	Order of Protection
PSR	Psychosocial Rehabilitation
RCC	Rape Crisis Center
SANE	Sexual Assault Nurse Examiner
SART	Sexual Assault Response Team
SASETA	Sexual Assault Survivors Emergency Treatment Act
SOF	State Operated Facility

Tool 2: Cultural Humility Resources

DISABILITY HUMILITY: A NEW WAY OF THINKING

By Amy Walker, Illinois Voices

When it comes to working with people with disabilities, "cultural" and "disability competence" have been the working models on which to base services. Cultural and disability humility are relatively new approaches, which incorporate tenets of cultural and disability competence but add a focus on the support workers.

1. **"Disability Competence"** means that support workers know about all types of disabilities and disability issues before they ever work with people who have them. This is an offshoot of "cultural competence," which means that support workers know about all cultures of people they may encounter on the job and the issues that people from these different cultures face. The extensive knowledge and training of the support worker comes before working with people.

2. **"Cultural and Disability Humility"** means that support workers learn about disabilities and cultures from the people they work with *while* they're working with them, and not necessarily in advance. Disability humility means that support workers examine themselves, their perceptions of people with disabilities, their biases and possible misconceptions, and their own vision in regards to the goals of the person they're serving. The humility aspect of this approach acknowledges that the worker is not the expert on the culture/disability and says "it is okay to inquire." This gives the support worker permission to invite the woman with disabilities to state what she needs in relation to accessibility. The table on the next page lists a few of the differences between these two concepts.

Disability Competence

- Identifies support workers as "experts."

- Support workers need to be pre-trained extensively in disability etiquette issues, nuances, terminology, sensitivities and characteristics BEFORE they can work with people with disabilities. ("We can't have staff saying or doing the wrong thing").

- Pushes support workers to have mastery of vast catalog of cultural/ disability attitudes.

- Support workers could inadvertently rely on "veritable laundry lists of traditional beliefs and practices ostensibly characteristic of particular ethnic [and disability] groups." (Denise Bissonette).

- Could promote stereotyping and treating all people of a particular culture or with a disability as part of the same group.

- Focus on training process and content specific.

Disability Humility

- The person served is the "expert" and helps to inform support workers about unique characteristics and needs.

- Support workers need to evaluate themselves and their perceptions of people with disabilities, their biases and possible misconceptions. They must be willing to do this and do not need extensive training in all disability issues before serving people who have disabilities.

- Affirms that it is okay for support workers to inquire about client needs related to disability.

- Instead of learning long lists of characteristics related to various cultural and disability groups, support workers learn about the disability and culture from each individual person they support.

- Treats every person of a different culture or with a disability as a unique individual.

- Support workers are humble, inquisitive, open, ready to learn.

- Lifelong, "real-life" learning process. Mutual respect and understanding between person/support worker.

DISABILITY HUMILITY FOR EMPLOYERS: A FRAMEWORK FOR TRAINING

By Rob McInnes

Cultural Competence

Prior to the introduction of the Cultural Humility perspective, the predominant paradigm for addressing cultural differences in health care systems was “cultural competence”. The Cultural Competence paradigm posits that, in order to well-serve people from different cultures, all health care workers need to be extensively pre-trained and informed on the etiquette issues, cultural nuances, terminologies, and sensitivities of each diversity group that might be represented by any particular client or coworker.

While this is certainly a well-intentioned objective, this approach has some major problems associated with it.

The sheer amount of information that would have to be acquired and assimilated by each worker is so extensive that it is really impractical on a system-wide basis. (It has been suggested that cultural competence presents “veritable laundry lists of traditional beliefs and practices ostensibly characteristic of particular ethnic groups.”)

While focusing on the development of an information base for each health care worker, this approach tends to overlook the inherent cultural biases of the workers themselves. This approach also leaves little room for exploring the extent to which any particular individual is influenced by, or representative of, the generalized characteristics attributed to the cultural group that they belong to. The cultural competence model may, in fact, actually reinforce cultural stereotyping.

Cultural Humility

As an alternative approach, the concept of Cultural Humility has been gaining widespread acceptance. Rather than promoting the acquisition of an extensive informational inventory, it advocates that health care workers learn both to reflect on the biases of their own “cultures” and to engage in highly individualized and respectful interactions with each client – a mutually enlightening exchange, a resourceful partnership that recognizes the unique experiences, traits and perspectives that each patient brings to the clinical encounter.

My partner, Denise Bissonnette, recently wrote some brilliant articles on Cultural Communication and her thoughts are very consistent with the argument for the Cultural Humility approach:

"During the melting pot era, however, what I witnessed in others and exemplified myself, was that in our attempt to achieve "cultural sensitivity" we instead practiced "cultural assumptiveness." For example, it was generally agreed upon that most of the folks coming from Indochina would likely agree to anything one asked of them in order to maintain harmony in the situation, the Ethiopians were highly educated, assertive and articulate who would bring a freshness to any job they did, while the Romanians were a hard-working, industrious and ambitious lot… and the cultural stereotyping went on and on.

Through trial and error, what I later came to understand is that learning about a particular culture did not necessarily shed much light on what I needed to learn about the individual. In fact, most of the time it only got in the way! I hated to think that anyone from outside the U.S. would presume to understand me based on what they think they know about Americans, and I realized that it was important to extend the same courtesy to people from other cultures. This is equally true of disability, ethnicity, nationality, and every other dimension of diversity! Within each of these categories there is such a fantastic range of experience and individual distinction, such that anything we think we know about that group should best be put aside." (See True Livelihood Newsletter, November 2006 http://www.diversityworld.com/Denise_Bissonnette/TLN06/TLN0611.htm)

Disability Competence

There is a strong parallel between Cultural Competence and much of the way we have approached the education of employers on disability issues. Well-meaning, but perhaps somewhat arrogantly, we have too often asserted that employers should all be well-versed in all the different types of disability, varieties of accommodations and legal minutiae.

Overtly or subtly we have suggested that, in order to successfully employ people with disabilities, employers must be experts in disability e.g. they must have high levels of Disability Competence. Since most employers, particularly small business owners, know that they will never have the time to develop that competence, they may consequently conclude that they can never effectively employ people with disabilities. With a focus on Disability Competence, we can discourage, rather than encourage, employers to be more proactive about adding people with disabilities to their work-forces.

Disability Humility

As an alternative to Disability Competence, a Disability Humility approach to training employers would empower and support them to interact with people with disabilities with inquisitiveness and an open mind. An employer who is able to come to the table humbly (willing to be open, inquisitive, creative and respectful), is likely to be an effective employer of people with disabilities – more so than one that only comes well-armed with the "book learning" of disability types, demographic studies, proper etiquette, and accommodation strategies. With a clear understanding of their own biases and confidence in their ability to engage in an open and productive dialogue with people with disabilities, employers can drop their pretences about being well-informed, their fears about being politically incorrect, their feelings of social awkwardness, and simply have honest conversations with people with disabilities that are likely to engage and enlighten both parties.

Many materials already exist to help employers understand the misconceptions and biases that are likely part of their disability perspective. (The "Pick a Disability" module in the Windmills attitudinal training program is a great tool.) Beyond that, employers also need to be helped to overcome their reluctance and discomfort in interacting with people with disabilities. Certainly disability etiquette training can help, but I would advocate opportunities more like the "Encounters" program that I have run – which gives employers the occasion to engage collaboratively with people with a variety of disabilities.

Happily, many people who conduct disability training sessions already underline their training with; "Remember to treat everyone with a disability as a unique person – not as part of a particular group." This need to focus on the specific individual is integral to the Disability Humility approach. "We don't come in teams" as my friend Lance Dawson used to say. As someone who was blind, Lance knew from personal experience how erroneous it was to lump people with disabilities (even with the same disabilities) together.

Personally, I have also always favored training formats that maximize the opportunities for employers to actually meet and interact with people with disabilities. I believe it is the most effective way to dismantle barriers and make way for productive interpersonal dialogue between employers and people with disabilities. (See the Power of Presence http://www.diversityworld.com/Disability/DN06/DN0611.htm.) That is probably one of the main reasons why I am so enamored with the concept of Disability Humility.

Remember, It Takes Two…

Disability Humility is really a two-way street. It can't work effectively unless people with disabilities are just as ready to put aside their stereotypes about employers, their expectations that employers should be disability experts, and any "shoulder chips" that they carry from past experiences. It demands an honest attempt by the person with a disability to understand and appreciate the position of the employer and the culture that they operate within. There is a lot of work to be done by education programs, disability organizations and workforce development programs to prepare people with disabilities to effectively engage in dialogues based on Disability Humility.

As we seek to empower employers to more readily hire and more effectively employ people with disabilities, I believe that the concept of Disability Humility holds a lot of promise. It represents a conceptual framework within which we can better tune and hone the informational content that we direct at employers and the educational seminars that we engage them in. I hope that it captures your imagination as much as it has mine…

~ Rob McInnes

If you are interested in further exploring the notion of Cultural Humility, these two articles are a good place to begin:

Article: Beyond Cultural Competence http://www.parkridgecenter.org/Page1882.html

Article: Are You Practicing Cultural Humility? – The Key to Success in Cultural Competence
http://www.cahealthadvocates.org/news/disparities/2007/are-you.html

Tool 3: Team Building

Initial Collaboration Meetings

The following activities set the stage for collaboration and are essential in early team meetings. It is crucial that the collaboration members have an overview of the project goals and also begin to develop a trust of one another and the organizations they represent. Throughout each meeting, emphasize the importance of the collaboration process and systems change.

Ground Rules

A key to a respectful meeting is the establishment of ground rules. Brainstorm, record ideas on a flip chart and establish agreement on the rules that will guide your work together. Think about the membership of your collaboration team. Group rules can empower all individuals to contribute and correct any potential power imbalance, i.e. self-advocates working with executive directors on the team. Additionally, solid rules for working together can minimize conflict and expedite group process. The following are samples of rules that can help create the necessary chemistry for a successful meeting.

- ❍ Keep focused on what's important – why we are here
- ❍ Avoid "hallway meetings" – deal with things in meetings; be direct and open
- ❍ Respect privacy
- ❍ Keep in touch, communicate
- ❍ Appreciate differences and diversity
- ❍ Take action
- ❍ Be practical
- ❍ Follow through and honor commitments
- ❍ Suspend old assumptions and "think together"
- ❍ Honor experiences and embrace change
- ❍ Regard each other as colleagues
- ❍ Look for shared interests, not positions
- ❍ Master the practice of dialogue and discussion
- ❍ Be quick to listen

Collaborative Values

Embracing shared ideas can reinforce your collaboration. You can arrive at your own list of values by brainstorming, recording values on a flip chart and identifying those that are embraced by all members. Think about factors that motivate team members to be a part of the collaboration or speak to the importance of the work. Consider values that will guide how the team will work together as well as direct project activities. Below is a sample list of values.

- Embrace diversity and individualism
- Radical
- Hopeful
- Tenacious
- Do what's right
- Fluid
- HLAM (harm less, affirm more)
- Be students and teachers (dual role)
- Non-judgmental
- Empowering
- Straight forward (no hidden agenda)
- Survivor driven
- Motivating/inviting/appealing
- Real and practical
- Respectful
- Flexible

It is beneficial to record the shared values. The core values provide the foundation for decision-making, conflict resolution, strategic planning and other team interactions and activities. Additionally, the recorded list of values can be pulled out as a reminder during difficult times.

Strenghts and Contributions

In order to further integrate team members into the group near the end of the first meeting, it is helpful to ask each team member to share what they consider to be a strength that they can bring to the group and the areas where they feel they will provide a primary contribution. Consider both individual and agency strengths. Sample questions may include: "What resources does your agency have that could benefit our work together?" "Think about your individual skills, knowledge, experience and relationships. What do you think you can contribute to the group?" Be sure to move the discussion beyond subject matter expertise to bring out individual interests and characteristics. You can utilize this in a read around method. Examples of strengths people may identify follow.

- ❍ Access to specific provider agencies
- ❍ Access to statewide advisory council
- ❍ Creativity
- ❍ Insight
- ❍ Daily contact with women with disabilities
- ❍ Willing to take chances
- ❍ Writing skills
- ❍ Passion
- ❍ Knowledge of legislators
- ❍ Knowledge of public policy
- ❍ Access to individuals in nursing homes
- ❍ Access to peer counselors
- ❍ Access to Community Mental Health Centers
- ❍ Knowledge of Dual Diagnosis Issues
- ❍ Autonomy
- ❍ Training
- ❍ Understanding disability and sexual violence
- ❍ Access to self-advocates
- ❍ Access to rape crisis centers
- ❍ Policy
- ❍ Critical analysis
- ❍ Focused, task oriented
- ❍ Understanding issues: women and disabilities
- ❍ Work experience with sexual violence
- ❍ Public speaking skills
- ❍ Fresh set of eyes
- ❍ Challenge the system: Why not?
- ❍ Feminist philosophy

The list of strengths and contributions can be used to match individuals to assignments in future meetings. One key to promoting ongoing commitment to the group is engaging team members in authentic tasks which align with their personal and professional interests and expertise.

Meeting Structure

YOUR FIRST MEETING

- ❍ Introductions
- ❍ Ice Breaker
- ❍ Pass Around Membership Roster
- ❍ Establish the General Rules
- ❍ Discuss Charter, Vision Statement and Mission
- ❍ Identify Agencies to Recruit
- ❍ Discuss Leadership. Identify Chair/Co-chairs
- ❍ Schedule Next Meeting(s)
- ❍ Distribute Materials

YOUR SECOND MEETING

- ❍ Introductions
- ❍ Ice Breaker
- ❍ Select Chair/Co-Chairs
- ❍ Discuss Charter and adopt, if possible. (see Tool #4)

FOR EVERY MEETING

Logistics

- ❍ Pre-meeting – Send Meeting Notice/Reminder
- ❍ Agenda and Sign-in Sheet
- ❍ Meeting Minutes
- ❍ Refreshments

Content

- ❍ Build rapport and team connection
- ❍ Work on strategic plan – development and implementation (see Tool #5)

Closing Each Meeting

At the end of each meeting it can be useful to take a few minutes and allow each member to express their thoughts or feelings about the progress in one word. This continues to elicit buy in and interaction among the group and ends each meeting with an open thought process. Conduct this either as a “go-around” or “popcorn” style activity.

Meeting Icebreakers and Closing Activities

My Memoir

Purpose: Opening icebreaker activity to help participants become acquainted.

Time: 20 minutes (depending on the size of the group).

Instructions:

1. Identify the purpose of the activity.

2. Ask participants to think of how they would like to be remembered after they die. Another way of framing it is to consider what you would like to say in your memoir.

3. Now ask participants to share their obituary or memoir in SEVEN WORDS only.

4. Give a few examples:
   "Fell in love. Let her slip away."
   "Made lots of money. Lost it all."
   "Did good work, had fun, loved all."

My Big Blue Bic

Purpose: Opening icebreaker activity to help participants become acquainted.

Time: 20 minutes (depending on the size of the group).

Instructions:

1. Identify the purpose of the activity.

2. Ask participants to think of an adjective that:
   - Describes them in some way; and
   - Begins with the same letter as their first name.

3. Explain that you will start the activity with the ink pen in hand and state, "This is my big blue bic and I'm Fantastic Facilitator. I've been with my agency one year."

4. Select a participant to pass the pen to and instruct participants to state, "This is my big blue bic. That was Fantastic Facilitator, and I'm Peppy Participant…."

5. The blue ink pen will be passed to the next participant who repeats the statement and all participant names prior, before stating their name and background information. The process continues until all have possessed the blue ink pen.

To further self-introductions, participants should also be prepared to provide short background information on themselves.

Materials: Blue ink pen

Two Truths and a Lie

Purpose: Opening icebreaker activity to help participants become acquainted.

Time: 20 minutes (depending on the size of the group).

Instructions:

1. Identify the purpose of the activity.

2. Ask participants to share three statements about themselves with the group; two true facts and one false.

3. As each individual shares their statements, ask the group to guess which statement is false.

Brag on Yourself

Purpose: Opening icebreaker activity to help participants become acquainted or closing activity to facilitate positive group dynamics.

Time: 10 minutes (depending on the size of the group).

Instructions:

1. Identify the purpose of the activity.

2. Ask participants to share a recent accomplishment (big or small) in which they are proud of themselves for achieving.

3. Following, emphasize that celebrating accomplishments is critical to being an effective agent for social change.

Nobody Has All the Candy Bars

Purpose: Opening icebreaker activity to help participants become acquainted or closing activity to facilitate positive group dynamics.

Time: 20 minutes (depending on the size of the group).

Instructions:

1. Identify the purpose of the activity.

2. Ask participants write down the names of all the candy bars they can think of in 60 seconds.

3. Ask for a volunteer to record their list on a flipchart.

4. Following, ask for another person to add from their list any candy bars not listed by the previous person.

5. Repeat until everyone has had a turn. The results will show that no single individual has all the candy bars. Everyone brings something new to the table. It takes everyone to have all the candy bars.

Materials: Flipchart and markers

Life is Good Because….

Purpose: Opening icebreaker activity to help participants become acquainted or closing activity to facilitate positive group dynamics.

Time: 10 minutes (depending on the size of the group).

Instructions:

1. Identify the purpose of the activity.

2. Ask participants to share their ending to the following statement: “Life is good because….”

Rainbow Connection

Purpose: Opening icebreaker activity to help participants become acquainted.

Time: 20 minutes (depending on the size of the group).

Instructions:

1. Identify the purpose of the activity.

2. Provide each participant with an individual snack-size package of colorful candy (i.e. Skittles, M&M's).

3. Choose a topic for each color, for example: Red = books; Green = music; Yellow = sports; Orange = food/drink

4. Ask participants to share one fact about themselves for each color.

Materials: Individual snack-sized package of colorful candy for each participant.

Academy Award Speech

Purpose: Opening icebreaker activity to help participants become acquainted or closing activity to facilitate positive group dynamics.

Time: 20 minutes (depending on the size of the group).

Instructions:

1. Identify the purpose of the activity.

2. Instruct participants to identify an individual who contributed to their professional development.

3. Ask participants to publicly thank their identified individual in the style of an Academy Award speech.

4. Select a talking piece (e.g. pencil, bottle of water) to represent an "Oscar" for participants to hold as they make their speech.

5. Empower the group to begin humming lightly (pick any song) should any individual speech exceed 2 minutes.

Personal Slogan

Purpose: Opening icebreaker activity to help participants become acquainted or closing activity to facilitate positive group dynamics.

Time: 10 minutes (depending on the size of the group).

Instructions:

1. Identify the purpose of the activity.

2. Ask participants to share a personal motto or slogan ("words to live by").

3. Give a few examples:
   "Let it be."
   "Be the change you wish to see in the world."
   "Everything's a thousand dollars."
   "Winner! Winner! Chicken Dinner!"
   "He had it coming!"

Let's Do Lunch!

Purpose: Opening icebreaker activity to help participants become acquainted or closing activity to facilitate positive group dynamics.

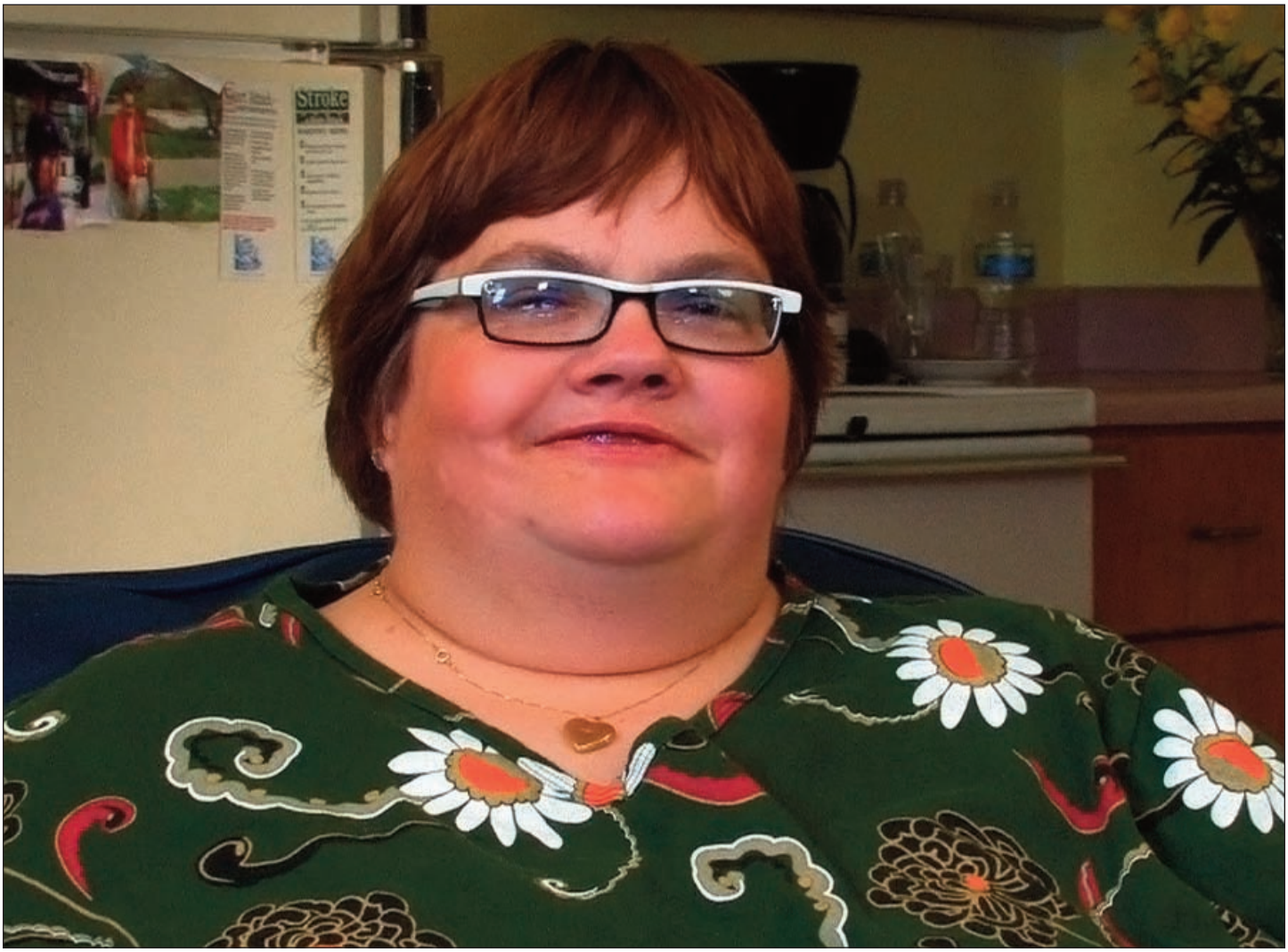
Time: 10 minutes (depending on the size of the group).

Instructions:

1. Identify the purpose of the activity.

2. Ask participants, if given the opportunity to choose an individual to have lunch with, whom it would be and why.

3. Invite folks to share their answers and encourage them to provide additional details (e.g., Going out? Home cooked? Carry-out?)


Stroke

The ABCs of Meetings

By Amy Walker

A is for APPRECIATION of the gifts and strengths of all partners, both together and as separate entities.

B is for BALANCE of everyone's various points of view so that everyone feels listened to and respected.

C is for CLARITY. We're all going to speak in plain language, mean what we say, and say what we mean.

D is for DECISIONS. We're going to make some concrete, doable, clear, and meaningful decisions on how to move forward.

E is for ETHICS. We're going to listen to our own personal codes of ethics and how they would help us proceed in the most harmonious way.

F is for FAIRNESS. We're going to be fair to each other and give each other the benefit of the doubt when we need to.

G is for GROUNDEDNESS. We're all going to remember the basic reason why we're here, first and foremost—to help women with disabilities.

H is for HELP. If any of us has a question or doesn't understand something, we're going to ask for help.

I is for INSIGHTS and IDEAS. We're going to share both and not hold back, even if they come to us in a split second.

J is for JUSTICE. We're going to do what we know and feel is right for the empowerment of the women with disabilities we're trying to support.

K is for KNOWLEDGE. We're going to share what we know and what we need to know in order to move forward.

L is for LEARNING. We're all going to learn many new things about each other and each others' organizations.

M is for MEASURABLE MEASURES. We will give each other assignments and clear action steps to “take it to the next level”.

N is for NEXT STEPS. We’re going to decide what those are, and they will be like stairs that we can climb—steady and supportable.

O is for OPPORTUNITIES. We’re going to take every opportunity we can to speak up, speak out, speak our minds, and speak the truth.

P is for PEACE. We’re going to have a sense of peace about this work.

Q is for QUESTIONS. We will ask questions boldly and unashamedly if we have them.

R is for REASONING. We’re going to discuss the reasoning behind our ideas, plans, and philosophies when we need to.

S is for SUPPORT. We’re going to support each other and struggle together, “for that gives rise to self-reflection”.

T is for TRUTH. We’ll tell it as we see it, no matter what.

U is for UNDERSTANDING. We’ll try our best to understand each other’s perspective, background, logic, and points of view.

V is for VICTORY. Winning comes not by “beating” someone, but by playing our best game.

W is for WONDER. We’re going to reestablish our sense of wonder at the things we’re about to accomplish in Illinois!

X is for X-CELLENCE. That will be our highest goal and standard in whatever we decide to strive for next.

Y is for YES! We can do this!

Z is for ZOOMING into the work with an attitude of confidence, boldness, cooperation, and openness to ...

Tool 4: Collaboration Documents

Statement of Agreement - Sample

Rape Crisis Center
AND
Disability Service Agency

The disability service agency (DSA) and rape crisis center (RCC) consent to the following working agreement. This agreement will be on-going unless terminated in writing by either party. This agreement will serve to provide quality comprehensive service delivery to all survivors of sexual assault in our community.

RCC agrees to:

- Designate a liaison/contact to facilitate on-going communication.
- Provide sexual assault advocates professionally trained and supervised by RCC staff to respond to women with disabilities referred by DSA.
- Conduct in-service training to DSA staff on issues related to sexual assault trauma response annually.
- Supply accessible visual/text materials for public distribution to be displayed in lobbies of DSA.
- Meet with DSA liaison/contact, twice yearly, to evaluate coordination of services.
- Provide technical assistance to DSA on policies and practices related to identification and response to sexual violence.
- Initiate and support survivor involvement in planning, implementation and evaluation of programming.

DSA agrees to:

- ❍ Designate a liaison/contact to facilitate on-going communication.
- ❍ Inform sexual assault survivors about RCC advocacy/counseling services.
- ❍ Facilitate opportunities for RCC staff or trained volunteer to provide crisis intervention, advocacy and counseling services to sexual assault survivors.
- ❍ Conduct in-service training to RCC staff on considerations for providing culturally competent services to women with disabilities annually.
- ❍ Meet with RCC liaison/contact, twice yearly, to evaluate the coordination of services.
- ❍ Provide technical assistance to RCC on policies and practices related to enhancing service delivery to women with disabilities.
- ❍ Initiate and support self-advocate involvement in planning, implementation and evaluation of programming.

RCC

By: _____
Name

_____
Title

_____
Date

DSA

By: _____
Name

_____
Title

_____
Date

COLLABORATION CHARTER (SAMPLE)

Name of Collaboration (e.g., Illinois Imagines)
Date Approved _____

PURPOSE

The Collaboration Charter represents the shared commitments of *number of* community based organizations and/or individuals in *community name* coming together to end violence against women with disabilities and to aid survivors of sexual violence. This commitment begins with the members' promise to promote change within their own organizations and extends to the work in the community at large

The charter membership of the *community name* collaboration is comprised of self-advocates and the following organizations, all of which will play a vital role in the team:

- Mental Health Center *(name)*
- Developmental Disability Service Agency(ies) *(name)*
- Rape Crisis Center *(name)*
- Rehabilitation Services *(name)*
- Center for Independent Living *(name)*
- Other agencies serving women with disabilities *(name)*
  (e.g. substance abuse provider, homeless shelter, etc.)

Individually, each organization provides direct intervention, support, advocacy and recovery oriented services for individuals with disabilities or survivors of sexual violence. Collectively, this group of providers joins together as one unit to develop an integrated system of service delivery specific to meeting the needs of individuals with disabilities who are survivors of sexual violence. It is an inter-connected system whose actions will strengthen the response and service system for the survivors, their families and the community.

VISION

All survivors of sexual violence or abuse who have disabilities will have access to high quality, integrated supports that are person-centered and responsive to the distinct needs of each individual.

MISSION

The Collaboration together with survivors of sexual violence will:

- ❍ Learn of the distinct needs from survivors with disabilities.
- ❍ Develop and strengthen partnerships to meet the needs of those survivors.
- ❍ Promote practices that recognize and support survivors.
- ❍ Remove obstacles faced by women with disabilities who are seeking services as survivors of sexual violence.
- ❍ Educate survivors about their rights.

CORE VALUES

The Collaboration is committed to working together in agreement of the following values:

Accountability – We believe we must hold ourselves, and each other, responsible for our commitments to survivors with disabilities.

Collaboration – We believe collaboration is the most effective method of response to sexual violence against women with disabilities in our community. We will act together to combat the problem of sexual violence in our community and the effect of such violence on women with disabilities.

Respect – We believe each individual has the right to be treated with dignity and respect, including the right to confidentiality. We are committed to following this as a guiding principle in all of the efforts we undertake.

Survivor- driven – We believe service provision should always recognize, honor and reflect the experience and needs of victims and survivors of sexual violence.

Empowering – We believe all individuals are resilient and capable of achieving full potential. As such, we believe each individual is capable of making decisions regarding their own lives, including speaking and acting on their own behalf and advocating in their own best interest.

Unity – We believe that sexual violence is not a problem that can be addressed by single entities. It is OUR problem and we will combat the problem together.

Forward driven – We believe we should learn from and build on the lessons learned in the past while always working to improve the response of our community to the issues we confront. We are committed to being continually proactive, not reactive, in addressing the issues of sexual violence against women with disabilities.

ROLES AND RESPONSIBILITIES OF EACH MEMBER

Each member of the *Collaboration (name)* agrees to the following responsibilities:

- **Participate** in collaboration meetings.
- **Strive** toward achieving our vision.
- **Share** agency and system-specific expertise and knowledge.
- **Reflect** on and unlearn personal bias, judgments and attitudes.
- **Engage** in open, honest and fair communication.
- **Share** the work and result of this project with members of each respective organization and/or peer groups.
- **Incorporate** the best practices learned through this project in each respective organization and/or peer groups.
- **Educate** other community organizations and/or peer groups of the impact of sexual violence in the community
- **Advocate** for and support survivors of sexual violence.
- **Support** systems change in their agency and the community at-large.

DECISION MAKING

Our Collaboration will strive to achieve unanimous decisions about the issues that affect us and the actions we choose to implement.

The following is the process for decision making/problem solving:

1. Identify the problem.
2. Brainstorm all of the possible ways to solve the problem.
3. Evaluate the advantages/disadvantages of each of the possible solutions.
4. Choose a solution that has more advantages than disadvantages.

If the process for decision making/problem solving does not result in a unanimous decision, a formal vote shall be taken and the majority will rule.

COLLABORATION STRUCTURE

MEMBERS:

The Collaboration will be comprised of representatives from the community based organizations and women with disabilities and/or women who are survivors of sexual violence who are committed to this project.

New agencies and women with disabilities may join the Collaboration upon agreement of all the members. Membership size will be conducive to the development of collaborative working relationships (8 – 15 members).

LEADERSHIP:

The group will be governed by a chair selected from the project participants. The chair(s) will convene and facilitate meetings.

DUTIES:

Duties of all collaboration members include active participation in the meetings, work toward accomplishment of the project goals. Group members may have work tasks pertaining to this project outside of the regularly scheduled meetings.

MEETINGS

Typically, the team will meet one time per month for two hours. The meetings are scheduled for the second Thursday of each month, but may be adjusted to respond to needs of members.

WORK PLAN

The collaboration team will develop a work plan that reflects the team's survivor-driven philosophy and is based on information obtained from the statewide needs assessment conducted by the Illinois Imagines statewide workgroup. This work plan will be a fluid document and modified as needed to ensure that the project is responsive to the needs of women with disabilities and maintains the integrity of the team's vision, mission and values.

COLLABORATION MEMBERSHIP ROSTER – [insert date]

NAME	POSITION/	AGENCY	ADDRESS	PHONE	E-MAIL
				( )	
				( )	
				( )	
				( )	
				( )	
				( )	
				( )	
				( )	
				( )	

MEETING SIGN-IN SHEET

COLLABORATION NAME:

MEETING DATE:

NAME	CENTER/ORGANIZATION

Tool 5: Needs Assessment

Needs Assessment Questionnaires and Surveys

THE ASSESSMENT SURVEYS

The following tools can be used by local collaborations to provide a baseline understanding of the policies in place, training level, staff understanding and commitment against sexual violence against women with disabilities by each individual agency in the collaboration. There are two sets of tools for this assessment. Focus group questionnaires are to be completed by women with disabilities, staff at disability service agencies and rape crisis centers. Surveys are to be completed by staff at disability service agencies and rape crisis center staff. The assessments are best conducted by a third party, outside the collaboration team. Though this is not essential to success.

> “Disability is a matter of perception. If you can do just one thing well, you're needed by someone.”
>
> *Martina Navratilova*

DISABILITY SERVICE AGENCIES INTERVIEW QUESTIONS FOR FOCUS GROUPS

1. Has your agency served any women with disabilities during the past year that disclosed a history of sexual violence or reported a recent incidence?

2. What have you learned from working with women with disabilities who have experienced sexual violence? What went well? What could be improved? What are the barriers, if any, this agency faces when working with women with disabilities who have experienced sexual violence?

3. Does your agency have polices and procedures around responding to women with disabilities who disclose sexual violence? If not, why not? If yes, please describe agency response to sexual violence including client safety, offender issues, reporting, and linkage to services. If yes, please share an example of a policy which makes it easier/more difficult to serve women with disabilities. If yes, how are the policies enforced? *Move discussion beyond rule 50 reporting. Get a copy of policy.*

4. How comfortable or confident do you feel responding to disclosures and/or working with survivors of sexual violence? What do you need to feel more comfortable with identifying and responding to sexual violence against women with disabilities?

5. Describe any training you have received about how to identify and respond to sexual violence against women with disabilities. What topics were covered? How long was the training?

6. Is your agency networking and communicating on a regular basis with local rape crisis centers? Describe your relationship and any joint activities including training, community outreach, referrals, and formal linkage agreements.

7. What are the barriers, if any, when working with local rape crisis centers? What are the successes you have experienced when working with local rape crisis centers?

8. Do you have the resources necessary to respond to sexual violence against women with disabilities? If not, what more do you need? Training? Policies? Connections with rape crisis centers? Help with building collaboratives with rape crisis centers?

WOMEN WITH DISABILITIES INTERVIEW QUESTIONS FOR FOCUS GROUPS/INDIVIDUAL INTERVIEWS

1. What would make you or someone you know trust someone else to tell her/him that you were sexually abused?

2. Raise your hand if you or someone you know would trust a (fill in with list below) to tell them about sexual abuse.

   _____ Family member
   _____ Friend
   _____ Staff (disability service, sexual assault)
   _____ Caregiver
   _____ Police
   _____ Other person

   Note to Recorder: Record approximate number for each.

3. Do you think that service providers working with women with disabilities should ask women whether they have been sexually assaulted? Would this be a good way to help victims? When should this be done?

4. If you or someone you know were sexually assaulted, what would you want to happen? What kind of response would be helpful? What can disability service providers do? Mental health centers? Sexual assault centers?

5. Do you feel you know what resources are available to get assistance for sexual violence? If sexual assault centers want to talk to women with disabilities, where should they go to talk about services? What do you think would work to get more women to go to sexual assault programs?

6. If you or someone you know wanted to access sexual assault services, what do you think would work best? What obstacles do you think may stand in the way?

7. Are there rules to help you if you are sexually abused? How did you learn about the rules? Are the rules followed where you live? Where you work? *Provide examples of rules.*

8. What advice would you give about how to better serve women with disabilities who have experienced sexual violence? Disability providers? Sexual assault?

RAPE CRISIS CENTERS INTERVIEW QUESTIONS FOR FOCUS GROUPS

1. Has your agency served any women with disabilities during the past 2-3 years? If yes, what types of disabilities did the women report? i.e. cognitive, physical, mental illness. What type of disability is reported most often?

2. What have you learned from your experiences in providing services to women with disabilities? What went well? What could be improved? What are the barriers, if any, this agency faces when working with women with disabilities who have experienced sexual violence?

3. Does your agency have policies and procedures around serving women with disabilities? If not, why not? If yes, please share an example of a policy which makes it easier/more difficult to serve women with disabilities. If yes, how are the policies enforced? Get a copy of policy.

4. How comfortable or confident do you feel working with women with disabilities who are survivors of sexual violence? What do you need to feel more comfortable with identifying and responding to sexual violence against women with disabilities?

5. Describe any training you have received about ways to serve women with disabilities who have experienced sexual violence? What topics were covered? How long was the training?

6. Is your agency networking and communicating on a regular basis with local agencies serving women with disabilities? If yes, what types of disability service providers are represented i.e. employment workshops, CILAs, advocacy organizations, community mental health centers. Describe your relationship and any joint activities including training, community outreach, referrals, and formal linkage agreements.

7. What are the barriers, if any, when working with local disability services providers? What are the successes you have experienced when working with local disability services providers?

8. Do you have the resources necessary to work with women with disabilities? If not, what more do you need? Training? Policies? Accommodations support? Connections with disability organizations? Help with building collaboratives with agencies that serve women with disabilities?

RAPE CRISIS CENTER STAFF SURVEY

Hello. Thank you for filling out this survey. A group of local disability services organizations and the local rape crisis center are conducting surveys to assess services for women with disabilities who are victims of sexual violence. Our goal is to improve services for women with disabilities who experience sexual violence. Your participation in this project is invaluable, and we thank you for taking part in this project.

SURVEY QUESTIONS FOR RAPE CRISIS CENTERS

1. How big of a problem do you believe sexual violence is for women with disabilities?

Huge				Minor
5	4	3	2	1

2. Do you know what agencies in your community serve women with disabilities?

❑ Yes ❑ No ❑ Don't Know

3. Is your agency networking and communicating on a regular basis with local agencies serving women with disabilities?

❑ Yes ❑ No ❑ Don't Know

If Yes, please identify the type of agencies. *Check all that apply.*

❑ Community Mental Health Centers
❑ Centers for Independent Living
❑ Vocational Services (job training, supportive employment, sheltered workshops)
❑ Community Residential Services (CILA, Intermediate Care Facility, group home)
❑ Other: _____

In general, how would you rate your relationship with local agencies serving women with disabilities?

Collaborative		Cooperative		Detached
5	4	3	2	1

4. Has your agency served any women with disabilities during the past 2-3 years?

❑ Yes ❑ No ❑ Don't Know

If yes, what types of disabilities did the women report? *Check all that apply.*

❑ Cognitive ❑ Physical ❑ Mental Illness ❑ Don't Know ❑ Other:_____

If yes, what was the most common type of disability reported?

❑ Cognitive ❑ Physical ❑ Mental Illness ❑ Don't Know ❑ Other:_____

5. How frequently do you think your program provides advocacy for sexual abuse/assault survivors with disabilities?
❑ Never ❑1-2x annually ❑ 3-6x annually ❑ Monthly ❑ Weekly

6. Does your agency have policies and procedures in place around serving women with disabilities? If yes, what areas are covered? *Check all that apply.*
❑ Accessibility of services
❑ Providing reasonable accommodations for survivors using your services
❑ Training and use of TTY and Relay Operator procedures
❑ Recruiting, hiring and working with American Sign Language interpreters
❑ Survivors who use personal attendants or service animals
❑ Alternative formats for written materials
❑ Advocacy for survivors with mental illness, cognitive, and physical disabilities
❑ Coordination of services with disability service providers
❑ Hiring practices regarding applicants with disabilities
❑ Other: _____

7. In the past 2-3 years, has your agency made any changes in policies and procedures to accommodate a survivor with a disability?
❑ Yes ❑ No ❑ Don't Know

If yes, in what area: _____

8. How comfortable are you with working with women with disabilities?

Very				Not at all
5	4	3	2	1

How prepared are you to provide services to women with disabilities who experience sexual violence?

Very				Not at all
5	4	3	2	1

What additional knowledge or skills are needed? *Check all that apply.*
❑ Disability awareness and sensitivity
❑ Identifying and serving women with cognitive disabilities
❑ Identifying and serving women with mental illness
❑ Identifying and serving women with physical disabilities
❑ Local and state resources for women with disabilities
❑ Independent living philosophy
❑ Communicating with persons who use alternative devices
❑ Strategies for increasing accessibility
❑ Other: _____

9. How many hours of mandatory staff training on sexual violence and women with disabilities does your agency have in a year?
❑ 0 ❑ 1-5 ❑ 6-10 ❑ over 10

DISABILITY SERVICE AGENCY STAFF SURVEY

Hello. Thank you for filling out this survey. A group of disability services organizations and local rape crisis center are conducting surveys with service providers to assess services for women with disabilities who are victims of sexual violence. Our goal is to improve services for women with disabilities who experience sexual violence. Your participation in this project is invaluable, and we thank you for taking part in this project.

SURVEY QUESTIONS FOR DHS SERVICE PROVIDERS

For purposes of this survey, sexual violence means non-consensual or coercive sexual conduct. Sexual violence includes any unwanted behavior or contact of a sexual nature, from sexual harassment/bullying to sexual assault.

1. How big of a problem do you believe sexual violence is for women with disabilities?

Huge				Minor
5	4	3	2	1

2. Do you know what agencies in your community serve women with disabilities who have experienced sexual violence??

❑ Yes ❑ No ❑ Don't Know

3. Is your agency networking and communicating on a regular basis with local rape crisis centers?

❑ Yes ❑ No ❑ Don't Know

In general, how would you rate your relationship with local rape crisis centers?

Collaborative		Cooperative		Detached
5	4	3	2	1

4. Has your agency served any women with disabilities who have disclosed a history of sexual violence or reported a recent incident during the past 2-3 years?

❑ Yes ❑ No ❑ Don't Know

If yes, who was the offender? *Check all that apply.*

❑ Peer ❑ Guardian ❑ Staff ❑ Community member ❑ Other ❑ Don't know

5. How frequently do you think your agency responds to sexual abuse against women with disabilities? *Response includes reporting, referrals to rape crisis centers or counseling programs, advocacy, etc.*

❑ Never ❑ 1-2x annually ❑ 3-6x annually ❑ Monthly ❑ Weekly

6. Does your agency have policies and procedures in place around serving women with disabilities who have experienced sexual violence? If yes, what areas are covered? *Check all that apply.*

❑ Screening for sexual violence
❑ Reporting
❑ Referrals to rape crisis centers
❑ Coordination of services with rape crisis centers
❑ Training on sexual violence
❑ Advocacy for survivors with mental illness, cognitive, and physical disabilities
❑ Victim safety and offender services
❑ Background checks on job applicants for possible history of sexual violence
❑ Other: _____

7. In the past 2-3 years, has your agency made any changes in policies and procedures to enhance identification and response to sexual violence against women with disabilities?

❑ Yes ❑ No ❑ Don't Know

If yes, in what area: _____

_____

8. How comfortable are you discussing sexual violence with women with disabilities?

Very				Not at all
5	4	3	2	1

How prepared are you to provide services to women with disabilities who experience sexual violence?

Very				Not at all
5	4	3	2	1

What additional knowledge or skills are needed? *Check all that apply.*

❑ Awareness and identification of sexual violence
❑ Responding to sexual violence
❑ Local and state resources for women with disabilities who experience sexual violence
❑ Implications of sexual violence on program planning
❑ Implications of sexual violence on policy development
❑ Other: _____

9. How many hours of mandatory staff training on sexual violence and women with disabilities does your agency staff have in a year?

❑ 0 ❑ 1-5 ❑ 6-10 ❑ over 10

10. How many times each year does the sexual assault center conduct training with your agency staff?

❑ 0 ❑ 1 ❑ 2 ❑ 3+

11. Do you have outreach efforts that target women with disabilities who have experienced sexual violence?
❑ Yes ❑ No ❑ Don't Know

12. Does your intake tool include questions to screen for sexual violence?
❑ Yes ❑ No ❑ Don't Know

Do you have educational materials about sexual assault available for women with disabilities?
❑ Yes ❑ No ❑ Don't Know

13. Are women with disabilities involved in policy and program decisions in your agency?
❑ Yes ❑ No ❑ Don't Know

If yes, how? *Check all that apply.*
❑ Board members
❑ Hiring of staff
❑ Training of staff
❑ Committees
❑ Needs assessment: surveys, focus groups
❑ Evaluation of services
❑ Other: _____

14. Do you feel your agency has the resources needed to serve women with disabilities who have experienced sexual violence?
❑ Yes ❑ No ❑ Don't Know

If not, what is needed? *Check all that apply.*
❑ policy ❑ training ❑ physical accommodations support ❑ interpreters
❑ educational materials for women with disabilities ❑ peer support programs
❑ specialized staff ❑ linkage with sexual assault center
❑ other, specify: _____

15. Are there any comments or suggestions you would like to make regarding responding to sexual violence against women with disabilities? *Please comment below.*

_____

_____

_____

Tool 6: Strategic Planning

STRATEGIC PLANNING QUESTIONS

When conducting strategic planning, design the plan to respond to needs you learned about in the needs assessment. Following are some key questions to help with strategic planning.

- What did the needs assessment tell us about gaps and barriers?
- How do the systems work? How could they work better?
- How will we ensure full access to integrated services?
- How can we facilitate referrals for women?
- How do we maintain our focus on people (survivors)?
- How will we get individual agencies and practitioners to change?
- How do we make it work on the ground level where the people get services?
- How do we get the message to the field?
- How will we get the message to women with disabilities and the community?
- How can we make activities creative, positive, high impact – spin positive?
- What are our timelines?
- Are the action steps ordered properly? What groundwork must be in place?
- What resources do we need?
- How does change happen in each organization? How do these changes compliment each other?
- How are we going to sustain the work?
- How do we sustain ourselves? Commitment, passion, etc.

STRATEGIC PLAN (sample)

Collaboration Team: _____

Date: _____

Goal 1: Continue local collaboration team work.

Activities	Who	When
Meet six times per year to review progress, plan new initiatives and coordinate services to women with disabilities who experience sexual violence.	Collaboration team	

Goal 2: Ensure accessibility of rape crisis services and mutual referral among team member agencies.

Activities	Who	When
Draft working agreements between all team agencies	Collaboration team	
Secure Executive Director signatures on the working agreements.	Agency Leaders	
Review/update agreements yearly.	Team Members	

Goal 3: Launch campaign to announce the collaboration team and its vision/goals to the community. Direct toward victim awareness.

Activities	Who	When
Develop event/activities to engage public about disabilities and sexual violence (information fairs, gala event, etc.).	Collaboration team	
Promote launch event (write and distribute press release and flyers.	Public Relations Committee (Ad Hoc)	
Prepare or purchase materials for launch event (e.g., brochures, posters, information cards, key chains).	Public Relations Commitee Collaboration team	
Hold event		

Goal 4: Utilize the Illinois Imagines Toolkit to enhance local work.

Activities	Who	When
Review the Illinois Imagines Toolkit as a team.	Collaboration team	
Discuss sample policies and procedures regarding how to respond to people who disclose sexual violence.	Collaboration team	
Consider recommended policies and procedures for approval and implementation.	Directors of disability service agencies	
Identify physical, attitudinal and informational barriers within rape crisis centers and develop remedies.	Directors of rape crisis centers	

Goal 5: Assure ongoing cross-training among team members.

Activities	Who	When
Provide in-service trainings for rape crisis center employees about disabilities and accessibility.	Collaboration team Disability service agencies	
Provide in-service trainings for disability service organizations about sexual assault and rape crisis center services.	Rape crisis center director and educator(s)	
Assure that self-advocates are included in all training events, as participants and/ trainers.	Collaboration team	
Annually review training needs/ opportunities and schedule joint and mutual trainings.	Collaboration team	

Goal 6: Reach out to women with disabilities regarding availability of rape crisis center services.

Activities	Who	When
Disability organizations will display brochures/materials about the rape crisis center.	Disability service agencies	
The rape crisis center will participate in events sponsored by other team member organizations.	All team members to invite rape crisis center. Rape crisis center will send staff/materials to event	

Goal 7: Educate women with disabilities regarding sexual assault awareness and prevention, their rights and reporting sexual assault.

Activities	Who	When
Select curriculum from Illinois Imagines Toolkit.	Collaboration team	
Schedule trainings.	Collaboration team	
Conduct trainings.	Rape crisis center educator(s) in cooperation with disability services agency staff and women with disabilities	

Notes:

Notes: