Guide for Disability Service Agencies

Illinois Imagines Project

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Section 1
Introduction

Introduction

What will You Find in this Guide?

1. **Creating the Environment** – Process and tools to enhance the "Trauma Responsiveness" of the disability service agency and conduct outreach with the rape crisis center.

2. **Training Your Staff** – Guidance to create an environment where women with disabilities feel safe to disclose sexual violence and workers provide a victim-sensitive, empathic response.

3. **Responding to Sexual Violence** – Guidance regarding how to respond to indicators or disclosures of sexual violence.

4. **Training Handouts** – Handouts to accompany training sessions.

5. **Tools** – Additional resources to support your response.

Disability service agencies understand disabilities and how to work with women with disabilities to meet their various, individual needs. Yet, workers may feel unprepared to respond to indicators of sexual violence or disclosures of sexual violence by the women they serve. Since women with disabilities experience sexual violence at a disproportionate rate, it is critical for their primary support workers to be prepared to respond effectively.

This guide will help a disability service agency

- **engage in self-evaluation;**
- **enhance outreach and connection with the local rape crisis center;**
- **prepare staff to serve women who experience sexual violence; and**
- **enhance the crisis response to indicators and/or disclosures of sexual violence.**

Be sure to read the other sections of this Toolkit as you work to enhance your center's response to women with disabilities.

Terminology

(See 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. The 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), that 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
CREATING THE ENVIRONMENT

Creating the Environment

Introduction

In order to serve women with disabilities who experience sexual violence, the disability service agency needs to accomplish two goals:

1. **Be trauma responsive** – To achieve this goal, the disability service agency needs to be aware that it may need to make some adaptations to respond to sexual violence. To find out what adaptations are needed, the disability service agency needs to conduct a trauma responsiveness assessment. The agency may also need to adapt policy specific to responding to sexual violence.

2. **Collaborate with a rape crisis center** – In order to respond to women with disabilities who experience sexual violence, the disability service agency needs to be aware of sexual violence and its impact on survivors. One way to learn about sexual violence and respond effectively to indicators and/or disclosures of sexual violence is to conduct outreach with the local rape crisis center. Collaboration with the rape crisis center can facilitate cross training and development of response protocols.

Be Trauma Responsive

SELF-ASSESSMENT

To enhance trauma responsiveness, the disability service agency can begin with self-evaluation. The Trauma Responsiveness Assessment (see Tool #1) is designed to help the disability service agency evaluate its responses, both formal and informal, to women with disabilities who experience sexual violence. The Assessment will identify how the agency responses are

- designed to increase identification of sexual violence;
- based on understanding of the trauma affects of sexual violence;
- designed to reduce traumatic effects;
- directed toward sensitive response and empowerment of women with disabilities who experience sexual violence; and
- coordinated with the rape crisis center.

To conduct the Trauma Responsiveness Assessment, use Tool #1 at the end of this module. The best way to use this tool is to invite partners from your collaboration to help you conduct the assessment. Whether you conduct the assessment yourself or in concert with an ally, the tool provides you with guidance about areas of strength and areas where enhancement is needed.

RESPOND TO ASSESSMENT FINDINGS

After the assessment, the agency can use findings from the assessment to develop a plan to better serve women with disabilities who experience sexual violence. The goal of this plan will be to ensure that the agency is engaged in meaningful change. The plan can be simple and direct – save your energy for the actual work required to implement changes. See Tool #2 for a sample action plan. Some areas of focus might include:

- ❍ Build staff understanding of the high prevalence of sexual violence among women with disabilities and the level of underreporting.
- ❍ Plan for agency action to resolve barriers that prevent women with disabilities from disclosing history of sexual violence and/or current experience of sexual violence.
- ❍ Plan to enhance staff's capacity to provide an empathic, supportive response to an incident/disclosure of sexual violence.
- ❍ Ensure victims of sexual violence are offered a referral to a rape crisis center.
- ❍ Remove barriers to rape crisis services by assisting with accommodations and transportation for women with disabilities.
- ❍ Collaborate among service agencies to respond in ways that are victim-centered, supportive and designed to inform and empower the survivor to lead her own response and recovery process.

REVIEW AND REVISE AGENCY POLICY

It is useful to review all agency policies and procedures to assess whether agency policy helps workers respond effectively to women with disabilities in relation to sexual health. Policy can aid workers in responding to observations and/or disclosures of sexual violence. For sample policies, see Tool #3.

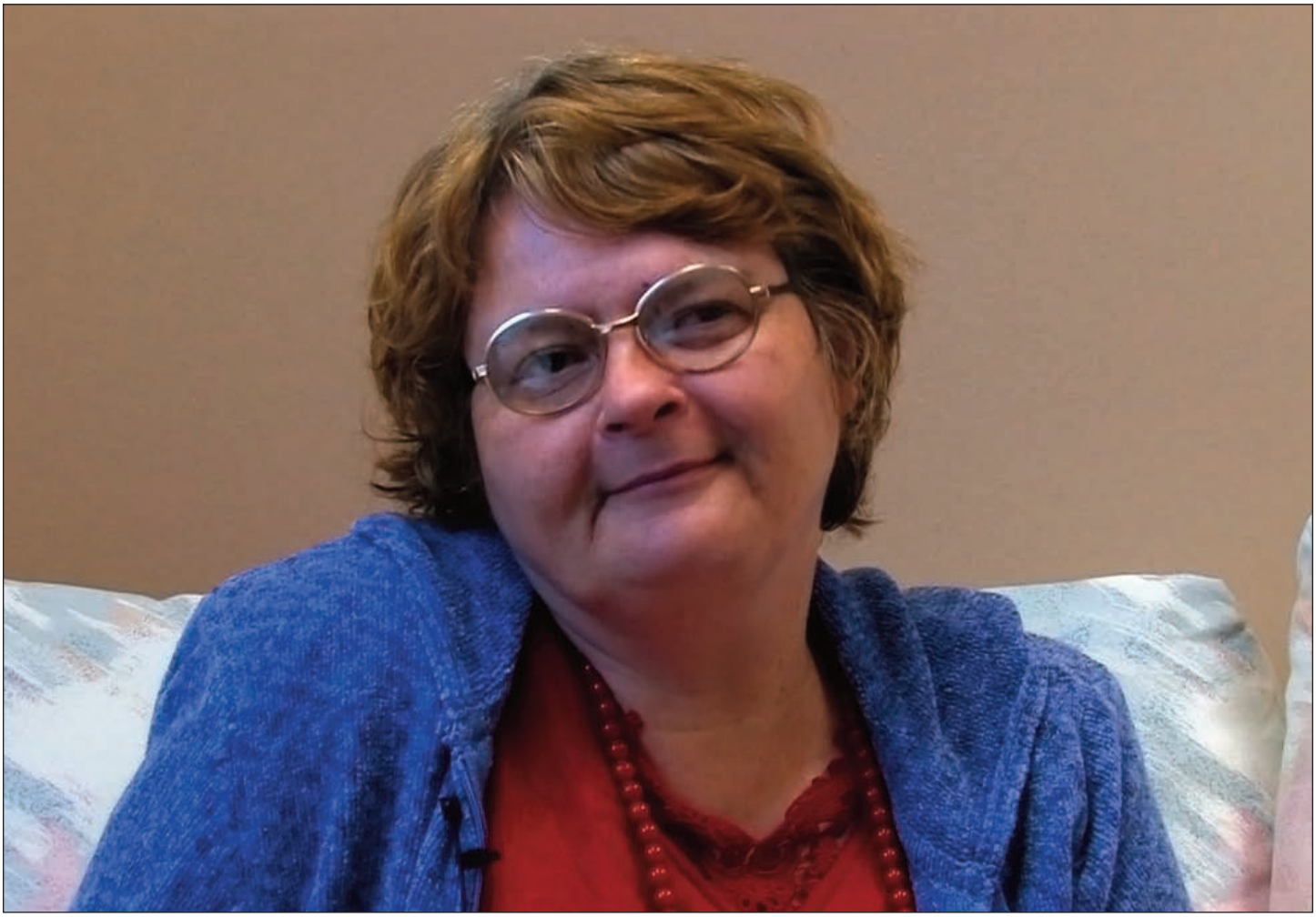
SMALL CHANGES: BIG RESULTS

With a few manageable changes, every agency can create an environment that makes women with disabilities feel safe to disclose sexual violence and to ask for help when they need it, which will prevent or interrupt abuse and assault. Policy change is one obvious step. Training staff is another. Educating women with disabilities is a key step. Making information about sexual violence readily available to staff and women with disabilities also contributes to an environment where women with disabilities feel safe and workers feel ready to respond. See Module 5 for multi-media material for women with disabilities.

Collaborate with a Rape Crisis Center

In addition to conducting the Trauma Responsiveness Assessment, it is useful to work with your local rape crisis center (see Tool #4 for a list of Illinois rape crisis centers). The goal of this outreach is to learn about the local rape crisis center and make sure the center knows about your agency. This will ensure that women with disabilities, family/friends and support workers are aware of the rape crisis center and services when they need these services. Be sure to tell the rape crisis center

- ❍ the services you provide;
- ❍ that your agency is key to the ways women with disabilities access services;
- ❍ how you access services for the women with disabilities you serve; and
- ❍ how to collaborate with you to serve women with disabilities who experience sexual violence.



Strategies to Collaborate with Rape Crisis Center

1. **Schedule** a meeting with the local/regional rape crisis center to discuss how to coordinate responses to women with disabilities who experience sexual violence.

2. **Invite** the rape crisis center to attend agency training events.

3. **Support** self-advocacy groups. Invite the rape crisis center to facilitate a group with women with disabilities regarding sexual violence and sexual violence prevention services.

4. **Attend** functions sponsored by the rape crisis center; e.g., Take Back the Night rally.

5. **Invite** an employee from the rape crisis center to serve on the agency's Human Rights Committee, Behavior Intervention Committee, Safety Committee and/or agency Quality Management Committee or similar committee/task force.

6. **Invite** an employee from the rape crisis center to serve on the agency's Board of Directors.

7. **Ask** the rape crisis center to assist in review of agency policies and procedures related to response to sexual assault.

8. **Invite** the rape crisis center to conduct an in-service for employees on sexual violence and the center's services.

9. **Develop** a working agreement with the rape crisis center to delineate sharing of resources and the referral process.

10. **Ask** the rape crisis center to conduct sexual assault prevention classes for persons served by the agency.

11. **Participate** in 40-hour volunteer training conducted by the rape crisis center.

12. **Share** cross-training opportunities on an ongoing basis.

13. **Include** a link to the rape crisis center on the agency's website.

14. **Invite** the rape crisis center to meet with persons served to discuss the issue of sexual violence.

15. **Collaborate** on grants to increase services to persons with disabilities.

16. **Include** the rape crisis center's contact information in client handbooks or other information provided to clients.

17. **Post** or make available information about the rape crisis center at each agency location (e.g., group homes).

18. **Invite** self-advocates to write poems, articles, or short stories for the rape crisis center newsletter.

19. **Start** collaboration in your community with the rape crisis center and others interested in violence against people with disabilities.

20. **Collaborate** with the rape crisis center and the phone book companies to get the rape crisis center phone number in the front section of the local phone books.

21. **Recruit** interested self-advocates to participate in the above activities.

Conclusion

If you have engaged in self assessment and developed a relationship with the rape crisis center, you have taken important steps to create an environment that is conducive to serving survivors with disabilities. One final element of readiness is train your staff. The next section of this module provides a staff training guide to enhance the capacity of staff to serve women with disabilities who experience sexual violence.

SECTION 3
TRAINING THE STAFF

Training Guide

We know that women with disabilities who experience sexual violence and assault have unique needs that are often unmet. In order to adequately identify and address these needs, staff members benefit from training to give them the education, skills and confidence to provide the optimal service response. The following Training Guide is designed to give staff a fundamental understanding of the issues and needs faced by women with disabilities who experience sexual violence.

The training can be provided in one three-hour session, or broken into smaller segments for multiple sessions. Two facilitators, at least one being a person with a disability, are recommended. The Training Guide includes handouts that will be needed for the training. While minimal preparation is needed to conduct training, trainers should know the Guide. While most material is provided, name tags, sign-in sheets, and some materials (indicated in the guide) for the activities will need to be created prior to the training. The facilitator may also want to consider creating a "Certification of Completion" for participants to document and honor their completion of training.

Learning Objectives

At the end of the training session, participants will be able to

- Define sexual violence and identify myths and facts about sexual violence and women with disabilities;
- Recognize indicators of sexual victimization (physical, emotional) and trauma associated with sexual violence;
- Demonstrate sensitivity and openness to the experience of women with disabilities;
- Provide empathic response to women with disabilities who disclose sexual assault; and
- Help survivors connect with the rape crisis center for crisis support, advocacy and counseling.

Session Information

Length of time required: 3 hours and 30 minutes

Facilitators: Two facilitators are recommended, with one being a rape crisis worker and one a woman with a disability.
Supplies needed: Flipchart and markers, copies of handouts, name tags, sign-in sheets, certificates of completion

Lesson		Page #	Handout*	Minutes
I.	Why are We Here?	12	N/A	15
II.	Women with Disabilities	13	#1	10
III.	Sexual Assault Statistics about People with Disabilities	13	#2	5
IV.	Myths/Facts about People with Disabilities and Sexual Violence	14	#3	15
V.	Definitions and Language	14-17	#4	15
VI.	People First	18-19	N/A	20
VII.	Sexual Violence and Trauma	20	#5	30
VIII.	Indicators of Sexual Violence	20	#6	15
IX.	Responding to Survivors	20-21	#7	25
X.	Reducing Risk of Sexual Violence	22	#8	15
XI.	Message to Disability Providers	23	#9	15
XII.	Closing	23	N/A	30

*** Handouts used:**

- ❍ Handout #1 Women with Disabilities Read-Around Slips
- ❍ Handout #2 By the Numbers
- ❍ Handout #3 Myths and Facts about People with Disabilities and Sexual Assault
- ❍ Handout #4 Contrast of Paradigms
- ❍ Handout #5 Response to Trauma
- ❍ Handout #6 Indicators of Sexual Violence
- ❍ Handout #7 Disclosure of Sexual Violence, How to Respond
- ❍ Handout #8 Reducing the Risk of Sexual Violence
- ❍ Handout #9 The Top 10 Things I'd Like to Tell Disability Service Providers About Sexual Violence
- ❍ Universal Sexual Rights of Women with Disabilities

The Lessons

I. Why Are We Here?

- **Introductory Remarks**
- **Time:** 15 minutes
- **Handout:** None

Before the session starts, list the following learning objectives on the flip chart.

- Define sexual violence and identify myths and facts about sexual violence and women with disabilities.
- Recognize indicators of sexual victimization (physical, emotional) and trauma associated with sexual violence.
- Demonstrate sensitivity and openness to the experience of women with disabilities.
- Provide empathic response to women with disabilities who disclose sexual assault.
- Help survivors connect with the rape crisis center for crisis support, advocacy and counseling.

Introduce yourself and review the learning objectives for the training session.

Invite the participants to introduce themselves. As they do, ask them to share one thing they hope to learn during the session. Write these on a flipchart and post on the wall for later reference.

> "Don't walk in front of me, I may not follow. Don't walk behind me, I may not lead. Just walk beside me and be my friend."
>
> *Albert Camus*

II. Women with Disabilities

- **Read-around Activity**
- **Time: 10 minutes**
- **Handout #1: Women with Disabilities Read-Around Slips**

Before the session, prepare Handout #1 by cutting it into slips of paper to be passed out to the participants.

Give each participant a read-around slip to read aloud to the group. Instruct each participant to pause for a count of 5 seconds between the reading of the last card and reading her own card. Ask that there be silence when the cards are read, with no comments or questions.
After each person has read a statement, have the group sit quietly with their reactions for a few minutes. Then ask if anyone would like to share their reactions. An alternative is to ask participants to write their reactions, which may or may not be shared with the group.

III. Sexual Assault Statistics about People with Disabilities

- **Group Lecture and Discussion**
- **Time: 5 minutes**
- **Handout #2: By the Numbers**

Ask the participants what they have heard, read, seen, or believed about sexual assault/violence and women with disabilities. Write their responses on the flipchart and post them on the wall. Responses may include:

- At our agency, we have a policy about no abuse/neglect.
- Women with disabilities probably don't get sexually abused very often.
- We watch our staff and our clients very carefully.
- I don't know - are they assaulted by strangers a lot?
- It may happen, but it doesn't happen here.
- Some clients make up abuse stories.
- Briefly discuss whether this data has changed anyone's perceptions about the likelihood that women served by the agency have been assaulted and the impact of sexual violence.

IV. Myths and Facts About People with Disabilities and Sexual Violence

- **Read-Around/Group Discussion**
- **Time: 15 minutes**
- **Handout #3: Myths and Facts About People with Disabilities and Sexual Violence**

Before the session starts, use Handout #2 to make a set of Myth and Fact slips to distribute. The Myth slips will show common myths about women with disabilities, and the Fact slips will show facts.

Ask participants to share what they have heard about people with disabilities and sexual assault. Write these on the flipchart.

Distribute the Myth and Fact slips for a read-around. Ask the participants to each read a slip and go around the circle, starting with the Myth #1 slip. The person with the Myth #1 `slip reads the myth, pauses for 5 seconds, and then the person with the Fact #1 slip reads the fact. Then the person with the Myth #2 slip reads the myth, followed by Fact #2, etc.

Invite the group to discuss what they learned from this activity. Point to any myths on the flipchart and ask for people to correct them with facts.

V. Definitions and Language

- **Group Lecture/Discussion**
- **Time: 15 minutes**
- **Handout #4: Contrasts of Paradigms**

Explain to the group that the definition of disability has evolved from the many ways we have thought about disability. The most recent evolution of the definition emphasizes functional ability over a medical diagnosis and makes a very important distinction between two concepts – functional limitation and disability.

A person may have a functional limitation; she may not be mobile without a wheelchair. This limitation is only a disability in particular environments (e.g., a building without ramps or elevators). Thus, disability is not something that a person has but, instead, something that occurs within the environment, outside of the person. Disability occurs in the interaction between a person, functional ability, and the environment.
Her environment can be the physical environment, communication environment, information environment, and social and policy environment.

This new way of looking at disability helps us to understand that it is a matter of degree: one is more or less disabled based on the intersection between herself, her functional abilities, and the many types of environments with which she interacts.

Moreover, the experience of disability can be minimized by designing environments to accommodate varying functional abilities and providing individualized solutions when needed.

In 2001, the World Health Organization (WHO) established a new definition of disability, declaring it an umbrella term with several components:

- Impairments: a problem in body function or structure.
- Activity limitations: a difficulty encountered by a person in executing a task or action.
- Participation restrictions: a problem experienced by a person in involvement in life situations.

The new definition is based on human rights or social models, and focuses on the interaction between a person with a disability and the environment. Similarly the definition from the civil rights model of disability says that a disability is a social construct, meaning that it is society that is not set up to support and empower people who have disabilities. Distribute handout #4 “Contrasts of Paradigms” to participants. Ask them to compare the way the old approach to disabilities differs from the current one.

Ask participants to describe ways in which individuals may have functional limitations. Write these on the flipchart. Responses may include:

- Mobility
- Cognition/processing information
- Speech/Communication
- Vision
- Hearing
- Sensory (sensitivity to lights, sounds, smells, etc.)
- Psychiatric

Now ask participants to list some of the words they have used to describe people with disabilities. Encourage risk-taking and honesty. Write the responses on the flipchart. Responses may include:

- Mentally retarded
- Incapacitated
- Deaf and dumb
- Special
- Crippled
- Incompetent
- Slow/slow learner
- Handicapped
- Delayed
- Crazy

Other, less negative responses may include:

- Mobility impaired
- Developmentally delayed
- Mentally ill
- Wheelchair-bound
- Disabled

Explain that all these terms focus on an individual's limitations as opposed to their strengths and abilities. This language is hurtful to people with disabilities. It is more sensitive and respectful to use appropriate terminology and "people first language" that focuses on the individual first rather than the disability. For this reason, it is preferable to use the term "people with disabilities" rather than "disabled people" or "the disabled."

VI. People First

- **Lecture/Activity**
- **Time:** 20 minutes
- **Handout:** None

Before the session starts, fill out a sheet of name-tag label stickers with the following descriptors (one descriptor per sticker): autistic, mentally retarded, blind, non-verbal, schizophrenic, attention-seeking, manipulative, history of lying, etc.

Discuss with the group the use of "people first language." Remind the group of the negative language that is used to describe people with disabilities, and ask them to name a few, such as retarded, incompetent, delayed, slow, etc. Explain that these terms focus on an individual's limitations and challenges as opposed to strengths and abilities. This language is hurtful to people with disabilities. It is more sensitive and

respectful to use appropriate terminology and “people first language” that focuses on the individual first rather than the disability. For this reason, it is preferable to use the term “people with disabilities.”

Ask them to also consider how we describe these individuals and their behaviors in negative ways, such as manipulative, attention-seeking, needy, etc. Often, these behaviors are efforts to communicate and express what is going on for them, or efforts to cope with traumatic stress. Sometimes people receive diagnostic labels, such as autistic, schizophrenic, etc. that define them and who they are in medical terms. These labels can also limit a person’s potential when others view them only as a diagnosis and not as a total person.

Ask the participants to find a partner and get into pairs. Pass out a sticker with a descriptor to one person in each pair. This person will be role-playing a survivor characterized by this description. The other partner will role-play a staff member of the disability agency who is assisting this individual.

First, the survivor with the label sticker will disclose a scenario of sexual violence, and the person role-playing the staff will listen and respond. After five minutes, ask the participants to reverse roles. The survivor will give her staff/partner the label sticker, and the survivor will now take on the role of the staff. The new survivor will disclose a scenario of sexual violence, and the new staff will listen and respond.

After the second five minute role-play is finished, ask the participants the following:

- How did you feel while disclosing the sexual violence scenario?
- How did you react as a staff member to a survivor’s disclosure?
- What impact did the label sticker have on both your disclosure as a survivor and how you responded to that disclosure as a staff?
- How much did the sticker, and the label, matter in relation to the survivor’s disclosure and how you reacted to it?
- Were you relieved to take the stickers off/throw them away? How will you respond to those who can never throw their labels away?

Discuss how using people first language (e.g. saying “people with disabilities” instead of “disabled people”) diminishes the impact of negative labels. Stress the importance of seeing each individual as a person first and responding to them with respect and dignity in all circumstances

VII. Sexual Violence and Trauma

- **Lecture**
- **Time:** 30 minutes
- **Handout #5:** Response to Trauma

Explain to the group that, historically, issues related to sexual behavior have been avoided when the sexual behavior involves people with disabilities. Yet, people with disabilities may have a range of sexual experiences, including abuse and assault. Sexual violence includes a continuum from inappropriate and unwanted sexual touch to penetration. Sexual exploitation such as pornographic photography is also abusive.

Inform the group that sexual assault represents a trauma that can have significant impact on an individual's level of functioning. Sexual violence can interfere with an individual's ability to lead a happy and successful life and to reach her full potential. Sexual assault takes away an individual's sense of control and her connection to herself, others, and the world around her. Survivors often do not understand the reactions they are experiencing and may feel as if something is wrong with them.

Rather than being an indication of personal weakness, these reactions are actually a normal response to an abnormal event. Helping survivors gain a sense of control over their own lives and re-connect with themselves and others in a positive way is central to recovery.

The trauma of being sexually assaulted is similar to the trauma faced by those in combat, or victims of natural disasters. Trauma can affect survivors physically, emotionally, psychologically, socially and spiritually. It can change the way a victim views herself, others, and the world around her.

Define Rape Trauma Syndrome for the group: The reaction that a victim of sexual assault has before, during and for a considerable period of time after a sexual assault is characterized as Rape Trauma Syndrome.

The impact of trauma can last from a few weeks to a few years, depending on the nature of the event, the characteristics of the survivor, and, most importantly, the nature of the support system available. It is critically important for the survivor's recovery to have a supportive system of family and friends who understand sexual violence as a traumatic event that was out of their control. Survivors need time, patience, understanding and compassion in order to heal.

It is not uncommon for women with disabilities to have a history of sexual violence, multiple incidents and perpetrators. An individual who has experienced repeated incidents of sexual violence may have a prolonged recovery process and more complex trauma. Repeated exposure to violence may greatly impact a victim's ability to trust.

Distribute Handout #5. Tell the group this handout describes the basic framework of a trauma-informed response to survivors. Review the description of trauma-informed response and compare it to the list of non-trauma informed responses.

Emphasize that the support, or lack of support, they provide can have a significant impact on the survivor's recovery. Tell participants that understanding trauma is key to meeting the needs of sexual violence survivors. If we are informed about trauma and how it affects survivors, we can tailor our responses.

"Education is the jewel casting brilliance into the future."

Mari Evans

VIII. Indicators of Sexual Violence

- **Lecture/Discussion**
- **Time:** 15 minutes
- **Handout #6:** Indicators of Sexual Violence

Ask the group to brainstorm reactions they think a survivor may have after an experience of sexual violence. Write these on a flipchart and post them on the wall. Distribute Handout #6 and review the list of trauma indicators. Note areas of overlap between this list and the list generated by participants. Be sure to note that there is no particular way a woman is supposed to respond to the trauma of sexual violence. Although there are common responses, each woman will respond in her own way, which is the right way for her. Familiarize yourself with Handout #6 prior to handing it out to the participants.

IX. Responding to Survivors

- **Guided Discussion**
- **Time:** 25 minutes
- **Handout #7:** Disclosure of Sexual Violence: How to Respond

Refer to list of indicators of sexual violence discussed during the previous lesson.

Ask some questions to guide discussion about these indicators of abuse:

- Have you noticed these signs before with women with disabilities? Moreover, have you ever suspected they were signs of trauma?

- Do you mention “possible sexual abuse” or sexual violence in your “incident and accident reports” when reporting these signs? If not, would you be willing to do so in daily practice? Are there any hesitations/reservations you might have about doing so?

- What is your agency’s policy on reporting such indicators? Ask, “are you the one who calls, or do you assist the survivor to call?”

Brainstorm about how to make reporting more empowering to the survivor.

Remind the group that the first response to a disclosure of sexual harm should focus on the needs of the person disclosing, not on what the person hearing the disclosure is required to do. Reporting can be done after emotional support is provided.

Remind the group that research shows that the most critical factor that influences a person's ability to positively recover from sexual harm is the immediate response from others around the victim. If the survivor immediately receives a positive, affirming, supportive response, she is more likely to have a positive recovery, in a shorter period of time. If she is not believed or is blamed and shamed in the aftermath of the trauma, she is more likely to have a more difficult time in recovery. Therefore, first response is critical.

Tell the audience that you are going to help them formulate and practice a victim-centered crisis response to a survivor of sexual violence – one of compassion, empathy, and support.

Distribute Handout #7 and review it with the group. Discuss the key responses to the handout and note the central tenets on the "do" and "don't" lists.

Remind the group that it is critical to avoid saying anything to make the survivor feel that she is not believed, that what happened isn't important, or that it is her fault.

Tell the group it is useful to practice these responses. Ask the participants to find a partner in the group and get into pairs. One person in each pair will role-play a survivor of sexual violence with disabilities, and the other person will role-play a support staff member. The survivor will disclose a scenario of sexual violence, and the staff member will role-play a response using the information from Handout #7. After five minutes, have the partners switch roles.
After the second five-minute role play, discuss experience with the participants. Ask them about their thoughts and feelings during the role-plays, and if they have any questions/concerns about how to respond.

Remind the group that rape crisis centers are here to help. They have 24-hour crisis hotlines, counseling, and advocacy, as well as public education and training. The goal of a rape crisis center is to assist the survivor in her recovery. This is done through focusing on the survivors' strengths, providing information, exploring options and resources, supporting the choices they make and empowering them to help plan their own response and recovery.

Ask about the networking agreement that your program has with the local rape crisis center. Encourage networking agreements if none exist.

X. Reducing Risk of Sexual Violence

- **Group Discussion**
- **Time: 15 minutes**
- **Handout #8: Reducing the Risk of Sexual Violence**

In advance, prepare a flip chart with the information from Handout #8. Write risk factors on one page and strategies to minimize risk on another page.

Begin discussion by noting that risk reduction is one approach to stopping sexual violence. Though stopping the behavior of perpetrators is the only sure way to prevent sexual violence, women and their support workers can take steps to reduce their vulnerability to sexual violence. However, it is critical to remember, and to tell all women, that sexual violence is not their fault. No matter what they did or did not do, the behavior of forcing sexual contact is always the fault of the perpetrator, not the victim. Keeping that caveat at the forefront, staff and agencies can take steps to minimize the risk of sexual violence against women with disabilities.
Review the risk factors on Handout #8 that you listed on a flipchart.

Following the review of risk factors, ask the participants for ideas about how to minimize these factors. Review Strategies to Minimize Risk from Handout #8 that you previously wrote on a flipchart.

Distribute Handout #8 and suggest the participants share it with others in their agency and consider how to implement the strategies for risk reduction.

XI. Message to Disability Providers

- **Read Around**
- **Time:** 15 minutes
- **Handout #9:** The Top Ten Things I'd Like to Tell Disability Service Providers about Sexual Violence

Ask participants for silence during this activity. Begin by having someone read Handout #9 "Ten Things I'd Like to Tell Rape Crisis Centers" aloud to the group. If there is a person with a disability present, ask in advance if she/he would be willing to read the handout. Otherwise, ask for volunteers from the group. Ask the group to withhold comments after the handout is read. Allow a few moments of silence after reading the handout before moving on.

Ask participants for any comments about what they just heard.

XII. Closing

- **Time:** 30 minutes
- **Material**: DVD: Our Rights, Right Now – A Guide for Disability Service Providers

Tell the group you have a DVD that reviews the highlights of the training. **Show the DVD entitled: Our Rights, Right Now – A Guide for Disability Service Providers from Module 5 of this Toolkit.** Ask for questions or comments.

Encourage participants to share the information from this training with their colleagues, with the women they serve and with family members and support people. Suggest they work in their agency to achieve changes to reduce the risk of sexual violence and provide the best possible response to disclosures or observations of sexual violence. Ask for any final questions. Instruct the participants to think of one word that describes what they will take away from this training with them when they leave. Ask participants to sit quietly with that word in mind for a few moments without sharing it aloud.

Ask for a volunteer to start by sharing a single word (with no other comments from the volunteers or other participants). Proceed around the room until everyone has responded.

Thank everyone for their interest and attention.

SECTION 3
RESPONDING TO SURVIVORS

Responding to Survivors

Introduction

This section of the Toolkit provides basic information to guide disability service agencies as they respond to women with disabilities who experience sexual violence. Additional resources are available from your local rape crisis center.

Intake and Service Planning

As part of the needs assessment, Illinois Imagines spoke to women with disabilities about whether they wanted to be asked about past incidents of abuse on an intake form. The responses were mixed; some women wanted to be asked because it would save them the emotional energy of having to disclose, while others did not want to be asked directly. Instead they wished for indirect opportunities to bring up the abuse such as during educational workshops or in groups. It will be up to the agency to decide if they will ask whether a client is a survivor of abuse. However, women with disabilities reported that, if asked, they wanted to have the option to not answer. The agency should strive to create other safe spaces for clients to discuss abuse in addition to the intake process.

If a client does disclose at intake, then the service plan can address any needs related to the sexual violence (e.g., counseling). In all cases, a service plan should be something that the client and the service provider create together. The client is the expert on what will best help her to heal. Work with her to determine a plan of action, including connecting her with the rape crisis center and ensuring that her living arrangements are safe. The content of the service plan will vary with the individual, but the goal will always be to ensure the survivor's safety and promote healing.

Sexual violence can affect all aspects of a woman's life. Regardless of the nature of your work with a woman with a disability, it is important to note that the trauma of sexual violence can affect her participation in work, leisure activities, and other activities of daily living. Any type of service planning that you do with women with disabilities should be attentive to special needs related to trauma recovery.

Indicators of Sexual Abuse

People who experience sexual violence respond in a myriad of ways. Responses depend on many factors: the length and severity of abuse, the relationship of the survivor to the abuser, where the abuse occurred, whether the abuse was recent or many years ago, and whether the survivor told anyone and received any support. No two survivors respond and cope in the exact same way. Obviously, the most certain indicator of abuse is a disclosure by the victim. Short of a direct disclosure, various indicators can signify a need to be attentive and inquire more directly about a woman's experience. The presence of one or more of the indicators listed below may suggest that a woman is a survivor of sexual violence.

Physical

- ❍ Abdominal pain, nausea, gastrointestinal difficulties
- ❍ Changes in appetite, weight gain/loss, eating disorders
- ❍ Tension headaches
- ❍ Sleep disturbances, fatigue
- ❍ Hypersensitivity to light, sound, etc.
- ❍ Unexplained bruises, scratches or other bodily injuries
- ❍ Bruising in genital and/or anal area
- ❍ Menstrual cycle disruption
- ❍ Pregnancy or a sexually transmitted infection

Emotional

- ❍ Changes in temperament or sudden mood shifts
- ❍ Anger, anxiety, irritability
- ❍ A sense of vulnerability, powerlessness, helplessness
- ❍ Diminished ability to concentrate, confusion
- ❍ Depression
- ❍ Sense of blame, guilt, shame, humiliation
- ❍ Numbing and dissociation
- ❍ Avoidance behaviors
- ❍ Nightmares, flashbacks
- ❍ Distrust of others
- ❍ Fear or avoidance of particular people or places
- ❍ Concerns and fears about pregnancy, sexually transmitted disease, etc.
- ❍ Secrecy
- ❍ Self-consciousness, particularly related to the body

Behavioral

- ❍ Sudden rejection of normal physical affection
- ❍ Perfectionism or attempts at over-achievement or pleasing others
- ❍ Overzealous in cleanliness with regard to personal hygiene
- ❍ Refusal to bathe or bathing excessively
- ❍ Refusal to go to bed or going to bed fully clothed
- ❍ Withdrawal from family and/or friends
- ❍ Isolation from peers or withdrawal from usual activities
- ❍ Sudden change in performance in school or work settings
- ❍ Running away
- ❍ Drug or alcohol misuse
- ❍ Criminal behaviors
- ❍ Promiscuity/Prostitution
- ❍ Any disclosure of abuse – even if it is delayed, conflicting or “unconvincing”
- ❍ Self-injury/Self-destructive behavior, suicide attempt
- ❍ Aggressive or bullying behaviors
- ❍ Acting out behaviors or the appearance of new behaviors
- ❍ Not speaking, even though the person has the ability to do so
- ❍ Frequent use of words like bad, dirty, or slang for sex acts or body parts
- ❍ Unexplained accumulation of extra money or gifts

Some of these indicators are more decisive than others, such as a pregnancy, the presence of a sexually transmitted infection (STI) or physical injury, but no one indicator or combination of indicators is a guarantee that abuse has occurred.

If you notice any of these indicators, there are several things that you can do. You can ask the client directly what has happened, provide them with opportunities to talk with you privately or write things down, provide them with the contact information of the local rape crisis center, and/or contact the Office of the Inspector General (OIG). The survivor may not want to disclose right away. Keep the door open to disclosure at any time.

Responding to Disclosures

The response a survivor gets when she discloses has a significant impact on her ability to cope and heal, as well as on whether she will feel comfortable making a disclosure in the future. If the survivor feels she was not believed, or that the person she told did not care, or if the disclosure brought about unwanted consequences (removal from living situation or work, etc.), she may be very reluctant to continue seeking help. On the other hand, if the person making the disclosure feels validated and believes as though the person hearing the disclosure is willing to help, the healing process can begin.

When listening to a disclosure, it can be tempting to find out as much information as possible, but that is not your job in that moment (action may come later).

At that moment, your job is to LISTEN, carefully and without judgment and to communicate that you understand.
Let the survivor guide the direction of the conversation.

She may not tell you the whole story, or tell it in chronological order. It isn't necessary to know all of the details. It is much more important to tell the survivor that she is believed, that she did the right thing by telling someone, and that she will be helped. After making a disclosure, a survivor needs information about what she can do next. Referral to a rape crisis center and assistance contacting the rape crisis center, law enforcement or obtaining medical care are great next steps. Describe all of the survivor's choices and let her decide what to do next. She may not want to do anything, and that is okay. Tell her that she can change her mind at any time, and that someone will be available to talk if she needs to.

If you are a required reporter, it is important to tell your client this as early in the conversation as possible and to explain that you cannot keep the conversation confidential and are required to report to the Office of Inspector General (OIG). Explain what will happen if she discloses abuse to you, and find out if that is what she wants to happen. That way, she can choose whether or not to continue the conversation. If she does not wish to continue, explain that there are other people she can talk to who are not required reporters, such as a rape crisis worker. Then, help her get in touch with those people as quickly as possible.

Empathic Response

An empathic response to a disclosure is pivotal to a survivor's healing and recovery. A survivor of sexual violence has had her sense of power and control taken away, so the most important element of an empathic response is restoring that power and control, and re-establishing the sense of personal safety.

First and foremost, ensure the survivor that she is believed and that she did the right thing in disclosing the abuse. Give the survivor back her sense of power and control by letting her make decisions about what she needs to begin the recovery process. Giving the survivor information and options so that she can make an informed choice about what to do next is a key component of an empathic response; making decisions for her or leading her into a particular decision is not. The survivor must direct her own recovery process.

Key considerations in providing an empathic response are as follows:

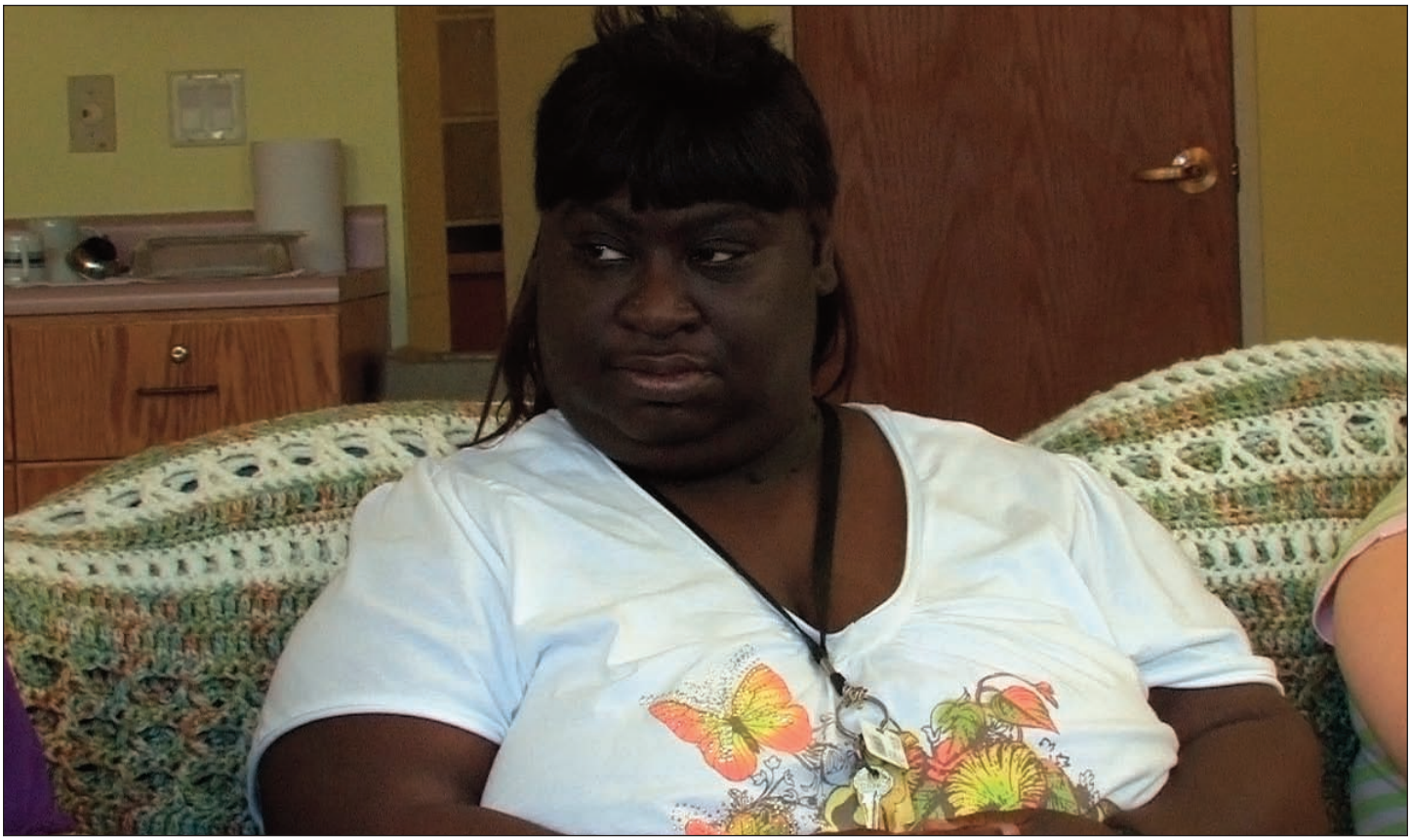
The first priority should be to create a safe, comfortable environment for the survivor.

Next, empower the survivor by sharing information with her and describing options available to her. The survivor has the right to make her own choices and decide which options will be part of the recovery process.

If the survivor desires, agency staff should assist her in contacting a rape crisis center or law enforcement, and accessing medical care. The survivor and the agency should work together to create a plan of action following the disclosure guided by the needs and concerns of the survivor.

REMEMBER:

- ❍ If you are a required reporter, fully explain the implications of what disclosure to you will mean.
- ❍ ALWAYS believe what the survivor is telling you.
- ❍ Tell the survivor that you believe her.
- ❍ Listen carefully, and let the survivor do the talking.
- ❍ Give the survivor information about options and what steps she can take next.
- ❍ Then, assist with those steps.
- ❍ Do not make decisions for the survivor.
- ❍ Do not assume that you know what will help the survivor or what she wants.



Reporting Abuse

Be aware of your agency policy regarding reporting of abuse. All staff in any disability service agency licensed, funded, monitored or under the authority of the Department of Human Services has a responsibility to report any confirmed or suspected abuse to the OIG, but there are other avenues of reporting in addition to the OIG. The survivor may also wish to report the abuse to law enforcement and pursue criminal justice intervention. If a survivor chooses to report, it can be a difficult but empowering process. She will have to answer detailed questions about the abuse. That's why it must be the survivor's choice to speak to law enforcement.

Referrals

Every survivor has a variety of needs related to care and healing from an experience of sexual violence. The disability service agency may not be able to meet every one of those needs. Other agencies, such as the rape crisis center, hospital emergency department or law enforcement can help survivors. After a disclosure, you have an opportunity to inform the woman about services available to her and to ensure she is connected with services that can help her.

Rape Crisis Center

Always offer a survivor a referral to a local rape crisis center. The rape crisis center can assist a victim of a recent assault or an assault that occurred long ago, even in childhood. The rape crisis center offers a 24-hour hotline response, medical advocacy, legal advocacy and counseling. All of these services are free of charge and available to any survivor. Give the survivor a confidential space to call the rape crisis hotline to start the process (see Tool #4 for a list of rape crisis centers).

24-hour Hotline – The rape crisis center's 24-hour hotline provides confidential crisis intervention to survivors of sexual violence. The crisis counselors who answer the hotline are trained to listen, offer information and options and provide empathic responses to a survivor. They can also dispatch an advocate to meet the survivor at the hospital emergency department.

Medical Advocacy – Medical advocates at the rape crisis center will accompany a survivor to the emergency department when she seeks treatment. Advocates can help explain the medical and forensic exams and will stay with the victim during the exam if she wishes. They will also speak with family members to provide information and support.

Legal Advocacy – Legal advocates will provide emotional support and provide information about the entire criminal justice process, from initial report to law enforcement through case disposition. They will assist with completing and filing any paperwork, obtaining accommodations in court and accompanying the survivor to meetings and hearings. Advocates can also assist the survivor while she is working with local law enforcement and prosecutors by getting updates on the status of the case and advocating with law enforcement and prosecutors to pursue charges against the perpetrator. Advocates at the rape crisis center can assist the survivor in obtaining a Civil No Contact Order if she still has contact with the abuser and feels unsafe.

Counseling – Once a survivor discloses abuse, she may want to seek counseling at a rape crisis center. They have a 24-hour hotline, which can be a great resource if a survivor has questions or is struggling emotionally. They also offer confidential counseling at no charge. The survivor can receive individual counseling or participate in family counseling or a support group. Counseling is available to survivors whether the assault took place yesterday or several years ago.

Law Enforcement

A survivor may want information about how to report the abuse to local law enforcement. You will want to provide her with the contact information of the local department in the jurisdiction where the abuse occurred. Rape crisis advocates can also help a survivor make a report. Advocates can explain what the reporting process entails, and answer any questions the victim may have about the rest of the legal process.

Medical Care

Refer a woman who has experienced recent sexual violence to the local emergency department for medical care. Most emergency departments will call the rape crisis center to request an advocate. You can also call the rape crisis center. The emergency department is required by law to call law enforcement when a sexual assault victim presents for treatment. However, the victim can decline to speak with the reporting officer at the emergency department.

In addition to performing evidence collection, emergency department staff can check for any injuries and test for sexually transmitted infections. A survivor has to go to an emergency department in order for the evidence collection kit to be completed. However, a survivor does not have to have an evidence collection kit done. If she simply wants to rule out STIs and injury, that is an option as well.

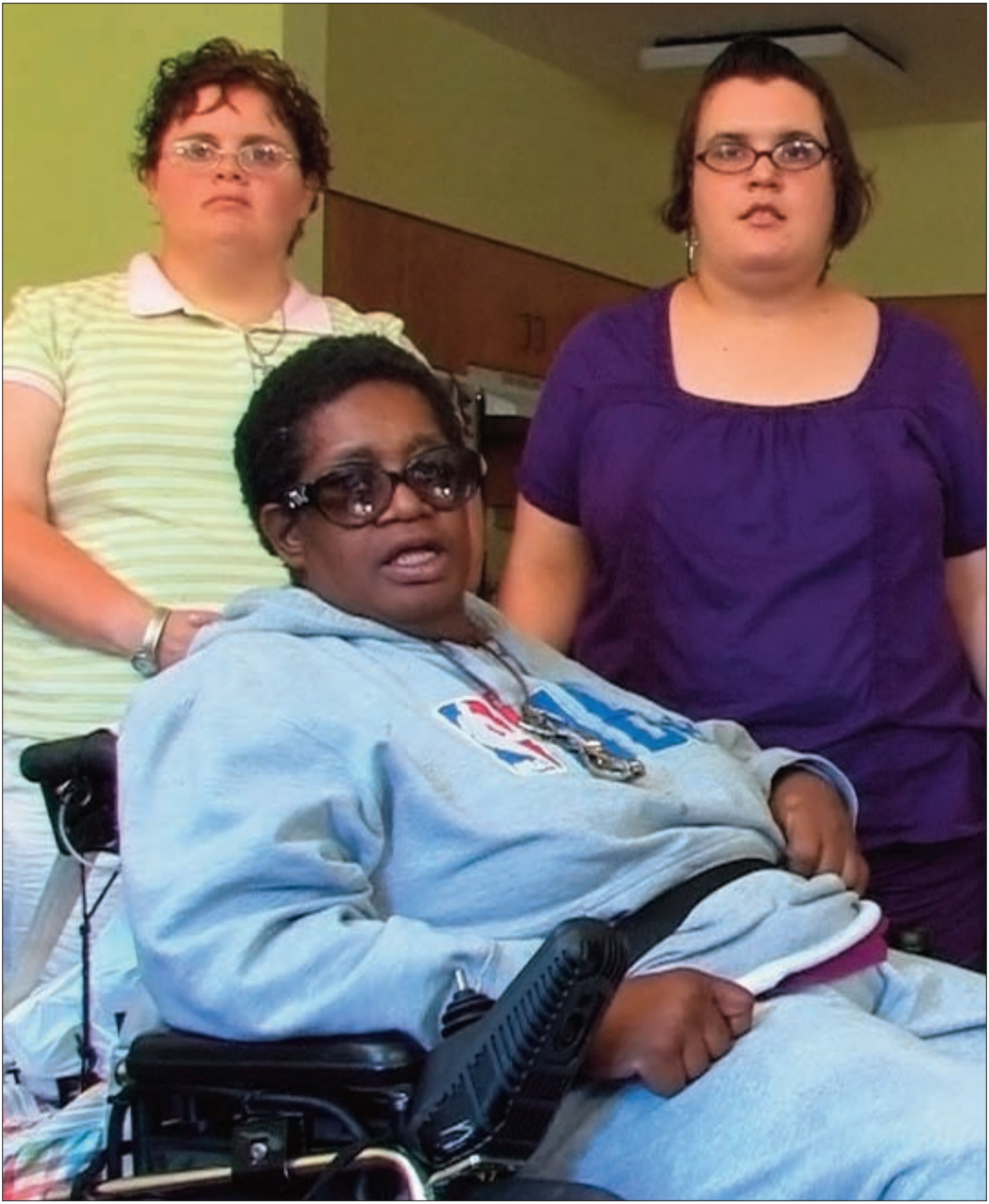
It is important to remind women with disabilities that their medical care after they experience sexual violence is protected by Illinois law. The Sexual Assault Survivors Emergency Treatment Act is an Illinois law that governs the healthcare that hospitals are required to provide to sexual assault survivors, establishes a statewide forensic evidence collection system, and creates a reimbursement program for the cost of emergency department care, evidence collection, and follow-up care for victims who are not covered by private insurance or Medicaid.

Remember

The first response to a survivor of sexual violence is key to her recovery. Listen to her. Believe and support her. You don't have to be an expert in sexual violence or trauma to respond sensitively and assist the woman in getting the help she needs. Call the rape crisis center for help as you work to help a woman with a disability who has experienced sexual violence.

Your attitude and actions will make a difference in her recovery.

SECTION 4
TRAINING HANDOUTS



Training Handouts

❍ **Handout 1**	Women with Disabilities Read Around Slips
❍ **Handout 2**	By the Numbers
❍ **Handout 3**	Myths and Facts about People with Disabilities and Sexual Assault
❍ **Handout 4**	Contrast of Paradigms
❍ **Handout 5**	Response to Trauma
❍ **Handout 6**	Indicators of Sexual Violence
❍ **Handout 7**	Disclosure of Sexual Violence, How to Respond
❍ **Handout 8**	Reducing the Risk of Sexual Violence
❍ **Handout 9**	The Top Ten Things I'd Like to Tell Disability Service Providers About Sexual Violence
Universal Handout	Sexual Rights of Women with Disabilities

Women with Disabilities Read Around Slips

Instructions: Copy this activity sheet and cut into slips of paper. Pass out the slips. Follow the instructions in the Training Guide, page 12.

I will only tell someone I've been sexually abused if it is someone who is comfortable with my disability and sees me as strong. I won't talk to someone who just focuses on my disability or someone who thinks I am not intelligent because I am in a wheelchair.	People need to take time and listen, to be there. It is not something that just takes a few minutes but rather you need a long time to talk about it. People should listen and let you talk and not interrupt or stop you or ask a lot of questions.
People need to protect you and give you confidence in yourself, not judge you. They need to believe you no matter what. They shouldn't laugh at you. They should take you seriously.	I stay inside more now. I don't just walk around. I only go out when I have an activity.
I didn't know how hard it would be. I felt lost.	I would want to talk to someone who would believe me and support me.
You need to feel that the person will take what you say and keep it confidential. They should not use my disability as a reason to question my credibility.	I would want to talk to someone who would not be judgmental. would not treat me different; I want someon to comfort me when I am upset.
	Rape is a confusing issue for women. Women with disabilities may have some challenges that can make it even more difficult for them to navigate the medical, legal and service delivery systems.

Women with disabilities are often unfamiliar with their rights as people. This might make them even less aware of their rights if they are victimized.	I would want to talk to someone who looks at me and listens; someone who is compassionate; someone who would believe me.
Abuse by a male often makes women uncomfortable with male staff or counselors, especially those they do not know and/or trust due to past interactions.	I would want to talk to someone who connects with me. I want someone who can be trusted and who respects me.
The facility I was in was accessible but the staff was not. The staff's fear of the unknown or their concern about liability got in the way of services and I did not get what I needed after I was abused by the guy down the hall.	My rape crisis center helped me talk by letting me use a sand tray to get my feelings out and show them what happened. They let me talk about it. I get to choose to talk about it. It is my business.
I would like for service providers to be patient with me, treat me with respect and bring me to a safe place.	If they are a good worker, you should be able to trust them. Some are not. If they are the good ones, they are safe people to be with and you feel good with them. You are safe.
I would like for service providers to make sure the perpetrator could never come near me again. I want to report it to the police. I want to make sure my body is okay.	My favorite staff person listened to me and waited for me to tell the whole story about my dad raping me. Then we talked about what to do next. She believed me.
You have to know you can trust someone first …like they don't treat you like you are stupid.	

By the Numbers: Data about People with Disabilities and Sexual Violence

Among adults who have developmental disabilities, as many as 83% of the females and 32% of the males are the victims of sexual assault. (Johnson, I., Sigler, R. 2000. "Forced Sexual Intercourse Among Intimates," *Journal of Interpersonal Violence. 15 (1)*.

Women with disabilities and Deaf women 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).

Women with disabilities experience increased severity of violence (Brownridge, 2006; Nannini, 2006; Smith, 2008), have 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).

The social context of disability and Deafness increases a woman's risk for victimization. This context includes:

— reliance on support services,
— poverty,
— inaccessibility and isolation,
— devaluation and stigma,
— discrimination.

(Powers, et. al. 2002; Saxton et. al., 2001).

Potential consequences of abuse include negative financial, physical and social effects, such as:

— difficulty seeking or maintaining employment,
— increased depression,
— low self-esteem, mental health concerns,
— increased poor health, loss of independence.

(Hughes et.al., 2001; Nosek et. al., 2003; Nosek, et. al., 2006).

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

Myths and Facts about People with Disabilities and Sexual Assault

Instructions: Copy this activity sheet and cut into slips of paper. Pass out the slips. Follow the instructions in the Training Guide.

1. MYTH: I am a child in an adult's body.
1. FACT: I am an adult in all respects, including sexual desires and feelings.

2. MYTH: I am innocent and should stay that way; I don't need to know about sex.
2. FACT: I have a right and a need to know about healthy sexuality and about sexual abuse/assault.

3. MYTH: If I claim to be sexually abused, I'm making it up or seeking attention.
3. FACT: If I get up the nerve to tell you I've been hurt sexually, you need to believe me.

4. MYTH: If I can't communicate in traditional ways, I can't tell you I've been sexually abused.
4. FACT: I can still disclose sexual harm or trauma. Watch my body, face, and emotions for signs.

5. MYTH: You should not believe me if I disclose. I have a history of lying.
5. FACT: People with a history of lying are at higher risk for sexual violence because nobody believes them. I can lie about things and still be abused.

6. MYTH: If I experience sexual violence, I must have done something to cause it to happen.
6. FACT: Sexual violence is NEVER the survivor's fault.

7. MYTH: Because I have a disability, I can never be a credible witness.
7. FACT: With the right support and accommodations, I can tell what happened in court.

8. MYTH: I'm not reacting to trauma. I'm just acting out or having a behavior problem.
8. FACT: I'm trying to tell you something with my actions! Don't punish me. Listen to me! Help me!

9. MYTH: Because I have a legal guardian, I can't give consent for anything.
9. FACT: I still have the right to speak for myself. Check the laws on it!

10. MYTH: If I experience sexual violence, it's usually with a complete stranger.
10. FACT: If I experience sexual violence, it's usually with a family member or caregiver.

Contrast of Paradigms

	"Old" Approach	"New" Approach
How are people with disabilities viewed?	People with disabilities are limited because of their diagnosis. They are mostly considered "abnormal" or incompetent, and in some cases, less than fully human.	People with disabilities are fully human, and having a disability is a natural part of the human experience. They can and should be in control of their own lives.
How do we support people with disabilities?	"Fix" the people with disabilities and try to help them correct their weaknesses and deficits	"Fix" society through providing access and accommodation, supporting universal design and self-direction
What kinds of services do people with disabilities need?	Rehabilitation Psychoanalysis/therapy Congregate care Day training/programs "Special" education Supervision	Personalized support Relationships Individual housing Community employment Assistive technology Inclusive education
Who is in charge of the person's services and ultimately, her life?	Professionals, clinicians, and other rehabilitation providers Legal guardians, family, friends, "caregivers."	The person himself or herself, above all else. Other people that THE PERSON chooses to support him/her
How are you eligible for services?	You're only eligible if the government considers your disability severe enough in their "criteria"	You are eligible for services because you're a human and it's your civil right to get them
People with disabilities are…	Receivers of services Patients Research subjects Receivers of intervention	People first Self-advocates Empowered people Decision-makers
A disability is…	A medical "problem" The "problem" of the person with the disability	Society's construct; an issue of equity, access, support & human rights

Response to Trauma

Non Trauma-Informed	Trauma-Informed
Lack of education on trauma prevalence	Recognition of a high prevalence of trauma
Over-diagnosis of schizophrenia and bipolar disorder, conduct disorder and singular sexual assault disorders	Recognition of primary and co-occurring trauma diagnoses
Service plan without family/social history	Attention to life context/exposure is appreciated
No trauma assessment	Assessment for traumatic histories and symptoms
"Tradition of toughness" valued as best care approach	Recognition of culture and practices that are re-traumatizing
Culture reflects need for security, uniforms, keys, authoritarian demeanor and tone of voice	Minimize power and control
Staff function as techs and guards	Staff act as caregivers and counselors
Staff assumes survivor is to blame or is making up all or part of story	Staff trained to improve knowledge and sensitivity
Behavior is seen as intentionally provocative and volitional	Behaviors and other indicators of sexual violence are viewed as useful and responded to openly
Language labels such as "manipulative, needy, attention seeking" etc.	Language is objective and neutral
Staff and others direct care of survivors	Survivor participates in her own recovery plan
Over-reliance on medication	Psycho-education and alternative skill development are central to service plan
Closed system where advocacy is discouraged	Transparent service system is open to

Response to Trauma

Non Trauma-Informed Language	Trauma-Informed Language
Calling people by name without permission or last name without title	Ask people how they prefer to be addressed
Yelling “lunch” or “medications” or “art therapy”	Quietly making rounds and informing people of schedules and activities, etc.
“If I have to tell you one more time”	“Let’s talk and find you something to do”
“Step away from the desk”	“May I help you?”
Non Trauma-Informed Setting	**Trauma-Informed Setting**
Large barrier around staff station/office – “us/them”	Modified staff station/office without barrier – welcoming and open
Staff checks to determine location only, focus on task and not person	Staff routinely checks-in with the person, makes eye contact
Coming and going without staff acknowledgement	Staff says hello and goodbye when coming and going

(Fallot and Harris, 2002; Cook et al, 2002; Ford, 2003; Cusack et al, 2004; Jennings, 1998; Prescott, 2000)

Indicators of Sexual Violence

Physical

- Abdominal pain, nausea, gastrointestinal difficulties
- Changes in appetite, weight gain/loss, eating disorders
- Tension headaches
- Sleep disturbances, fatigue
- Hypersensitivity to light, sound, etc.
- Unexplained bruises, scratches or other bodily injuries
- Bruising in genital and/or anal area
- Menstrual cycle disruption
- Pregnancy or a sexually transmitted infection

Emotional

- Changes in temperament or sudden mood shifts
- Anger, anxiety, irritability
- A sense of vulnerability, powerlessness, helplessness
- Diminished ability to concentrate, confusion
- Depression
- Sense of blame, guilt, shame, humiliation
- Numbing and dissociation
- Avoidance behaviors
- Nightmares, flashbacks
- Distrust of others
- Fear or avoidance of particular people or places
- Concerns and fears about pregnancy, sexually transmitted infection, etc.
- Secrecy
- Self-consciousness, particularly related to the body

Behavioral

- Sudden rejection of normal physical affection
- Perfectionism or attempts at over-achievement or pleasing others
- Overzealous in cleanliness with regard to personal hygiene
- Refusal to bathe or bathing excessively
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- Isolation from peers or withdrawal from usual activities
- Sudden change in performance in school or work settings
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- Any disclosure of abuse – even if it is delayed, conflicting or "unconvincing"
- Self-injury/Self-destructive behavior, suicide attempt
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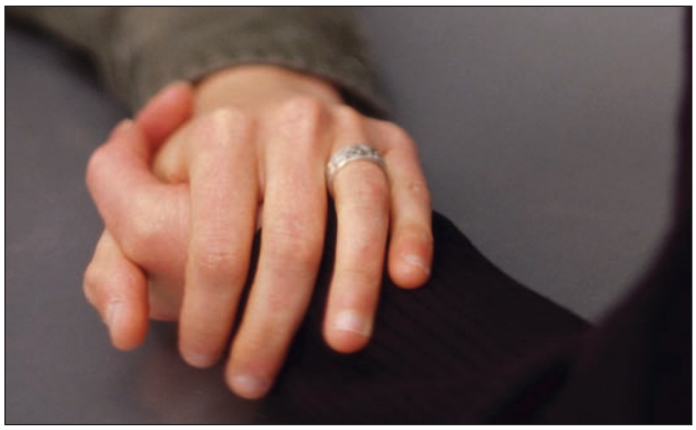
- Not speaking, even though the person has the ability to do so
- Frequent use of words like bad, dirty, or slang for sex acts or body parts
- Unexplained accumulation of extra money or gifts

Disclosure of Sexual Violence

How to Respond

- Provide Privacy
- Explain Options
- Support Choices
- Ensure Safety



DO		DON'T	
■ Believe	■ Respect	■ Doubt	■ Judge
■ Support	■ Assist	■ Blame	■ Punish

Say: I believe you. I'm sorry this happened to you.

Ask: How can I help you? What do you need right now?

Tell: We have a crisis center in town that can help you - on the phone or in person.

Help: Would you like to call them? I can help you with that.

Protect: What would make you feel safe right now? Let's make a safety plan.

Rape Crisis Hotline: 1-800-656-4673

www.dhs.state.il.us www.icasa.org

Reducing the Risk of Sexual Violence

In order to prevent sexual violence, it is critical to be aware of risk factors and consider ways to reduce risk.

Risk Factors for Sexual Violence for Women with Disabilities

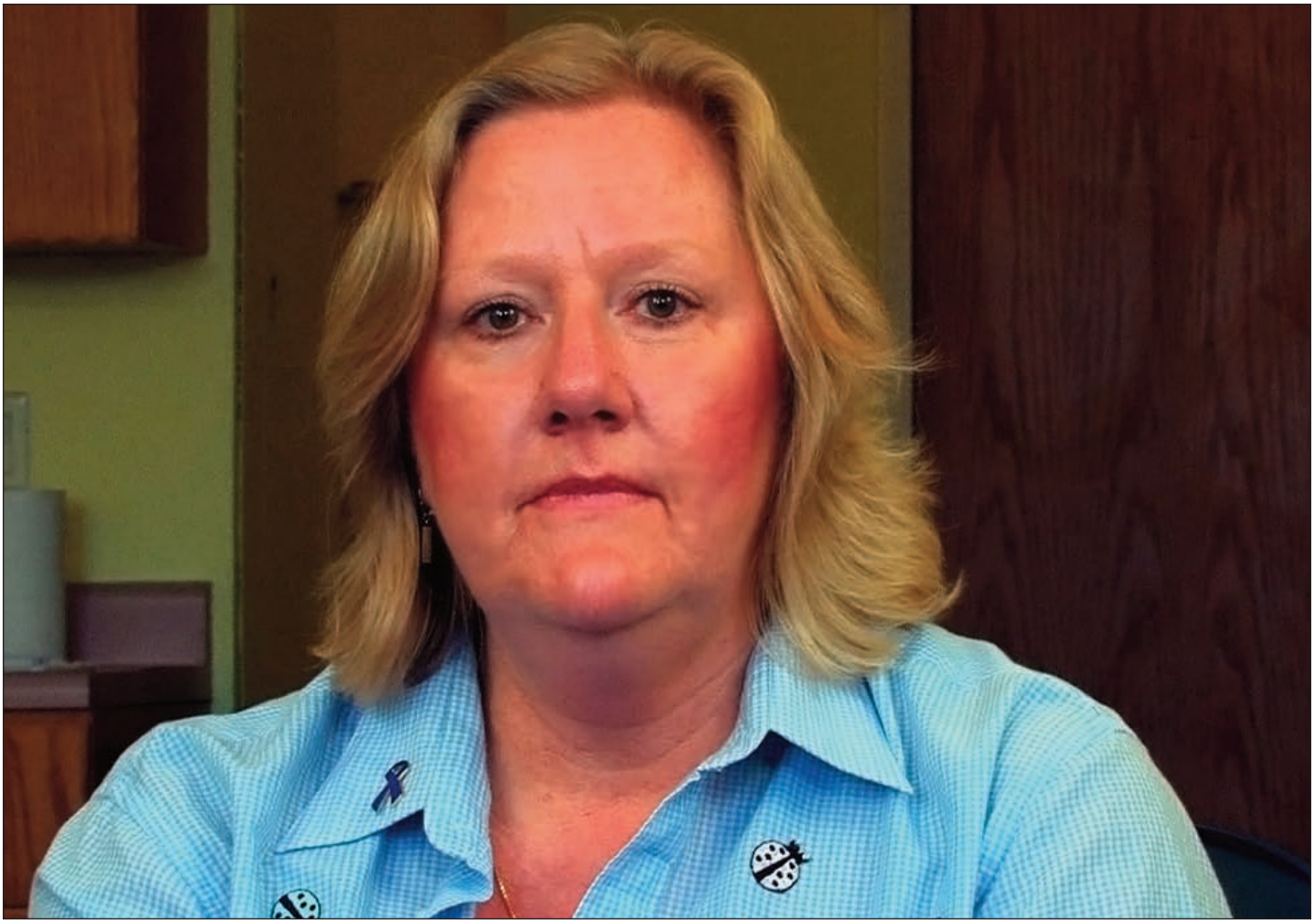
1. Unequal power relationships between staff/caregivers and women with disabilities.
2. Women with disabilities are trained to be “compliant” and to“behave.”
3. Isolation, especially from the community at large.
4. Lack of knowledge about relationships and safe, healthy sexuality.
5. Lack of personal privacy and belief by others that women with disabilities are not entitled to privacy or personal boundaries.
6. Communication and mobility barriers may make it difficult for a woman with a disability to escape or communicate danger or abuse to others.
7. Women with disabilities often receive little or no information about sex and sexuality and may be unaware that they have choices about sexual expression and/or that someone’s sexual conduct is inappropriate.
8. Women with disabilities may not report sexual violence for fear of not being believed, being blamed or being punished. Perpetrators may believe they will get away with abuse and assault against a woman with disabilities.

Reducing the Risk of Sexual Violence

In order to prevent sexual violence, it is critical to be aware of risk factors and consider ways to reduce risk.

Strategies to Minimize the Sexual Violence against Women with Disabilities

1. Treat people with disabilities as equals and not "less than." Promote more equity between staff/caregivers and women with disabilities.
2. Inform women with disabilities about rights and choices. Empower women with disabilities to ask questions and assert their rights. Adopt policy that promotes self-advocacy.
3. Create opportunities for women with disabilities to become more fully integrated into the community. Educate them about community resources/activities and remove barriers to their participation.
4. Educate women with disabilities about relationships and healthy sexuality.
5. Teach staff to respect the need for private space. Adopt policy that affirms the right of women with disabilities to privacy. Teach and model healthy boundaries.
6. Eliminate barriers. Promote universal design/access. Pay attention to what women with disabilities say about their lives and experience. Promote independence and self-sufficiency.
7. Educate staff/care givers and women with disabilities re: women with disabilities and healthy sexuality/sexual violence and their rights.
8. Educate staff, care givers and women with disabilities about how to report sexual violence and local services that can help them.



"Don't let anything stop you. There will be times when you are disappointed, but you can't stop."

Mari Evans

The Top Ten Things I'd Like to Tell Disability Service Providers About Sexual Violence

By Shirley Paceley

As a survivor of childhood sexual violence and a professional in the disability services world for over thirty-five years, I have a passion for understanding sexual violence against people with disabilities. I have been honored to hear many stories and to support people at the hospital following an assault, as well as during court proceedings to pursue justice and through the twists and turns of the recovery process. I have learned so much from the brave individuals who have let me walk beside them and I want to share the 'top ten' lessons in hopes of empowering others. In the words of those deeply affected by sexual violence, we honor their voices.

We have been hurt. Sexual violence is a very real part of our lives. We feel shame and guilt and fear and confusion. It may not be in our record. No one may know that we suffer. It most likely happened many times and by more than one person. For some of us, it has been so common, we think it is just a part of life. If you work with people with disabilities, you know survivors of sexual violence, and probably many of them. The person in front of you today may be a survivor. If I choose to tell you what has happened to me, please…

Believe me. My healing begins with how you respond when I tell you what happened. Don't tell me I am lying. Don't say the person wouldn't do something like that. The person most likely to cause sexual violence is someone I know and trust, and you may know and trust them too. Believe me. Listen to my story. Help me to feel safe. Help me understand my choices. If I decide to go to the hospital or call the police, please…

Don't tell people my "mental age." They will think I am a child, and I am not a child. It is impossible to live as long as I have lived and still be a child. Don't let others believe myths about me. They may look to you for the truth, and I need you to believe in my abilities. Please educate them, and tell them that if they take their time, I can show them that…

I am more than my labels. My diagnosis does not tell you anything about me. I want you to know my *abilities* and talents and contributions. I want you to know my deepest dreams and even my purpose. When you know my strengths, you can help me to expand my life possibilities. You can balance out what has been taken from me. You can see me as a person, very much like yourself, doing the best I can. As you recognize that we are more alike than different, please know that…

My "behavior problems" may be a response to trauma. What you view as "inappropriate" or my "need for attention," may actually be my way of coping with the trauma I have experienced. Certain smells, sounds, sights, tastes, and feelings can trigger my memories of the terror I felt when I was being assaulted. What you see and hear is behavior…so please look closer and listen with your heart. You may discover that…

I need your support to move forward. I need you to listen and be patient. I need to know that it wasn't my fault. I need to know that I am not alone. I need you to help me understand what has happened and how I can be strong again. Recovery is not a straight path, and I need you to help me when I stumble. I need you to help me find the right people who can best assist me. As we walk through this together, it would be good for us both to know that…

Sexual violence is not about sexual attraction. A lot of people think that sexual violence is about a person who can't control their sexual urges when they are attracted to someone. But that is a lie. Sexual violence is a way for someone to dominate another person – to use power to control another person. People who are taught to do what they are told are at higher risk for sexual violence. Don't teach me to be compliant. Empower me. I need to be able to say no to the safe people in my life if I am to say no to others. You might think I am especially vulnerable to violence but…

I am at greater risk for sexual violence because of others' attitudes and actions towards me than because of my disability. Now that's a mouthful! But it's true. When I am not given critical information because you think I can't understand – I am at greater risk. When systems cover up allegations, I am at greater risk. When people touch me all the time without permission, I am at greater risk. One lady said, "I've been seen naked by hundreds of people and no one has ever asked permission." Now that's a problem, so please ask before you help. Some of my friends aren't able to talk the way that you and I do, so please…

Learn the indicators for sexual violence. If you know the indicators and observe closely, you may be able to help us, even if we don't talk very well. You may be the one who gives us the gift of safety. Or you may be the one who gives us the gift of unloading our burdens. Or you may be the one who helps us to heal. And for all of these things we say…

Thank you. Thank you for learning what you can do about sexual violence. Thank you for recognizing that my 'behaviors' may be a response to trauma. Thanks for being patient with me as I try to recover from what has happened to me. Thank you so very much for believing me and helping me to express myself. You are there for me in so many ways …thanks for being here for me in this way too.

Sexual Rights of Women with Disabilities

All women with disabilities have the same rights to sexual expression as all other women in society.

These rights include, but are not limited to:

1. The right to explore, identify, define and express their sexuality and sexual orientation without judgment or discrimination.

2. The right to receive education and information about sex, safe and healthy sexual relationships, and reproductive health.

3. The right to make decisions about their sexuality and sexual relationships, including who and how they choose to relate to sexually.

4. The right to privacy and dignity related to dating and sexual intimacy.

5. The right to receive education and information about sexual harassment, abuse and assault as well as access to information about sexual violence prevention.

6. The right to safety and freedom from sexual harassment, abuse, assault and other forms of sexual violence.

7. The right to receive supportive, trauma-focused, victim-centered response in the case of sexual harassment, abuse, assault or other forms of sexual violence.

SECTION 5
TOOLS

Tools

- **Tool 1** — **Trauma Responsiveness Assessment Tool**
- **Tool 2** — **Sample Action Plan**
- **Tool 3** — **Sample Policies**
  - Privacy
  - Human Sexuality
  - Employee/Individual Relationships
  - Sexual Assault/Abuse Allegations
- **Tool 4** — **Illinois Rape Crisis Services**

Trauma Responsiveness Assessment Tool

ASSESSMENT DATE: _____

AGENCY NAME: _____

ADDRESS: _____

TELEPHONE: _____ **E-MAIL:** _____

STAFF INTERVIEWED: _____

INTERVIEWERS: _____

SEND REPORT TO: _____

Connection and Readiness Section

1. Describe the relationship and networking between your agency and the local rape crisis center. Describe any specific outreach efforts or networking agreements.

2. How does your collaboration with rape crisis centers improve your readiness to serve women with disabilities who experience sexual violence and the broader community (e.g., police, court)?

3. How would a woman with a disability who experienced sexual violence know she could safely disclose to staff in your agency? Describe any specific awareness efforts.

4. Describe how agency materials and environment make it known that the agency is a safe place for women with disabilities to talk about sexual violence.

5. How are staff prepared to respond to disclosures of sexual violence? Describe staff attitude regarding disclosures.

6. Describe staff development opportunities regarding sexual violence. How much training is provided? How much is required? How are rape crisis centers included as trainers? Describe training approaches that enhance staff comfort and confidence in responding to sexual violence.

Training Topics		Number of Hours Per Year
Sexual violence and women with disabilities (incidence, impact, general information)	❑ Yes ❑ No	
Impact of sexual violence, injury, trauma, etc.	❑ Yes ❑ No	
Responding to disclosures	❑ Yes ❑ No	
System response/resources (emergency department, law enforcement, criminal justice system) to sexual violence	❑ Yes ❑ No	
Agency policies & procedures guiding service to women with disabilities who experience sexual violence	❑ Yes ❑ No	
Other	❑ Yes ❑ No	

CONNECTION AND READINESS SUMMARY

❍ Strengths:

❍ Challenges:

❍ Resources Needed:

Policies and Practices Section

1. How do you inform women with disabilities about healthy sexuality, sexual relationships and their rights to sexual safety?

2. Describe agency policy regarding personal boundaries among clients and between clients and staff. How does policy explain what it means to respect personal boundaries and the agency's response to boundary violations?

3. How does agency intake protocol include screening for history of sexual violence? How does ongoing service planning and delivery provide disclosure opportunities for women who experience sexual violence?

4. How do you inform women with disabilities about how to report if they experience sexual harassment or sexual violence? How do staff educate women with disabilities regarding required reporting (at point of intake and any point of potential disclosure)?

5. Describe immediate response to women with disabilities who disclose sexual violence (e.g., crisis intervention, medical care, reporting and safety planning). How does the response to disclosure support victim safety and healing?

6. How is privacy provided when a woman with a disability discloses sexual violence?

7. How does the woman participate in reporting sexual violence to others (e.g., family, rape crisis center, OIG, law enforcement)?

8. Describe the referral process and coordination of services with a rape crisis center. How would a woman be informed that she can use rape crisis services? Does the agency provide on-site space for rape crisis staff to serve women with disabilities?

9. How does the service plan incorporate a holistic response to the woman's sexuality, sexual orientation, sexual choices and safety?

10. How is understanding of and response to trauma integrated into the overall service plan (e.g., education, employment, counseling)?

11. How does the staff advocate for and/or arrange transportation and accommodations for individual women with disabilities in the agency and community settings (e.g., hospital, court)?

POLICIES AND PRACTICES SUMMARY

❍ Strengths:

❍ Challenges:

❍ Resources Needed:

Additional Resources Section

1. What resources (e.g., training, etc.) do you need to be more trauma responsive?

2. Comments:

Sample Action Plan to Achieve Trauma Responsiveness

WHAT	WHO	WHEN
Participate in local collaboration team to improve service system for women with disabilities who experience sexual violence.	Executive Director	Monthly meetings throughout fiscal year
Establish working agreement with local rape crisis center	Executive Director of rape crisis center and Executive Director of ARC	February
Enhance intake screening tool to provide the opportunity to assess trauma	Program Director	February - March
Conduct half-day training for all staff on trauma affects and sexual violence.	Executive Director of rape crisis center, Executive Director of ARC and women with disabilities	March
Display sexual violence awareness posters and brochures in waiting areas.	Receptionist	Beginning April
Expand Life Skills group curriculum to cover healthy relationships, healthy sexuality and sexual violence	Program staff	May
Assess policies and procedures. Revise policies to enhance identification and response to sexual violence against women with disabilities.	All staff in collaboration with local collaboration team, including women with disabilities from the collaboration	July-September

Policy and Procedure Directive (Sample)

SECTION: Human Sexuality

SUBSECTION: Privacy

POLICY TITLE: Privacy

POLICY STATEMENT:

ABC AGENCY shall ensure that all individuals served have a right to privacy. Individuals shall be trained in privacy issues and their privacy shall be respected. Privacy shall be considered fundamental to the development of a positive self-image and adult relationships.

DEFINITION:

Privacy - Private, secluded, away from a public place. Privacy factors include but are not limited to location, behavior, information, and employee routines.

PROCEDURES:

1. Employees shall ensure that each individual served has the right to privacy.

2. Individuals served shall be educated and trained individually to meet the person's needs and level of understanding about privacy.

3. Opportunities for privacy shall be made available to individuals who have roommates, while maintaining each individual's right to choose.

4. Each individual served in a 24-hour setting shall have sufficient privacy to have the opportunity for appropriate sexual expression.

5. Employees, volunteers, and interns shall be educated about privacy as well as their roles and responsibilities in maintaining individuals' privacy and confidentiality.

6. Employee responsibilities to respect and teach individuals about privacy include the following:
   a. Employees shall reinforce the principles of privacy as opportunities occur, e.g., closing the restroom doors if the individual leaves it open.

   b. Prior to assisting an individual with personal care, employees shall ask permission. If the individual is unable to give active permission, the employee shall state what action is about to occur, and wait briefly for a response.

   c. Employees shall ensure that all personal care assistance is performed with respect for the individual's privacy (e.g., behind closed doors, etc.)

   d. Employees shall always knock and seek permission to enter before entering an individual's bedroom and/or before entering a restroom. If the individual is un able to give active permission, the employee shall knock again and announce herself/himself before entering.

   e. Private areas may be entered by employees without permission/announcement, only when there is evidence of danger; the possibility of or the presence of violent behavior; or the belief that an individual's rights are being violated.

   f. Employees shall ensure that community standards of privacy are maintained by active intervention and redirection as needed.

   g. Discussions with individuals of a private nature (menses, sexuality, etc.) shall occur in private.

   h. Employees shall only share private information about an individual on a need-to-know basis, and only in a private setting where others cannot hear.

   i. When providing personal assistance in bathing/showering, employees shall avoid skin on skin contact with private body parts and increase visual and physical barriers to the degree possible.

   j. Employees shall actively model and train individuals served to discuss personal matters in a private area with a safe person.

Direction from the Interdisciplinary Team shall be provided for individuals with specific training or support needs in the area of privacy/sexuality.

AUTHORITY: U.S. Constitution; IDHS Mental Health Code;
IDHS Confidentiality Act

Policy and Procedure Directive (Sample)

SECTION: Human Sexuality

SUBSECTION: General Description

POLICY TITLE: General Description

POLICY STATEMENT:

ABC AGENCY recognizes that human sexuality is an important component of a person's individuality. Human sexuality encompasses much more than sexual activity and reproduction. Human sexuality includes one's thoughts, feelings, values, morals, ideas, and decisions, which help define how people feel about themselves and others. It includes behaviors, attitudes, and relationships. *ABC AGENCY* maintains that human sexuality is intrinsic to all individuals.

The ABC AGENCY believes that the rights of persons with disabilities in the realm of human sexuality include those same opportunities, responsibilities, and concerns as the general population. To this end, therefore, we hold that:

- People with a disability have the right to reach, express and experience the continuum of human sexuality development.

- Sexual expression of a person with a disability is a matter of personal choice as expressed within the context of community expectations and norms. Further, it is *ABC AGENCY's* obligation to make available to these individuals information and guidance for understanding and expressing the elements of human sexuality without imposing employees' personal values on them.

- Individuals have the right to access information and education regarding the subject of human sexuality consistent with the individual's/guardian's choice and with their level of learning, development, and understanding.

- Due to the personal and private nature of sexuality issues and the diversity of opinions, every effort shall be made to resolve any conflicts in a professional and equitable manner.

- Individuals have the right to privacy, confidentiality, free choice of association, and freedom from physical, emotional, and/or sexual abuse.

- Due to the personal nature of sexuality issues, every effort shall be made to resolve any conflicts between the individual and the guardian in a private and professional manner.

AUTHORITY:
- U.S. Constitution - IDHS Mental Health Code - IDHS Confidentiality Act

Policy and Procedure Directive (Sample)

SECTION: Human Sexuality

SUBSECTION: Employee/Individual Relationships

POLICY TITLE: Employee/Individual Relationships

POLICY STATEMENT:

All employees, volunteers, interns, of ABC Agency shall maintain professional relationships with individuals served at all times.

DEFINITIONS:

Non-Sexual Contact *Contact between an individual and an employee of a non-sexual nature, e.g., handshake; pat on back; side hug.*

Sexual Contact *Contact between an individual and an employee of a sexual nature, e.g., kissing on the mouth and/or breasts and/or genitalia; sitting on lap; touching genitalia, except for medical and hygiene purposes; exposure of private body parts.*

PROCEDURES:

1. Professional relationships between individuals served and employees shall not place either person in conflict. The needs of the individuals and family members shall be a priority.

2. Employees, interns, volunteers, etc. shall model and reinforce, in daily interactions with individuals served, the concept of appropriate vs. inappropriate touching, and assist individuals in setting limits for appropriate touching. Employees shall also recognize the importance of the individual's need for human contact and provide positive role modeling.

3. Individuals served and employees shall receive training about appropriate vs. inappropriate touch between individuals served and employees.

4. Individuals served shall receive training in assertiveness and/or prevention of sexual abuse.

5. Socially acceptable physical contact of a nonsexual nature between employees and individuals served shall be permissible and encouraged when in response to the individual's need for human contact and with permission of both the individual and the employee.

6. Employees shall utilize opportunities for promoting individuals' assertiveness on a regular basis.

7. Sexual contact between employees and individuals served is prohibited; it is considered sexual abuse and shall result in disciplinary action, including termination, and possible legal action.

   - Exceptions may be made in a case by case basis when the employee is a self-advocate. Requirement for exception shall be reviewed by the Human Rights Committee with the Executive Director making the final decision. An exception that could be considered includes a pre-existing relationship prior to the self-advocate's employment.

   - If an exception is made, the employee will not continue or be assigned to any role that would include authority over the individual.

8. In the event that an employee becomes aware that an individual served is sexually attracted to him/her, the employee shall notify his/her supervisor and discuss options for handling the situation. The supervisor and/or the Primary Case Manager shall counsel the individual about friendship, relationships, roles, boundaries and prohibition of staff/individual relationships.

9. In the event that an employee becomes aware that he/she is sexually attracted to an individual served and/or immediate family member and is unable to resolve the feelings in dependently, he/she shall inform his/her supervisor and discuss resolution, which may include alternate employment options.

10. In the event that an employee becomes aware of sexual contact between an individual served and another employee, the situation should be reported immediately to the Chair person of the Human Rights Committee. [See Policy and Procedure entitled "Sexual Assault/Abuse".] Any resultant discipline or remediation shall be directed at the employee, not the individual.

AUTHORITY:

- IDHS Mental Health Code; - IDHS Confidentiality Act

CONCEPT:

EFFECTIVE DATE: _____ BOARD APPROVAL: _____

REVISED DATE: _____ BOARD APPROVAL: _____

Policy and Procedure Directive (Sample)

SECTION: Human Rights

SUB-SECTION: Human Rights Committee/Human Rights Complaints

POLICY TITLE: Sexual Assault/Abuse Allegations

POLICY STATEMENT:

At ABC agency, all allegations of sexual assault or abuse are taken seriously and reported. Reporting and handling procedures shall be in accordance with current medical practices, legal procedures, and required reporting requirements.

PROCEDURE:

Employee Response:

When any employee of ABC agency has any reason (e.g., disclosure by individual, direct observation, report by staff or other individual) to believe that an adult individual served may be the victim of sexual assault or abuse, the following action shall be taken:

1. Maintain a relaxed attitude.

2. Let the individual know that you will contact someone who can help them.

3. Do not interview the individual.

4. Contact the HRC Chair/Emergency Services if after regular business hours) immediately and let him/her handle the situation.

5. Do not discuss the situation with anyone except the Program Director, Human Rights/Intake Referral Specialist, Executive Director and/or investigative entities.

Management Response:

The employee receiving the report (HRC Chair/ Emergency Services team member) shall meet with the adult individual immediately and:

1. Maintain a relaxed, non-judgmental attitude.

2. Build trust and rapport through an empathic approach.

3. Avoid projecting your own reaction into the situation. Provide verbal reassurance regarding four key issues. The individual is:

   - ❍ correct to disclose;
   - ❍ believed;
   - ❍ not responsible/guilty;
   - ❍ not alone.

4. Preserve evidence. Encourage the individual not to change clothing or bathe, if she has not done so since the incident.

5. If the individual cannot communicate in a traditional manner, the Human Rights/Intake Referral Specialist shall utilize the "guiding questions when sexual abuse is suspected" process.

6. If the information provided by the individual indicates any possibility that the individual was sexually assaulted/abused:

   - ❍ Explain the need to contact people who can protect them and help resolve the situation. Explain to the person that services are available at the Rape Crisis Center and offer assistance in contacting them if the person chooses.

   - ❍ Contact and discuss the situation with the Executive Director.

   - ❍ Contact the police station with jurisdiction if an employee is the alleged perpetrator.

   - ❍ In all other situations, adults without guardians have the right to decide whether or not to contact the police.

7. If the individual has a guardian, the guardian should be notified immediately. Ask the person if she wants to notify the guardian or if she want staff to do so. If the guardian is the alleged perpetrator, the guardian shall not be notified of the allegation. Instead, law enforcement shall contact the guardian.

8. If an individual lives with family but does not have a guardian, discuss with the individual the option of contacting family members and follow up accordingly. An alleged perpetrator shall not be contacted by ABC agency in this situation unless necessary to protect the individual.

9. If the individual lives in a licensed residential facility, the Residential Services Director (RSD) or the Director of Community Living Services (CLS) shall be notified. If that person (RSD/Director of CLS) is the alleged perpetrator, the residential owner or ABC agency Executive Director shall be notified.

10. During the above phone contacts, discussion shall occur regarding the individual's choice about an examination, who shall transport; and the individual's choice regarding who should be available for support.

11. If disclosure occurs within seven days of the sexual assault: the individual shall be offered support by employees of choice and transported to the local hospital emergency room of their choice where an examination shall occur. The hospital personnel should be told that a sexual assault has taken place. The evidence collection procedures shall be at no cost to the individual. The hospital will notify the police and the local Rape Crisis Center.

12. If the disclosure occurs more than seven days after the incident, the individual should be referred to his/her private physician, a hospital emergency room or Planned Parenthood for a general exam and to be tested for sexually-transmitted infection.

13. The responsible person (HRC Chair/ABC Emergency Services team member) shall:

- ❍ Complete written documentation of the allegation in an expedient manner.

- ❍ If the sexual assault occurred in a home or program funded by the Illinois Department of Human Services (DHS), a report should be phoned to the OIG within four hours of discovery. The person shall be notified of such requirement and involved in making the call if that is her choice.

- ❍ For persons who live in long-term care facilities or state-operated facilities, the residential facility shall be notified immediately and a report shall be phoned to the Department of Public Health within 24 hours. This should be discussed with the Residential Services Director of the facility.

AUTHORITY:
- DHS & DPH
- OIG Rule 50

CONCEPT:

EFFECTIVE DATE: _____ BOARD APPROVAL: _____

REVISED DATE:_____ BOARD APPROVAL: _____

Illinois Coalition Against Sexual Assault Resource Guide

Who Are We?

ICASA is a not-for-profit corporation of 33 community-based sexual assault crisis centers located throughout the state.

The purpose of the Illinois Coalition Against Sexual Assault is to end sexual violence and to alleviate the suffering of sexual assault victims. This work is inseparable from ICASA's commitment to eliminate oppression in all forms. To accomplish these goals, ICASA advocates for public policy that prevents sexual violence and guarantees sensitivity to victims and promotes social justice. ICASA uses the power of public education to change beliefs and attitudes about the causes and consequences of sexual violence and the devastation of oppression. Through community programs that provide advocacy, counseling and education, ICASA works for a safe, free and just society.

ICASA centers assist survivors of sexual assault. Each ICASA center provides counseling and advocacy to females and males of every age; to family members and friends of victims. These specialized services support survivors of sexual assault, child sexual abuse, acquaintance rape, sexual harassment and incest. The center's work may begin shortly after a victim is raped or years after an assault. In either case, the crisis center provides free and confidential services to promote healing and advance justice.

Contact Information

Phone: 217-753-4117
TTY: 217-753-9472
Website: www.icasa.org

Resources Available

Brochures

- A Guide to Civil Lawsuits
- Acquaintance Rape*
- Civil No Contact Guide
- Male Survivors*
- Parent Pamphlet*
- A Guide to Advocacy Services*
- After Sexual Assault
- How Can I Help?
- Men Responding to Sexual Assault*
- What Do I Need to Know

* Also available in Spanish

Manuals

- By the Numbers: Sexual Violence Statistics
- The Law Book: Illinois Criminal Sexual Assault Act & Related Statutes

Fact Sheets

- Sexual Violence
- Rape Myths
- Sexual Harassment
- Acquaintance Rape

Posters

- Our Rights, Right Now: Stop Sexual Violence
- Our Rights, Right Now: Report Sexual Violence
- Real Men Don't Rape

Library

- ICASA has a library collection of more than 1,200 books, articles and videos on sexual violence.
- Material may be checked out through www.icasa.org.

Ordering Information

- All publications are available for download at www.icasa.org.
- Hard copy orders can be submitted at www.icasa.org or by calling 217-753-4117.
- Publications are free.

Illinois Rape Crisis Centers

ARLINGTON HEIGHTS

Northwest Center
Against Sexual Assault
415 W. Golf Rd., Suite 47
Arlington Heights, Illinois 60005
Phone: (847) 806-6526
Hotline: (888) 802-8890
Fax: (847) 806-6531

AURORA

Mutual Ground, Inc.
P.O. Box 843
Aurora, Illinois 60507
Contact: Jan Faulhaber
Phone: (630) 897-8989
Hotline: (630) 897-8383
Fax: (630) 897-3536
website: www.mutualgroundinc.com

BELLEVILLE

Call For Help, Inc.
Sexual Assault Victims Care Unit
9400 Lebanon Road
Edgemont, Illinois 62203
Phone: (618) 397-0975
Hotline: (618) 397-0975
Fax: (618) 397-6836
TTY: (618) 397-0961

Satellite Offices:
Call For Help, Inc.
Sexual Assault Victims Care Unit
129 N. 8th St., Room 469
East St. Louis, Illinois 62201
Phone: (618) 271-8990
Hotline: (618) 397-0975
Fax: (618) 271-2326

Call For Help, Inc.
Sexual Assault Victims Care Unit
2421 Corporate Center, Suite 103
Granite City, Illinois 62040
Phone: (618) 797-1049
Hotline: (618) 797-1049
Fax: (618) 452-3094

BLOOMINGTON

Stepping Stones
Sexual Assault Services
YWCA McLean County
1201 N. Hershey Road
Bloomington, Illinois 61704
Phone: (309) 662-0461
Fax: (309) 662-4506
Hotline: (309) 827-4005

CARBONDALE

Rape Crisis Services of the Women's Center, Inc.
610 S. Thompson Street
Carbondale, Illinois 62901
Phone: (618) 549-4807
Hotline: (618) 529-2324 or
(800) 334-2094
Fax: (618) 529-1802
TTY: (618) 529-2324
Website: www.thewomensctr.org

Satellite Office:
Rape Crisis Services
100 Tower Square
Marion, Illinois 62959
Phone: (618) 993-0803
Hotline: (800) 334-2094
Fax: (618) 993-3178
TTY: (618) 993-0803

Illinois Rape Crisis Centers

CHARLESTON/MATTOON

Sexual Assault Counseling & Information Service
P.O. Box 858
Charleston, Illinois 61920
Phone: 217) 348-5033
Hotline: (888) 345-2846
Fax: (217) 348-5051
Website: www.sacis.org

Satellite Office:
Counseling & Information for Sexual Assault/Abuse
10499 North State Highway #1
R.R. #1, Suite 1
Robinson, Illinois 62454
Phone: (618) 544-9379
Hotline: (866) 288-4888
Fax: (618) 544-8890
TTY: (618) 544-9379

CHICAGO

Community Counseling Centers of Chicago
Quetzal Center
2525 W. Peterson Ave.
Chicago, Illinois 60659
Phone: (773) 765-0612
Hotline: (888) 293-2080
Fax: (773) 765-0650
TTY: (773) 769-1724

YWCA Metropolitan Chicago
Sexual Violence & Support Services
360 N. Michigan, 8th Floor
Chicago, Illinois 60601
Phone: (312) 762-2789
Hotline: (888) 293-2080
Fax: (312) 372-4673
Website: www.ywcachicago.org

Satellite Offices:
YWCA Metropolitan Chicago
Sexual Violence & Support Services
Logan Square Satellite Office
2858 W. Diversey
Chicago, Illinois 60647
Phone: (773) 862-3100
Hotline: (888) 293-2080
Fax: (773) 862-3169

YWCA Metropolitan Chicago
Sexual Violence & Support Services
Laura Parks and Mildred Francis Center
6600 S. Cottage Grove
Chicago, Illinois 60637
Phone: (773) 496-5627
Hotline: (888) 293-2080
Fax: (773) 955-0311

YWCA Metropolitan Chicago
Sexual Violence & Support Services
Englewood Satellite Office
641 W. 63rd St. – Main Level
Chicago, Illinois 60621
Phone: (773) 783-1031
Hotline: (888) 293-2080
Fax: (312) 747-0292

Illinois Rape Crisis Centers

YWCA Metropolitan Chicago
Sexual Violence & Support Services
Lawndale Satellite Office
3333 W. Arthington, #150
Chicago, Illinois 60624
Phone: (773) 265-9500
Hotline: (888) 293-2080
Fax: (773) 265-9505

YWCA Metropolitan Chicago
Sexual Violence & Support Services
RISE Children's Center
300 South Ashland, Suite 301
Chicago, Illinois 60607
Phone: (312) 733-2102
Hotline: (888) 293-2080
Fax: (312) 733-2188

Outreach Office:
YWCA Metropolitan Chicago
Sexual Violence & Support Services
Uptown Outreach Services
4753 N. Broadway, Suite 918
Chicago, Illinois 60640
Phone: (773) 596-5490
Hotline: (888) 293-2080
Fax: (773) 596-5502

Mujeres Latinas En Acción
2124 W. 21st Place
Chicago, Illinois 60608
Phone: (773) 890-7676
Fax: (773) 890-7650
Hotline: (888) 293-2080

Rape Victim Advocates (RVA)
180 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601
Phone: (312) 443-9603
Hotline: (888) 293-2080
Fax: (312) 443-9602
TTY: (312) 935-3401

Satellite Offices:
RVA-Stoger Hospital of Cook County
1901 W. Harrison, Fantus Health Center
Chicago, Illinois 60612
Phone: (312) 864-6112 or 6111
Hotline: (888) 293-2080
Fax: (312) 864-9918

Austin Community Satellite
Phone: (312) 672-9960
Hotline: (888) 293-2080
Fax: (312) 443-9602

CHICAGO HEIGHTS

YWCA Metropolitan Chicago
South Suburban Center
Sexual Violence & Support Service
320 West 202nd St.
Chicago Heights, Illinois 60411
Phone: (708) 754-0486
Hotline: (708) 748-5672
Fax: (708) 754-1585

Illinois Rape Crisis Centers

DANVILLE

Vermillion County Rape Crisis Center
1630 Georgetown Road, Suite #1
Tilton, IL 61833
Phone: (217) 446-1337
Hotline: (866) 61-REACH (73224)
Fax: (217) 477-7010
TTY: (217) 443-5566

DECATUR

Growing Strong Sexual Assault Center
270 W. Prairie St.
Decatur, Illinois 62523
Phone: (217) 428-0770
Hotline: (217) 428-0770
Fax: (217) 428-8537
TTY: (217) 362-9226
Website: www.growingstrongcenter.org

DEKALB

Safe Passage, Inc.
P.O. Box 621
DeKalb, Illinois 60115
Phone: (815) 756-7930
Hotline: (815) 756-5228
Fax: (815) 756-7932

ELGIN

Community Crisis Center
P.O. Box 1390
Elgin, Illinois 60121-1390
Phone: (847) 742-4088
Hotline: (847) 697-2380
Fax: (847) 742-4182
TTY: (847) 742-4057
Ayuda: (847) 697-9740
Website: www.crisiscenter.org

GALENA

Riverview Center Inc.
Sexual Assault Prevention
& Intervention Services
705 South Dodge
Galena, Illinois 61036
Phone: (815) 777-8155
Hotline: (888) 707-8155
Fax: (815) 777-2717

Satellite Offices:
Riverview Center Inc.
SAP&IS, Carroll County Satellite
1016 E. Market Street
Mount Carroll, Illinois 61053-1108
Phone: (815) 273-7772
Hotline: (877) 273-7772 (toll free)
Fax: (815) 273-2617

Riverview Center, Inc.
SAP&IS, Dubuque County Satellite
2600 Dodge Street, Suite D4
Dubuque, Iowa 52001
Phone: (563) 557-0310
Hotline: (888) 557-0310
Fax: (563) 582-8124

Riverview Center, Inc.
Sexual Assault Prevention
and Intervention Services
116 Guetzko Court
Manchester, Iowa 52057
Phone: (563) 927-1524
Hotline: (888) 707-8155
Fax: (563)927-3011

Illinois Rape Crisis Centers

GLENDALE HEIGHTS

YWCA Metropolitan Chicago
West Suburban Center
Sexual Violence and Support Services
739 Roosevelt Road, Suite 8-210
Glen Ellyn, Illinois 60137
Phone: (630) 790-6600 ext 240
Hotline: (630) 971-3927
Fax: (630) 790-8024
TTY: (630) 790-6600

GURNEE

Zacharias Sexual Abuse Center
4275 Old Grand Avenue
Gurnee, Illinois 60031
Phone: (847) 244-1187
Hotline: (847) 872-7799
Fax: (847) 244-6380
TTY: (847) 244-1367

HICKORY HILLS

The Pillars Community Services
8020 West 87th Street
Hickory Hills, Illinois 60457
Phone: (708) 485-0069 or
(708) 741-4500
Hotline: (708) 482-9600
Fax: (708) 485-0160
TTY: (708) 793-5000

Satellite Offices:
The C.A.R.E. Center
6918 Windsor
Berwyn, Illinois 60402
Phone: (708) 788-6759
Hotline: (708) 482-9600
Fax: (708) 788-6761
The C.A.R.E. Center at 104th
10401 S. Kedzie
Chicago, IL 60655
Phone: (708) 741-4500
Hotline: (708) 482-9600
Fax: (708) 485-0160

JOLIET

Sexual Assault Service Center
Guardian Angel Community Services
1550 Plainfield Road
Joliet, Illinois 60435
Phone: (815) 729-0930 x330
Hotline: (815) 730-8984
Fax: (815) 744-6087
TTY: (815) 744-6369

KANKAKEE

Kankakee County
Center Against Sexual Assault
1440 W. Court Street
Kankakee, Illinois 60901
Phone: (815) 932-7273
Hotline: (815) 932-3322
Fax: (815) 932-7298
TTY: (815) 932-7273

Outreach Office:
Iroquois Sexual Assault Services
550 S. 10th Street
Watseka, IL 60970
Phone: (815) 432-2779
Hotline: (815) 432-0420
Fax: (815) 932-7298

MACOMB

Illinois Rape Crisis Centers

Western Illinois Regional Council/
Community Action Agency/
Victim Services
223 S. Randolph St.
Macomb, Illinois 61455
Phone: (309) 836-2148
Hotline: (309) 837-5555
Fax: (309) 836-3640
TTY: (309) 837-5555

MCHENRY

Pioneer Center for Human Services
109 S. Jefferson St.
Woodstock, Illinois 60098
Phone: (815) 759-7066
Hotline: (800) 892-8900
Fax: (815) 759-7298

PEORIA

The Center for the Prevention of Abuse
– Sexual Assault Services
P.O. Box 3855
Peoria, Illinois 61612
Phone: (309) 691-0551
Hotline: (309) 691-4111 or
(800) 559-SAFE
Fax: (309) 272-2916
TTY: (309) 691-0551

PRINCETON

Freedom House, Inc.
440 Elm Place
Princeton, Illinois 61356
Phone: (815) 872-0087
Hotline: (800) 474-6031
Fax: (815) 872-5044

QUAD CITIES

Rape/Sexual Assault Program
Family Resources, Inc.
1521 47th Avenue
Moline, IL 61265-7022
Phone: (309) 797-6534
Hotline: (309) 797-1777
Fax: (309) 797-6565
TTY: (309) 793-1443
Website: www.famres.org

QUINCY

Quanada Sexual Assault Program
1900 Harrison
Quincy, Illinois 62301
Phone: (217) 223-2030
Hotline: (800) 369-2287
Fax: (217) 228-4161
TTY: (217) 223-2383

Satellite Office:
Pike County Satellite Office
941 W. Washington
Pittsfield, Illinois 62363
Phone: (217) 285-6119
Hotline: (800) 369-2287
Fax: (217) 285-6034

Illinois Rape Crisis Centers

ROCKFORD

Rockford Sexual Assault Counseling, Inc.
4990 E. State Street
Rockford, Illinois 61108
Phone: (815) 636-9811
Hotline: (815) 636-9811
Fax: (815) 636-9826

Satellite Offices:
Rockford Sexual Assault Counseling, Inc.
860 Biester Drive, Suite 101
Belvidere, Illinois 61008
Phone: (815) 544-6821
Hotline: (815) 636-9811
Fax: (815) 544-2846

Rockford Sexual Assault Counseling, Inc.
1201 South 7th Street, #109
Rochelle, Illinois 61068
Phone: (815) 562-8844
Hotline: (815) 636-9811
Fax: (815) 562-8833

Outreach Office:
Prevention Office
5301 E. State Street, Suite 218A
Rockford, Illinois 61108
Phone: (815) 398-9866
Hotline: (815) 636-9811
Fax: (815) 398-9997

SPRINGFIELD

Prairie Center Against Sexual Assault
3 West Old State Capitol, Suite 206
Springfield, Illinois 62701
Phone: (217) 744-2560
Hotline: (217) 753-8081
Fax: (217) 744-2563

Satellite Office:
Prairie Center Against Sexual Assault
2001 West Lafayette St.
Jacksonville, Illinois 62650
Phone: (217) 243-7330
Hotline: (217) 753-8081
Fax: (217) 243-6819

STERLING

YWCA of the Sauk Valley
412 First Avenue
Sterling, Illinois 61081
Phone: (815) 625-0333
Hotline: (815) 626-7277
Fax: (815) 625-5308
TTY: (815) 625-6870

Satellite Office:
YWCA of the Sauk Valley
115 W. 1st Street, Suite 200
Dixon, Illinois 61021
Phone: (815) 288-1232
Hotline: (815) 288-1011
Fax: (815) 288-1141

Illinois Rape Crisis Centers

STREATOR

ADV & SAS
P.O. Box 593
Streator, Illinois 61364
Phone: (815) 672-2353
Hotline: (800) 892-3375
Fax: (815) 672-4842

Satellite Office:
ADV & SAS
815 North Ladd Street
Pontiac, Illinois 61764
Phone: (815) 844-0982
Hotline: (800) 892-3375
Fax: (815) 844-1048

Outreach Offices:
ADV&SAS
1009 Boyce Memorial Drive
Ottawa, Illinois 61350
Phone: (815) 434-9650
Hotline: (800) 892-3375
Fax: (815) 434-9652

ADV&SAS
510 N. Bloomington St., 2nd Floor
Streator, Illinois 61364
Phone: (815) 673-1552
Hotline: (800) 892-3375
Fax: (815) 672-2084

URBANA/CHAMPAIGN

Rape, Advocacy, Counseling & Education Services
145A Lincoln Square
Urbana, IL 61801
Phone: (217) 344-6298
Hotline: (217) 384-4444 or (877) 236-3727
Fax: (217) 344-6604

VANDALIA

Sexual Assault & Family Emergencies
1410 Sunset Drive, Suite G
Vandalia, Illinois 62471
Phone: (618) 283-1414
Hotline: (800) 625-1414
Fax: (618) 283-1472

Satellite Office:
Sexual Assault & Family Emergencies
730 E. 2nd Street, P.O. Box 225
Centralia, Illinois 62801
Phone: (618) 533-0475
Hotline: (800) 625-1414
Fax: (618) 533-0476

Outreach Office:
Sexual Assault & Family Emergencies
P.O. Box 1641
Effingham, Illinois 62401
Phone: (217) 342-6623
Hotline: (800) 625-1414
Fax: (217) 347-0686