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GUIDE FOR RAPE CRISIS CENTERS

Illinois Imagines Project
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GUIDE FOR RAPE CRISIS CENTERS

SECTION 1
INTRODUCTION

INTRODUCTION

WHAT WILL YOU FIND IN THIS GUIDE?

1. **Creating the Environment** – Process and tools to enhance the “Disability Responsiveness” of the rape crisis center and conduct community outreach.

2. **Training Your Staff** – Guidance to create an environment where women with disabilities feel welcome and workers are ready to provide a victim-centered, empathic response.

3. **Responding to Sexual Violence** – Guidance regarding how to serve women with disabilities.

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

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

Rape crisis centers have a long history of serving women who have experienced sexual violence. These services are designed for victim-centered focus from moment of first contact through trauma resolution. These vital services are accessible to all citizens in a community. Yet, women with disabilities are under-represented in the client population, particularly in light of the disproportionate incidence of abuse against them.

This guide will help a disability service agency:

- **engage in self-evaluation;**
- **enhance accessibility (physical, communication, attitudinal);**
- **tailor services to meet needs of women with disabilities;**
- **expand outreach and connection to disability service agencies; and**
- **prepare staff to serve women with disabilities.**

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), which is non-consensual and is sexual in nature. The term "sexual violence" includes sexual harassment, exposure, voyeurism, sexual abuse, sexual assault and other forms of sexual exploitation. Sexual violence may be perpetrated by a family member, partner, acquaintance, caregiver or stranger.

SECTION 2

CREATING THE ENVIRONMENT

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CREATING THE ENVIRONMENT

INTRODUCTION

In order to serve women with disabilities who experience sexual violence, the rape crisis center needs to accomplish two goals:

1. **Be disability responsive** – To achieve this goal, the rape crisis center needs to be aware that it may need to make some adaptations to serve women with disabilities. To find out what adaptations are needed, the rape crisis center needs to conduct a disability responsiveness assessment. The center may also need to adopt policy specific to serving women with disabilities.

2. **Collaborate with disability service agencies** – The rape crisis center needs to conduct outreach to make women with disabilities, their families/support workers and disability service agencies aware that it is ready to serve women with disabilities who experience sexual violence. The primary points of access for this outreach are the agencies that serve women with disabilities.

BE RESPONSIVE

SELF-ASSESSMENT

To enhance responsiveness to women with disabilities, the rape crisis center can begin with self-evaluation. The Disability Responsiveness Assessment tool (see Tool #1) is designed to help the rape crisis center evaluate its responses to women with disabilities who experience sexual violence. The Assessment will identify how the agency responses are:

- ○ visible to women with disabilities in the community;
- ○ knowledgeable about disability issues and comfortable serving women with disabilities;
- ○ accessible to women with disabilities;
- ○ directed toward empowerment of women with disabilities who experience sexual violence; and
- ○ engaged with disability service agencies to serve women with disabilities.

To conduct the Disability 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 do 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.

Additional tools are available to assist in helping evaluate your program and services for accessibility. Two resources include:

> Accessibility Guide for DV and SA Providers (.PDF)
> (http://www.w-c-a.org/pdfs/vawaguide.pdf)
> This resource is a guide to assist sexual assault and domestic violence staff and agencies to embark on an action-oriented process to address more common accessibility barriers.
>
> Self Assessment Tool for Ensuring Access for People with Disabilities (.PDF)
> This resource is a tool to be used by sexual assault and domestic violence service providers to review their programs and services to ensure that people with disabilities have equal access and an equal opportunity to participate.

RESPOND TO ASSESSMENT FINDINGS

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

- ○ Conduct outreach to enhance agency visibility to women with disabilities and their service providers.
- ○ Train staff regarding the high prevalence of sexual violence among women with disabilities and the level of underreporting.
- ○ Train staff to enhance knowledge and attitude of agency staff regarding disabilities.
- ○ Train staff regarding adaptive communication methods and tools.
- ○ Address transportation barriers 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

The Disability Responsiveness Assessment will probably point out some areas where accessibility can be enhanced with both immediate and longer term adaptations of physical sites, as well as changes to policies and practices. It is useful to review all agency policies and procedures to assess whether policy is disability responsive, proactive and specific regarding inclusion of women with disabilities within the agency and adapting services to meet individual needs. For sample policies, see Tool #3 in this module.

SMALL CHANGES: BIG RESULTS

With a few manageable changes, every rape crisis center can create an environment that welcomes women with disabilities who have experienced sexual violence. Policy change is one obvious step. Training staff is another. Enhancing access to women with disabilities is a key step. Making information about disabilities readily available to staff also contributes to an environment where women with disabilities feel safe and workers feel ready to respond. See Module 5 for DVDs, flyers and posters for women with disabilities.

COLLABORATION WITH DISABILITY SERVICE AGENCIES

In addition to conducting the Disability Responsiveness Assessment, it is useful to work with your local disability service agencies. The goal of this outreach is to make women with disabilities and their service providers, family/friends and support workers aware of your services. They need to know:

- ❍ that a rape crisis center exists in their local area;
- ❍ the services the center provides;
- ❍ that your services are disability responsive; and
- ❍ how to collaborate with you to serve women with disabilities who experience sexual violence.

The statewide needs assessment conducted by the Illinois Imagines team showed that women with disabilities would be more comfortable working with a rape crisis counselor at their disability service center than they would be meeting with someone at the rape crisis center. There are two important reasons for this: familiarity and comfort with the disability service agency, and ease with which they can access the agency.

The disability service agency is a familiar place for the survivor. They already know and trust the people there. By having a rape crisis worker come to them, they are able to talk and get help in a safe and comfortable environment, and they don’t have to worry about how to get there. Transportation is a huge barrier that women with disabilities must negotiate, and disability service agencies usually have accessible transportation options that their clients are already quite familiar with.

Outreach or marketing efforts to reach women with disabilities will be most successful if they are conducted at or through the disability service agencies or self-advocacy groups. Therefore, the disability service agency is your greatest ally in reaching out to women with disabilities who experience sexual violence.

The following are some strategies to conduct outreach with local disability service agencies and others who work with women with disabilities.

1. Arrange to have a rape crisis counselor go to the disability service agency each week to meet with people who wish to access services.

2. Work with the disability service provider to establish a way for clients to call the center's hotline confidentially.

3. Set up a support group for abuse survivors at the disability service agency.

4. Arrange for educators to go to the disability agency to talk with clients about issues like healthy relationships or sexual violence.

5. Provide the disability service agencies with posters, pamphlets or business cards with rape crisis center hotline information and staff contacts.

6. Contact self-advocacy groups and ask if you can be a guest speaker on sexual violence and the right to be free from sexual violence.

7. Contact disability organizations (see #9 below) and self-advocacy groups when recruiting for new employees and board members.

8. When working in the schools, make sure you are also working with students with disabilities. They may be in separate classrooms or buildings.

9. Contact the local Center for Independent Living (CIL), local Mental Health/Behavioral Health Center(s), the local organization(s) that support people with developmental disabilities and Office of Rehabilitation Services. Schedule a meeting with each agency to discuss collaboration, including:

    ○ negotiating a working agreement;
    ○ discussing cross-training opportunities;
    ○ scheduling an in service for staff;
    ○ presenting an in service for ongoing groups;
    ○ attending special events/fundraising activities;
    ○ agreeing to create links to each other's websites;
    ○ sharing prevention education ideas, materials;
    ○ inviting them to assist with your center's 40-hour training.

10. Review educational and outreach materials to make sure they are accessible and inviting to women with disabilities. Provide information about rape crisis services that is written in simple, easily understandable language and/or provide posters with large print and/or pictures.

11. Partner with women with disabilities to design your outreach efforts and materials. Conduct a focus group, establish a committee, and engage women with disabilities as co-presenters.

12. Participate in diversity group events in the community, such as disability expos, etc.

13. Plan a “field trip” for all staff to a local disability organization.

14. Ask the Illinois Assistive Technology Project (http://www.iltech.org) to conduct a presentation on assistive technology.

15. Provide privacy tear-off materials accessible to persons with disabilities.

16. Serve on the regional Human Rights Authority Board (part of the Illinois Guardianship and Advocacy Commission).

17. Recruit women with disabilities to be board members, staff, and/or participants in ad hoc committees (e.g., training, policy and procedures and program reviews).

CONCLUSION

If you have engaged in self assessment and developed relationships with disability services agencies, you have taken important steps to create an environment that is conducive to serving women with disabilities. One final element of readiness is training 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

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TRAINING THE STAFF

TRAINING GUIDE

We know that women with disabilities who experience sexual violence 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 foundation 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 maybe 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 and auxiliary materials that will be needed for the training. Minimal preparation is needed for the training. However, the Guide should be reviewed prior to the training. 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 certificate 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 disabilities and use respectful and empowering language;**
- **identify myths/facts about people with disabilities and sexual violence;**
- **demonstrate sensitivity and openness to the experience of people with disabilities;**
- **recognize barriers for survivors with disabilities who disclose sexual violence;**
- **describe the legal issues related to consent and guardianship; and**
- **respond effectively to survivors seeking crisis support, advocacy and counseling.**

SESSION INFORMATION

Length of time required: 3 hours and 45 minutes

Facilitators: Two facilitators are recommended, with at least one being a disability service professional and one a woman with a disability.

Supplies needed: Flipchart and markers

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 and Facts about People with Disabilities and Sexual Violence	14	#3	15
V. Definitions and Language	14	#4	15
VI. People First	16	N/A	20
VII. Disability Humility	18	#5	10
VIII. Providing Barrier-free Services for Women with Disabilities	18	#6	20
IX. Guardianship	20	#7	15
X. Intervention with Survivors with Disabilities	20	#8 & #9	30
XI. Working in the Community	22	#10	15
XII. Message to Rape Crisis Centers	22	#11	15
XIII. 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 Violence
- ❍ **Handout #4** Contrast of Paradigms
- ❍ **Handout #5** Disability Competence vs. Disability Humility: Two Working Models
- ❍ **Handout #6** Barriers to Service
- ❍ **Handout #7** Overview of Guardianship
- ❍ **Handout #8** Facilitating Positive Interaction with People with Disabilities
- ❍ **Handout #9** Presentation Guide
- ❍ **Handout #10** Responding to Misinformation
- ❍ **Handout #11** Top Ten Things I'd Like to Tell Rape Crisis Centers about Prevention of Sexual Violence against People 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 violence.
- 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.

> “Education is the jewel casting brilliance into the future”
>
> *Mari Evans*

II. WOMEN WITH DISABILITIES

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

Before the session, prepare Handout #1 Women with Disabilities Read-Around Slips 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 their 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 could or could 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:

- Women with disabilities probably don't get sexually abused very often.
- Our services aren't helpful to women with disabilities.
- We don't know how to communicate with women with disabilities?
- 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 #3 **Myths and Facts about People with Disabilities and Sexual Violence** 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 violence. 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 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:** Contrast 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 should 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 these are all terms focused 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 her 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 her 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 her 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 in the 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 her with respect and dignity in all circumstances.

VII. DISABILITY HUMILITY

- **Lecture/Discussion**
- **Time:** 10 Minutes
- **Handout #5:** Disability Competence vs. Disability Humility: Two Working Models

Tell the group you are going to shift the focus from the ways we view women with disabilities to the approaches of workers. Introduce the concept of disability competence versus disability humility. Note that, as with issues of race, language, ethnicity and other cultural differences, we have long focused on building cultural competence. Recently, a variation on that approach has been developed; it is called cultural humility/disability humility. Pass out Handout #5. Review the premises of each model and ask the group to consider how this shifts their feelings of readiness to meet the needs of women with disabilities. Discuss ways to practice disability humility.

VIII. PROVIDING BARRIER-FREE SERVICES FOR WOMEN WITH DISABILITIES

- **Group Discussion**
- **Time:** 20 minutes
- **Handout #6:** Barriers to Service

Ask the participants to brainstorm barriers that people with disabilities may face when they try to disclose abuse or seek services. Write these on the flipchart.

Distribute Handout #6 Barriers to Service. Review the handout with the participants.

Ask the group to brainstorm ways they can minimize these barriers for survivors with disabilities. Write these on the flipchart. Ask participants to take notes on the second page of their handouts. They should, minimally, include the following:

- Make sure brochures and resources about local services are available at a variety of places visited by people with disabilities.
- Tell the survivor that you believe her and that you will support her in her journey of recovery. Provide positive reinforcement and advocacy on her behalf.
- Receive and share training and resources with all responders to sexual violence.
- Engage in cross training with disability providers and others.
- Form partnerships with local disability service providers to serve people with disabilities in a continuum of service.

Note that most of the strategies just identified are easy to implement. Explain to the group how many of us go through our days without realizing how small accommodations in design can greatly improve the way we navigate our world. Seemingly small details in physical location, information, communication and social environment can make a big difference.

For example, an inaccessible exam table, the painful glare of a bright light, a brochure in small print, or a person who speaks too fast or mumbles may turn an otherwise positive experience into a challenge for some people. For many people who experience disabilities, it is impossible to ignore the importance of accessible environments. Thus, a necessary step in developing accessible and welcoming services for survivors is to design environments for all.

Stress to the participants that to create welcoming and accessible environments that meet the needs of all, we will need to assess our own environments and note where we can make changes. A crucial element of this process is to invite survivors with disabilities to weigh in on the assessment process and to make suggestions for how to improve the environment. It can help to ask questions about what improvements to the environment, big or small, would improve the experience of those with disabilities. Then, we can review the status of our programs and services and develop a strategic plan to create welcoming environments.

It is important to remember, however, that accessibility is about more than just physical access. It is about removing any barriers to service. Rape crisis centers can ensure availability of support to persons with disabilities in a number of ways, including the following.

- Public awareness activities targeting people with disabilities.
- 24-hour availability of appropriate transportation, interpreters, communication assistance, and public transportation for emergency intervention.
- Physical accessibility of all facilities.
- Designated personnel who are trained to respond to people with disabilities.
- Designated personnel trained to monitor risk reduction and respond to survivors.
- Adaptation of services provided by medical practitioners, psychotherapists, and others to meet special needs (for example, home-based crisis and recovery counseling).

IX. GUARDIANSHIP

- ❍ **Lecture**
- ❍ **Time:** 15 minutes
- ❍ **Handout #7:** Overview of Guardianship

Tell the group that the area of guardianship and other legal issues can become very murky. It would be impossible to address all the issues during this training session. However, questions or confusion about legal issues should not keep a rape crisis center from responding in the same manner to survivors with disabilities as they would other survivors.

Review Handout #7 **Overview of Guardianship** with the participants.

X. INTERVENTION WITH SURVIVORS WITH DISABILITIES

- ❍ **Small Group Activity**
- ❍ **Time:** 30 minutes
- ❍ **Handouts:** #8 and #9

Ask group participants to count off from 1 – 3 to form three groups. Assign each group a topic area:

- ❍ Tips for Working with Survivors with Cognitive Disabilities
- ❍ Tips for Working with Survivors with Physical Disabilities
- ❍ Tips for Working with Survivors with Mental, Sensory or Psychiatric Disabilities

Before giving each group their assignment, refer back to the earlier discussion on disability competency and humility.

Note that while workers do not have to master a body of knowledge before successfully working with survivors with disabilities, it is helpful to be aware of respectful accommodations to make.

Instruct the group to divide into three smaller groups according to number (1s in one group, etc.). Distribute Handout #8 Facilitating Positive Interactions with People with Disabilities and Handout #9 Presentation Guide. Give each group a page from the flipchart, a marker and tape.

Instruct each group to review the handout. Using the handout and group discussion, instruct each group to respond to the following questions and write their answers on their flip chart page.

○ Name at least two assumptions that may be made about this survivor.
○ How might these assumptions affect the way advocates, other professionals or family members interact with this individual?
○ What steps might you take to better respond to this person’s needs during a crisis?
○ What are at least two things that might help an advocate support this survivor following an assault?

Inform the groups they will have 15 minutes to gather the information and complete the Presentation Guide. Then, the small groups will reconvene back in the larger group. Each small group will have five minutes (15 minutes total) to present their information to the larger group.

Remind participants that all survivors are worthy of respect and services to meet their individualized needs. It is part of our mission as survivor-centered service providers to listen to and honor the experience of every survivor, and support her in their journey of recovery based on her individual needs.

> “A true friend knows your weaknesses but shows you your strengths; feels your fears but fortifies your faith; sees your anxieties but frees your spirit; recognizes your disabilities but emphasizes your possibilities.”
>
> ***William Arthur Ward***

XI. WORKING IN THE COMMUNITY

- ❍ **Discussion**
- ❍ **Time:** 15 minutes
- ❍ **Handout #10:** Responding to Misinformation

Remind participants that most of us are not educated or informed about disabilities. This lack of information and awareness can pose serious barriers to services and shut down communication with a survivor. When advocating for survivors with disabilities, it is helpful to be prepared to respond to remarks made out of ignorance, to create the most positive environment for the survivor and help other professionals enhance their responses.

Now, ask participants to brainstorm uninformed comments they might expect from allied professionals, family members or others regarding people with disabilities. These may be reasons police or prosecutors give for not proceeding with action on behalf of the survivor. For example, "I can't prosecute this case; people with disabilities don't make credible witnesses." Or, they could be comments such as, "What's wrong with her? She functions at the level of a three year old."

Write all of these comments on the flipchart. Next, ask participants to brainstorm possible responses to these uninformed comments. Write the responses on the flipchart.

Distribute Handout #10 Responding to Misinformation. Review the handout. Note any additions that could be made to this tool based on the group's brainstorm. Suggest that participants practice these responses.

XII. MESSAGE TO RAPE CRISIS CENTERS

- ❍ **Conclusion**
- ❍ **Time:** 15 minutes
- ❍ **Handout #11:** The Top Ten Things I'd Like to Tell Rape Crisis Centers about Prevention of Violence Against People with Disabilities

Ask participants for silence during this activity. Begin by having someone read Handout #11 Top Ten Things I'd Like to Tell Rape Crisis Centers about Prevention of Violence Against People with Disabilities aloud to the group. If there is a person with a disability present, ask them in advance if they 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.

XIII. CLOSING

- **Time: 30 minutes**
- **Material**: DVD: Our Rights, Right Now – A Guide for Rape Crisis Centers

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 Rape Crisis Centers, from Module 5 of this Toolkit. Ask for questions or comments.

Encourage participants to share the information from this training with their colleagues. Suggest they work with the local rape crisis center to provide the best possible response to women with disabilities who have experienced sexual violence. Ask for any final questions.

Instruct the participants to each 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 their single word (with no other comments from the volunteer or other participants). Proceed around the room until everyone has responded.

Thank everyone for their interest and attention.

SECTION 4

SERVING WOMEN WITH DISABILITIES

ILLINOIS IMAGINES

OUR RIGHTS RIGHT NOW!

SERVING WOMEN WITH DISABILITIES

INTRODUCTION

The primary goals of intervention with all survivors of sexual violence and trauma are re-empowerment and re-connection. This is true regardless of disability.

Sexual violence takes away a survivor's sense of control and her connection to herself, others, and the world around her. Helping her regain a sense of control and re-connect with herself and others in a positive way is central to recovery. This is done through focusing on the survivor's strengths, providing information, exploring options and resources, supporting the choices she makes and empowering her to help plan her own response and recovery.

WORKER PREPARATION

In many ways, women with disabilities have many of the same needs as survivors without disabilities. They need to be believed, supported, and validated. They need information about their rights and options, and they need to feel safe and empowered. When responding to a woman with disabilities, the rape crisis worker needs to:

- acknowledge the limits of her knowledge and experience and strive to increase her knowledge;
- view the woman with a disability holistically and provide victim-centered services, as with any survivor;
- inquire respectfully about the particular needs of a woman with a disability;
- acknowledge and address attitudinal barriers; and
- respond positively and creatively to resolve barriers to service delivery (e.g., transportation, communication).

RECOGNIZE AND REMOVE BARRIERS

Women with disabilities often face specific barriers when seeking help.

Credibility – Women with disabilities are deemed less credible by most people, including medical and law enforcement personnel. It is paramount that the rape crisis worker assures the client that she is believed. By the time the woman connects with the rape crisis center, she may have already had some negative experiences with the service system. Make it clear that she did the right thing by reaching out for help. Be clear about what you can and cannot do for her.

Lack of Information – Another barrier that women with disabilities often face is not having had much education about sex, their bodies or relationships. They may not have the vocabulary that they need to describe what has happened to them. This can make disclosure difficult, particularly with law enforcement and medical personnel who need more specific information. The lack of education might also mean they don't fully understand what has happened. They may need confirmation that what happened to them was wrong, that it was something that should not have happened, and that their thoughts and feelings about the situation are normal and understandable.

Transportation – Transportation to and from the hospital, court or the rape crisis center may also be an issue. If the survivor doesn't have her own transportation, explore as many other options with her as possible – taxi, bus, a friend, an ambulance, etc. Ask the disability service agency to assist with transportation needs.

One adaptation may be the location where the services are provided. As mentioned previously, counseling or advocacy sessions may need to be held at an alternative location, such as the disability service agency the survivor frequents.

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

MAKE THE ENVIRONMENT WELCOMING

To make your environment one that feels welcoming for survivors with disabilities, consider the following:

1. Is your location easy to find and fully accessible? Is assistance offered and provided in a friendly and accommodating manner?
2. Are people with disabilities reflected in the art on the walls, brochures that are available, etc.?
3. Are materials written in plain, easy to understand language that includes pictures?
4. Do staff use people first language and treat each survivor with respect?
5. Are clients given options and choices? Are they respected and supported?

ADAPT COMMUNICATION

Advocates and counselors may need to adapt their communication style to meet the needs of the survivor. For example, some individuals do not communicate verbally. Instead, they communicate via pictures, sign language, or communication boards (a communication board contains letters or words that the individual points to, spelling out words or forming sentences). If a different communication style requires more time, the counselor might consider setting aside more time to meet with the client. Consultation with the woman and her disability service support person/agency can be helpful with adaptive communication.

RESPONDING TO SURVIVORS

Women with disabilities who face sexual violence need and deserve a survivor-centered response that respects their unique person and empowers them in their healing. Like all survivors of sexual violence, survivors with disabilities need to be believed and supported. They need to know

- **what happened to them is not their fault;**
- **it is okay to talk about what happened;**
- **they are not alone; and**
- **others are here to help.**

Sexual violence is often not reported by the person with the disability, especially if the person has a developmental disability. The individual may not have the language or cognitive ability to do so. She may be dependent on or fearful of a caregiver who is responsible for the abuse. Also, sexual violence may have happened before: the individual may not realize that it is not typical.

As with other clients you serve, confidentiality is essential. The woman with a disability may not be aware that someone is calling your agency about her, and may not have consented for them to do so. Ask the worker if the woman with a disability knows and understands why your agency is being contacted.

Inquire whether the woman with a disability has a guardian. If so, you need to know Illinois law and whether you need to contact that person or have the worker do so in order to provide services. If she is her own guardian, get specific written consent to release information about her to the worker or family members.

Find out what the person's support system is. If the person with the disability agrees, it may be beneficial for her if you work as a team with the other support system who knows the survivors well.

INTAKE AND SERVICE PLANNING

The principles of disability humility should be employed by the worker during intake. Inquire about any disability that may affect service planning and service delivery. The center's intake paperwork should have a place on it for a survivor to indicate what, if any, accommodations would make things easier for her. Remember, not all women with disabilities will be comfortable disclosing that they have a disability. Often, disclosing can lead to a loss of services or a difference in the way the person is treated. While that may not be the case in a rape crisis center, it is important to understand why the woman may be reluctant to ask for accommodations. Assure her that having a disability will not negatively affect the kind of help she receives. Rather, it will help rape crisis workers meet her needs.

When working with a woman with a disability, the service plan should be approached in the same survivor-centered way as a service plan for a survivor without a disability. As with any other survivor, women with disabilities should play a primary role in determining their needs and goals in the treatment plan.

MEDICAL ADVOCACY

Seeking medical care after an assault can be difficult for women with disabilities. Many women with disabilities have guardians who typically make decisions regarding medical care for the survivor. Even women who are their own guardians may be accustomed to asking for input from others before making decisions. They may not be used to making their own decisions about what they want. Therefore, it is important to emphasize that they have the ability and the power to make the decision they think is best, and that there isn't a "wrong" decision if it's what the survivor wants to do. An adult with a guardian can legally consent to emergency department services, forensic services and follow-up healthcare. She can also consent to release evidence and information about the sexual assault. If the survivor is unable to provide this consent and the guardian is unable or unwilling to do so, law enforcement may authorize the release.

When working with a survivor in the emergency department:

1. Remember the survivor may have never had a pelvic exam.
2. Explain all procedures slowly, in advance, and in simple language.
3. Use pictures as necessary.
4. Ask her if she wants a support person with her.
5. Remind her that her privacy and confidentiality are protected.
6. Remind her that the can refuse any procedure while agreeing to others, and that she can stop at any time.
7. Ask what would be helpful and respect her boundaries.
8. Model respect and good communication with the survivor to other medical personnel.
9. Work with the medical staff to make the situation as comfortable as possible. For example, certain positions or smaller instruments may be options that would make the situation more tolerable and less traumatizing for survivors with disabilities.
10. Work with medical staff to proceed slowly; do simple steps first and work toward more intrusive, complex procedures after some trust is established.

CRIMINAL JUSTICE ADVOCACY

WORKING WITH LAW ENFORCEMENT

1. Tell the survivor that the emergency room is required to contact the police to let them know that a crime has been committed. Even though the police are required to come to the emergency room, the survivor does not have to speak with an officer if she chooses not to do so.
2. Let the survivor know that the police officer may want to ask some questions in order to best respond to what has happened. Tell the survivor that some of these questions may make her uncomfortable, or be difficult to answer.
3. Reassure her that the purpose of giving information to the police is to help in stopping this from happening to anyone else and to keep her and others safe.
4. Let the survivor know that she is not in any trouble and that she was right to let others know what has happened.
5. Reinforce that the survivor never has to talk to a police officer if she does not want to do so. She has the right to refuse to speak to an officer at all, or to stop talking to the officer if she feels too uncomfortable.
6. Let the surivor know that she can have someone she trusts with her when she speaks with the officer. She also has a right to speak to the officer in private, and to go slowly and take breaks as often as she needs.
7. Work with the law enforcement officer to help guide him/her in working slowly with the survivor and in understanding any communication barriers.

BEFORE GOING TO COURT

1. Provide an opportunity to visit the courtroom and meet the personnel.
2. Explain who sits where.
3. Use simple language and explain what will happen.
4. Practice looking at the attorney and answering questions.
5. Role-play giving testimony.
6. Identify visual cues for calming down or taking your time.
7. Stress that it is okay to say “I don’t remember.”
8. Practice saying “Can you say that another way?”
9. Remind the survivor how brave she is and that an advocate will be with her.
10. Anticipate the court day and prepare a personal safety plan for getting through the testimony and returning home.

REMEMBER

Every client has different needs, and sometimes those needs are not what advocates typically perceive or address. The message here is to keep an open mind, be creative, be flexible and give every effort to making any accommodation that may be needed. Work together with the survivor to provide the best services possible.

TIPS

Below are good tips for working with any survivor of sexual violence, but may be especially important for survivors with disabilities:

1. Talk with the person in a quiet, private place that is free of distractions or excitement. Make sure the person feels safe.
2. Speak directly to the person. Put yourself at eye level and make eye contact.
3. Interact in an adult manner and use adult language; avoid condescending language or behavior.
4. Be respectful and patient. It may take more time than for other survivors of sexual violence with whom you work. Allow time for the survivor to respond. You may also need to take frequent breaks.
5. Use first names and plain language. Avoid bureaucratic language or jargon.
6. Establish rapport. It may be helpful to "chit chat" first until a connection is made between you and the survivor.
7. Ask about any assistance needs and what they would be.
8. Do not make assumptions about abilities or guesses about needs. For example, a person with slow or difficult speech may not be cognitively impaired.
9. Identify and accommodate the person's needs to the best of your ability. Be open to communicating in new and creative ways. Acknowledge and take responsibility for limitations.
10. Always use people first language. For example, say "People with disabilities," not "disabled people."
11. Offer choices as often as possible.
12. Respect boundaries. Remember, chairs and other support aids are part of a person's being, so don't touch or move support aids without permission.
13. Reflect and normalize feelings.
14. Provide facts and options.
15. Remember that certain disabilities may impact emotional affect. For example, just because a person is smiling doesn't necessarily mean she is happy, or a seemingly angry grimace may not mean the person is mad. Be calm and do not fear possible appearance.

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**	Disability Competence vs. Disability Humility: Two Working Models
○ **Handout 6**	Barriers to Service
○ **Handout 7**	Overview of Guardianship
○ **Handout 8**	Facilitating Positive Interactions with People with Disabilities
○ **Handout 9**	Presentation Guide
○ **Handout 10**	Responding to Misinformation
○ **Handout 11**	The Top Ten Things I'd Like to Tell Rape Crisis Centers About Prevention of Sexual Violence Against People 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 10.

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 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 didn't know how hard it would be. I felt lost.

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.

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.

I stay inside more now. I don't just walk around. I only go out when I have an activity.

I would want to talk to someone who would believe me, support me.

I would want to talk to someone who would not be judgmental, would not treat me different, would 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.

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.

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.

I would like for service providers to be patient with me, treat me with respect, bring me to a safe place.

I would like for service providers to make sure the perpetrator could never come near me again, help me report it to the police if I want, make sure I am okay, make sure my body is okay.

You have to know you can trust someone first…..like they don't treat you like you are stupid.

I would want to talk to someone who looks at me and listens, someone who is compassionate, someone who would believe me.

I would want to talk to someone who connects with me, someone who can be trusted, someone who respects me.

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.

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.

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. 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.

BY THE NUMBERS:
DATA ABOUT PEOPLE WITH DISABILITIES AND SEXUAL VIOLENCE

Among adults with 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; and
— 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 outline.

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," 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, their life?	Professionals, clinicians, and other rehabilitation providers. Legal guardians, family, friends, "caregivers."	The person herself, above all else. Other people that THE PERSON chooses to support 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

DISABILITY COMPETENCE VS. DISABILITY HUMILITY: TWO WORKING MODELS

When it comes to working with people with disabilities in a service environment (or any environment), two main paradigms, or working models, come to mind. One working model is based on **disability competence,** which means staff must be **extensively trained** on disability types, culture, etiquette, accommodations, legal and technical jargon, and related laws **before** they ever work with anyone who has a disability. In contrast, the other working model, **disability humility,** is based on the idea **that staff do not need extensive training beforehand** and learn about disability issues mainly through **working directly with each individual person.** Below is a table summarizing the main differences between the disability competence model and the disability humility model.

DISABILITY COMPETENCE	DISABILITY HUMILITY
Staff need extensive training beforehand	Staff do not need extensive pre-training
Staff are viewed as the "experts"	Clients are viewed as the experts on themselves and their needs
Tends to identify people with disabilities as a uniform group	Treats each person with a disability as a unique individual
Can cause people to rely on "laundry lists" of behaviors, characteristics, deficits, etc.	People with disabilities are not treated as if in such generalized categories
Mindset: "I know what you need to know"	Mindset: "I am open, curious, honest, ready and willing to learn"
Can sometimes be to blame for treating client "behavior" as a direct result of their disability or pathology	Takes into consideration culture, past history, trauma, etc. before making such judgments, if at all
Never say, "I don't know"	Be willing to say, "I don't know"
Often found as a part of staff curriculum for mandated training – this concept is very ingrained and practiced worldwide	Usually not found as a part of staff curriculum for mandated training – this concept is very new to most agencies

BARRIERS TO SERVICE

Survivors with disabilities face many of the same barriers to seeking help that survivors without disabilities do, but there are also a range of issues that are unique to survivors with disabilities. Some examples are listed below. It is important to remember, however, that each individual and each assault is unique. A survivor with a disability may not face all of these barriers, and may face barriers not listed here.

Fear – Because the perpetrators of abuse towards women with disabilities are often caregivers, a survivor may fear being punished by her caregiver for speaking out. A survivor may also fear loss of resources and/or services if she reports the caregiver, or may fear a new caregiver may be even worse.

Stigma and Prejudice – The stigma associated with having a disability may greatly decrease the perceived credibility of the survivor. Women with disabilities are often patronized and not taken seriously.

Isolation – Women with disabilities are often segregated from the general population in education, employment and housing which limits their participation in common social settings. Therefore they may not be aware of, or have access to, community services and resources.

Lack of Awareness Among Responders – A lack of awareness, education and training about women with disabilities among advocates, law enforcement, medical staff and others too often results in inappropriate or inadequate services.

Limited resources to accommodate needs – The limited resources of many non-profits and state agencies make it increasingly difficult to provide safe and appropriate services and accommodations for women with disabilities.

MINIMIZING THE BARRIERS

Brainstorm the ways rape crisis centers can minimize the barriers for women with disabilities in accessing services:

1.

2.

3.

4.

5.

OVERVIEW OF GUARDIANSHIP

DO ALL PEOPLE WITH DISABILITIES HAVE GUARDIANS?

The vast majority of people with disabilities, including cognitive disabilities, do not need guardians. An individual may require assistance from others or accommodations based on their disability but still be able to make informed decisions based on their own preferences. Most importantly, the presence of a physical or mental disability or the age of an individual does not indicate the need for guardianship. **Everyone deserves to exercise control over their own life to the extent possible.**

WHAT IS GUARDIANSHIP?

Guardianship is a legal designation that places the rights, safety, well-being, and legal choices of a person into the hands of another for the purpose of protection from abuse, neglect, or exploitation. Guardianship is conferred on a relative, friend, guardianship program, or private professional guardian by a judge's decision that a person is deemed incapable of making their own decisions.

IS THERE ONLY ONE KIND OF GUARDIAN?

No. Although most states provide alternatives for guardianship; in general there are three types of guardians:

- ❍ **Guardianship of the person,** which involves decisions about an individual's personal life such as where she/he will live, work, go to school, etc.

- ❍ **Guardianship of the estate,** with authority over such decisions as money and property.

- ❍ **Limited guardianship,** with authority to make only decisions about one thing or a few things. The probate judge decides which decisions and writes them on a paper called an order of limited guardianship. The order of limited guardianship is very clear about what decisions a limited guardian can make.

HOW DO I KNOW IF A PERSON HAS A GUARDIAN?

If you have concerns or questions about whether someone accessing services may have a guardian, the first place to go for information is that person. During the initial contact or intake process, staff should respectfully ask the individual if he/she has a guardian and how to contact the guardian if he/she does. If you are unable to determine guardianship status by talking with the individual, talk to the court with jurisdiction over guardianship cases in your area. Guardianship proceedings are public record; develop a relationship with the appropriate court and court personnel.

CAN RAPE CRISIS CENTERS WORK WITH A SURVIVOR WITH A GUARDIAN?

A rape crisis center should not be deterred from working with an individual based on the possibility that the person has a guardian. If you have questions about a specific person or situation, you should consult with an attorney, local court personnel, or the office of guardianship and advocacy, depending on the need or question.

Guardianship professionals and attorneys agree that there is not a duty for agency staff to investigate whether or not a person has a guardian. However, any agreement signed by an individual with a guardian may be voidable. The same may be true for an individual under limited guardianship, depending on how that guardianship is structured.

FACILITATING POSITIVE INTERACTIONS WITH PEOPLE WITH DISABILITIES

Tips for Working with Survivors with

- ❍ Cognitive Disabilities
    - ❍ Physical Disabilities
        - ❍ Mental, Sensory or Psychiatric Disabilities

SURVIVORS WITH COGNITIVE DISABILITIES

People with cognitive disabilities need post-assault counseling support as much as, and possibly more than, survivors without such disabilities. The following guidelines may help advocates/counselors when responding to sexual assault survivors with cognitive disabilities. In the immediate post-assault period:

Reassure the survivor that she is not in any trouble and did not do anything wrong. Use kind words and gentle actions. Use simple instructions that are easy to remember.

Allow time to process. Being silent for a few moments after your communication will allow the person who needs more time to process your communication to respond. In some circumstances, a few days off from work or school may be helpful so the survivor can process what happened and do so with counselors and support people rather than people at work, school, or on the street. If this is the case, it is important to frame it so that the survivor does not feel she is being punished.

Assist the survivor in deciding whom to tell. Anticipatory guidance is helpful. She will think everybody knows. Tell her, “You may think people know about this, but they don’t. No one will know unless you tell them.”

Ask the survivor who she trusts and who has helped her in the past when something bad has happened to her. For example, “You say Ann has always been a help to you. You trust Ann. It’s okay to talk to Ann about what happened. But you might not want to tell the people at your bus stop.”

Help significant others understand the importance of not blaming and providing positive feedback. Tell them they will need to exaggerate their positive comments and avoid criticism. Survivors will pay more attention to negative comments than to positive ones. Help significant others and caregivers understand that the immediate post-assault period is not the time for safety lectures.

Follow-up supportive counseling is recommended as with all survivors, and may need to include family, significant others, and caretakers.

Assess for depression.

DISCLOSING TO OTHERS

People with limited abstract reasoning skills need help in determining who to tell about the assault and who they want to know about it. Often, upon returning home or to school or work, people with cognitive disabilities freely disclose details of the assault and become re-traumatized by the attention of those around them. The advocate can assist the survivor by talking through how different people will react, who needs to know, how much to share with whom, and what the possible ramifications are of sharing information. For survivors who are unable to imagine other people's possible reactions and who are very verbal, it may be best to encourage a few days off from school or work so they can process their feelings and reactions with family, staff, or counselors.

In deciding whether to share information about the assault with other professionals in the survivor's life, the advocate considers the survivor's well-being, her right to confidential care, and her need to be in control of who is told. When staff from group homes or other social service agencies are present, it is important to honor the survivor's right to confidentiality and verify with her which information can be shared. Confidentiality should not be broken except when there is a clear need to involve another caring person to protect the survivor from additional harm.

COMMUNICATION BARRIERS

Remember, for a lot of individuals with disabilities, communication will be no different than with a client without disabilities. Regardless, following are some things to keep in mind when facing communication challenges.

- ❍ Try to determine the relationship between the suspected abuser and the survivor. Because many people with disabilities depend on others for their care, you will need to know what the relationship means to the survivor in terms of practical and emotional issues.
- ❍ Arrange for a support person to be present if possible.
- ❍ Let the person tell the story and lead the discussion.
- ❍ Use simple words and sentences. Pictures may be helpful.
- ❍ Be prepared to go slowly, and take frequent breaks as needed.
- ❍ Many individuals with cognitive disabilities may be very concrete in their thinking. Phrase questions and statements in such a way as to avoid ambiguity or confusion. Try to avoid words or phrases with multiple meanings, sarcasm or jargon.
- ❍ The use of metaphors, analogies and story examples can be very helpful.
- ❍ Especially for people with cognitive disabilities, avoid using leading, or “yes” and “no” questions when communicating. Open-ended, non-leading questions are best. If you are smiling and nodding when you ask a question, you may receive a nod and a smile, but no real information. People with all levels of ability could be led by particular actions of another person. Remember, people with disabilities are institutionalized to be compliant. They may be easily led and quick to please.
- ❍ Realize that you may need to ask the same question in several different ways before you are able to communicate your meaning clearly.
- ❍ Look for patterns of misunderstanding.
- ❍ Do not ask “Do you understand?.” If the person you are talking to is having trouble focusing or staying on track, help her to do so by rephrasing questions and providing structure to the subject you are discussing.
- ❍ If the person does not directly answer the questions asked, she may be associating it with something else of relevance. (“That’s interesting. How does it relate to…?”)
- ❍ You may suggest talking about things irrelevant to the current situation (“First we are going to talk about this, then we’ll talk about that or we’ll take a break.” Redirect the person to the question firmly and politely.
- ❍ Listen to all information and believe what you are told.

- ❍ Make every effort to get accurate information from the person with a disability before relying on information from others. What she is telling you may seem factually incorrect, but it's possible she has interpreted the words differently.
- ❍ People with developmental disabilities may be unable to tell you the exact order of events. They may have limited memory of routine or unimportant details. They may need memory cues. If a person cannot remember the exact time of an event, ask her what she was doing at the time the event happened. For example, ask the person what was happening that day, or if it was warm or cold outside.
- ❍ It is very helpful to use and engage all of the senses: sight, sound, touch, taste and smell. Art therapy, play therapy, sand tray therapy, are all useful with survivors with disabilities. Often, they are more effective than cognitive, talking approaches.

When you are having difficulty understanding the person, say this:

> **"I know you are trying hard to answer my question. Could you help me by slowing down or trying again?"**
>
> **"I hope you will forgive me if I don't always get what you say the first time. I really want to hear what you have to say. Take your time. I'll try harder to listen."**
>
> **"Do you have any communication needs I should be aware of?"**
>
> **"Would you like to answer the question now or later?"**

ADDITIONAL CONSIDERATIONS

Anxiety almost always exacerbates speech impairments, so survivors with such a condition need patient, reassuring questioning. Repeating what the survivor said assures her that her words were correctly understood and frees her from having to start from the beginning each time. If a certain word cannot be understood after several repetitions, ask her to spell it out.

Emotional trauma can affect blood sugar levels, which, in the case of those with diabetes, can make people appear to be intoxicated when they are actually experiencing a medical emergency. People with cerebral palsy also can be perceived (incorrectly) to be intoxicated. Advocates should ask survivors if they are diabetic or what kind of assistance they need and then see to it that their needs are met. It is important that advocates/counselors make no assumptions about the person's ability or disability and instead ask as many questions as necessary. The survivor should have total control over what is done to her and should direct any assistance that is provided. For example, if someone who is paralyzed needs to be moved, she should direct who does what in moving her; if a person usually catheterizes herself, the hospital personnel should be encouraged to allow her to do so in the emergency department. Caregivers must realize that a person with a disability faces the complex challenges of coping not only with the becoming a survivor but also with her disability and the barriers posed by agencies providing services.

COMMUNICATION WITH INDIVIDUALS WHO DO NOT COMMUNICATE THROUGH ORAL LANGUAGE

Some people with developmental disabilities are unable to communicate through oral language, yet possess receptive language and other ways of communicating which include: sign language, nodding, or a communication board that has pictures, symbols and words to which the person can point. A communication board may be attached to a wheelchair tray or the person may carry it in a book form. There are also augmentative communication devices, which are usually computerized. The person presses keys or symbols that come out as a synthesized voice. The person may also communicate in writing, drawing, hand or feet movements or by eye-blinking, hand squeezing, etc. When these are used, observe the person's reactions to the caregivers. Watch her body language, which may express what words cannot. If the person becomes agitated or fearful at the mention of someone's name, note this.

SURVIVORS WITH PHYSICAL DISABILITIES

People with physical disabilities may also be at greater risk for sexual violence, especially if they depend on others for personal care. When the offender is someone who is supposed to be in a helping relationship, the person with a physical disability may be concerned about a loss of services and independence. Survivors experience fear and anxiety over the potential of harm from people on whom they rely for assistance and support. This can lead to overwhelming feelings of vulnerability, stigmatization, and depression. When people with physical disabilities are sexually assaulted, they often experience compounded feelings of isolation, powerlessness, low self-esteem, and a sense of being different.

After having been sexually assaulted, people with physical disabilities respond emotionally in all the same ways as able-bodied survivors. They may, however, need to talk through the role they believe their disability played in making them more vulnerable to the assault. The advocate/counselor can listen to the survivor’s concerns and recollections of the experience. Survivors benefit from reviewing how force, threats, and coercion are a part of sexual violence. Remind them that anyone can be sexually assaulted.

Understanding these differences, the advocate has a very important role to play in ensuring the survivor’s needs are appropriately met.

In the rush of an emergency response to sexual violence, medical and legal personnel may miss important aspects of the survivor’s experience.

Consider the following “wheelchair etiquette”

- ❍ If the person uses a wheelchair, remember that the chair represents personal space and should not be touched or leaned upon without permission.
- ❍ Position yourself in front of the person, facing her at eye level.
- ❍ Providing assistance, like pushing a wheelchair, should be done only after asking the person if assistance is needed and how it should be provided.
- ❍ Some individuals in wheelchairs may choose to transfer from the wheelchair to a different chair (e.g. office chair). Volunteering to assist with this activity is never the wrong thing to do and is almost always appreciated, but remember to ask first.
- ❍ If a person has a dog to assist her, do not pet the animal without the person’s permission.

WORKING WITH SURVIVORS WITH HEARING IMPAIRMENTS

- ❍ If you suspect the person is Deaf or hard of hearing, ask her to let you know if she cannot hear you clearly. Ask if she needs any assistance.
- ❍ When working with someone who is hard of hearing, do not shout. Speak at your normal volume unless the person asks you to speak louder – hearing aids make sound louder, not clearer.
- ❍ Make sure you gain the attention of the individual who is deaf or hard of hearing (a.g. by tapping the person lightly on the shoulder) before beginning to talk.
- ❍ Identify who you are and make sure you look directly at the person as you speak.
- ❍ To make it easier for the individual to read lips, face the light, speak clearly in a normal tone, keep you hands away from your face, and use short simple sentences.
- ❍ If you do not know sign language, use a pencil and paper. You should not be embarrassed to use this method because getting the message across is more important than the medium used.
- ❍ If there is an interpreter present, be sure to talk directly to the person and not to the interpreter.

WHEN USING AN "INTERPRETER"

There will be times when getting information from a person with a disability or effectively understanding the way she communicates is not possible for you. To ensure that the person is receiving the help she needs, it may be beneficial to use an interpreter to assist you. Ask the person with the disability if she has an interpreter she would like you to contact. This should be a professional American Sign Language (ASL) interpreter not a family member, guardian, or friend. If the person with the disability agrees, contact the interpreter before you begin the interview or counseling session.

1. Have the interpreter sign a verification form indicating that for the purpose of assisting the client, all information discussed is confidential.
2. Define what the roles of the interpreter will be in the interview or counseling session.
3. Discuss the questions you wish to ask ahead of time so that the interpreter can best frame them.
4. Never use the interpreter without the survivor present.
5. Always talk directly to the person with a disability, not about her or solely to the interpreter.
6. Give the person with a disability time to answer each question, then ask, "Is it okay if I ask your friend to help us with this question in order to ensure that I clearly understand what you are saying?"

7. Do not allow the interpreter to take over the interview.
8. Watch for signs of corroboration from the survivor.
9. If the interpreter exerts control over the interview, intimidates, or talks for the person with the disability, this could indicate power and control in the relationship. It may be important to work with the survivor to find another interpreter the survivor trusts, but is not exerting control over that individual.
10. The interpreter is present for the benefit of the person with a disability and should not be used if the person is speaking for herself and being understood by you. The person's function is to interprete what the person with the disability is trying to say, not to speak for the person.

Working with Survivors who are Blind or Have Low Vision

- People who are blind or have low vision usually do not need assistance in familiar surroundings but do when they are at the hospital or clinic being examined, the police station filing a report, the rape crisis center receiving advocacy/ counseling, the district attorney's office or in the courtroom.
- Talk about everything being done around the person and provide verbal orientation to the surroundings.
- Before you touch the person, explain that you will be touching her, how and why.
- When moving from one room to another, offer your arm to grasp above the elbow for guidance. Verbally point out obstructions. Always tell her when you are leaving the room. If the survivor has a guide dog, do not be distracted by it or ask about the dog's reaction to the assault; this diverts the blame from where it belongs – with the rapist.
- When working with people who are blind or who have low vision, make sure you speak to the person as you approach: state clearly who you are, and introduce anyone who is with you and speak in a normal tone of voice.
- Do not attempt to lead the person without asking first; allow the individual to hold your arm and control her own movements.
- If you are assisting an individual in seating, place the person's hand on the back or the arm of the chair and allow them to sit herself.
- Be descriptive when giving directions; give verbal information that is visually obvious to someone who can see (e.g. when approaching steps, mention how many steps and in what direction they are).
- Always tell the individual when you are leaving, never leave a person who is blind or has low vision talking to an empty space.

Remember, after a sexual assault, an individual who is blind or has low vision can often provide a wealth of information about her assailant. She may be able to identify a voice, particular walk, type of clothing, etc. Law enforcement and legal personnel should be encouraged to accept these types of identifications, as well as visual ones.

SURIVIVORS WITH MENTAL ILLNESS

Trauma often leaves the individual feeling helpless or powerless and overwhelms the person's normal sense of control, connection, and meaning in life. The percentages are extremely high for individuals with psychiatric disabilities to be survivors of a variety of past traumatic life events (trauma victimization studies show a prevalence of PTSD between 51-98% among persons with serious mental illness in the public sector). With a prior trauma history complicated by a serious mental illness, a major stressful event like sexual assault will exacerbate symptoms that the person may have otherwise been managing successfully. We have to offer the hope that the survivor can gain back her ability to manage her life and illness.

Everyone is an individual first and we have to meet the survivor where she is. It is important to remember that not everyone, whether dealing with a psychiatric illness or not, will react to trauma in the same way. That is why building trust and taking the time to learn about that person is so important. Recognize and respect a person's coping mechanisms and where she is in that moment.

STAY CALM

Remaining calm when someone else is distressed is always helpful. When asked "what would have been helpful to hear? after crisis situations, individuals with psychiatric illness said they needed reassurance that how they were feeling at that moment would get better. They said hearing things like "You will be okay," "You will get better," "you will soon feel calmer," and "this will pass" helped. They also said that being reassured that the person was there to help them and was there to listen to them was helpful. Also, being asked how they can help, and being told that the person was not leaving – they would stay there with them was helpful. Being gentle, affirming, and comforting while asking what that person wants and needs is essential. Always ask permission before doing something that you think will help.

CREATE A SAFE SPACE

Creating the safest place possible is monumental. What is the room like that the survivor is in? Is it sterile? Does the person have privacy? Has she been asked what would help her calm down? Does she have any self-soothing strategies that you can help her access? Is she being barraged with questions? Maybe they want to wrap in a blanket, rock in a rocking chair, yell, cry, stomp her feet, listen to music, hug a teddy bear, or curl up in a ball. We are not there to judge appropriateness but are there to help that person feel safe.

GO SLOWLY AND TAKE SMALL STEPS

It is important to explain what is happening every step of the way. Not knowing what is going to happen next is very frightening. Talking the person through something is calming and takes the guessing out of it. If a person is hearing voices – internal or external – she may be being told other things. Others with PTSD might be numb or dissociating or having flashbacks. Being mindful and confident that a person is grounded before starting any procedure can make the experience for the survivor a safer one. To explain what to expect before it happens is good respectful health care practice.

AVOID RE-TRAUMATIZING

We must do no more harm thus de-escalation strategies that calm rather than escalate a situation are essential skills to have when working with survivors with psychiatric disabilities, as their ability to regulate emotions and behaviors would most likely be challenged after a recent traumatic event. Early intervention is key and intervention should always begin with determining what the individual feels is needed. Verbal and non-verbal communications need to relay the message that you are calm, you are there to help, that you are caring, and that you are open to hearing what the survivor needs to express.

TEACH/MODEL COPING SKILLS

De-escalation can be very effective when you can redirect a person to use a calming strategy that works for her. That is why safety plans can be so beneficial. They are done in collaboration with the individual to identify what upsets her (triggers), what calms her, and what early warning signs may be. Early warning signs are those behavioral or physical manifestations that someone is getting more upset and may lead to behavior getting out of control. It is also important to find out what you can do that will help and not upset the surivor more. This is very individualized. Someone may want you to hold her hand and another person might be triggered by any touch.

GENTLY AND CAREFULLY EXPLORE TRAUMA HISTORIES

We must allow safe places and safe persons – someone the survivor can trust to explore trauma histories. One survivor said "never being asked about the trauma is like being abused as a child." A person doing an intake should understand the fear of disclosing what has happened and be willing to take the time to listen and understand. Avoid probing questions that can feel cold, impersonal and intimidating. It is also very important to remember to ask the person what happened to her – *not* what is wrong with her.

It is important to be mindful that many survivors are easily drawn back into the blame game and guilt for what happened to them. The internalized stigma of living with a psychiatric illness makes sexual violence survivors very vulnerable to this kind of thinking. Also custodial care may have been justified by the belief that the survivor is incapable of making good decisions for herself. It is vital to one's healing that she not receive this type of message.

RECOGNIZE THE HISTORICAL OPPRESSION OF SURVIVORS WHO EXPERIENCE MENTAL HEALTH ISSUES

It is important to be sensitive to the experiences of survivors who have been subject to the traditional mental health (medical model) treatment for years. In this model, decisions are made for patients and independent thought is perceived as non-compliance, sometimes requiring coercive measures to ensure compliance. Failure of some mental health professionals to understand the connections between a person's symptoms and trauma history frequently leads to actions that re-traumatize the person. For example,

- ❍ failure to acknowledge the abuse perpetuates the secrecy and lack of validation experienced by the individual;
- ❍ locking a person in seclusion may replicate experiences of being isolated and helpless;
- ❍ stripping a patient may trigger flashbacks of sexual assault;
- ❍ misinterpreting cutting behavior as suicide attempts or "attention-seeking behavior" discredits the person and what they may be feeling;
- ❍ using restraints to control "unsafe behaviors," like the coping skills of cutting or self-injurious behavior, has no therapeutic value and will likely re-traumatize;
- ❍ many abuse survivors have become extremely mistrustful of the mental health system and angry with treatment providers;
- ❍ Others become overly dependent on the external controls provided by the system and are not helped to develop their own internal controls and competencies.

A rape or sexual assault yet again strips an individual of her power and control. As always, opportunities for choice are essential. A person's power and control has been taken from her and we need to give choices, reinforce her ability to regain control, and support the choices they make, even if we do not agree with the decision.

PRESENTATION GUIDE

When preparing your presentation, please address the following questions. These questions encourage you to think about strategies for working with a person with a particular characteristic. Focus your presentation on issues an advocate would need to be aware of when dealing with this person.

1. Identify the survivor. Who is she? What is her disability?

2. Name at least two assumptions that may be made about this survivor.

3. How might these assumptions affect the way advocates, other professionals or family members interact with her?

4. What steps might you take to better respond to her needs during a crisis?

5. What are at least two things that might help an advocate support this survivor following an assault?

RESPONDING TO MISINFORMATION

The following statements are typical of the misinformation you may hear from others (e.g. law enforcement, medical personnel, prosecutors) while you are advocating for women with disabilities. Following each statement are possible responses you could offer to correct the misinformation.

1. **She's not a credible witness.**

   Response: What is it that you need that you don't have?

   Response: Many women with disabilities are credible witnesses. Tell me what you need, and I'll try and help.

2. **"She was smiling as she told me about her attack. It couldn't have happened."**

   Response: A lot of people smile when they are nervous. That doesn't mean it didn't happen.

   Response: A lot of women with disabilities have been over-trained to be pleasant – that is what you are seeing. She is really very scared.

   Response: Some disabilities make it hard for the face to match the real feeling. It doesn't mean she isn't upset by what happened.

3. **Where does she live? (or any question directed to you and not the person)**

   Response: Please ask her that question.

   Response: She can tell you.

4. **I don't think I can examine her. She is too disabled.**

   Response: Let's ask her the best way to examine her.

   Response: I know some alternative positions that might work. Let's ask her what she prefers.

5. Do you know her mental age?

Response: The only age that counts is her age of 36.

Response: She has 36 years of life experience.

6. The staff (or significant other) said she is like a three-year-old.

Response: The truth is that no one can live 45 years and be like a three-year-old. That is a myth that some people don't understand.

Response: That only refers to one aspect of a person, and she is still an adult.

7. Her staff said that she has a history of lying.

Response: We need to treat every allegation with respect and dignity. Actually, people with a history of lying are at greater risk of sexual violence because the offender is hoping that no one will believe the survivor.

Response: Most people have lied at one time or another. We need to proceed with her statement and follow up accordingly.

8. I don't know how to communicate with this person.

Response: Let's ask her how we can best communicate with her.

Response: Everybody communicates in some way. How does she communicate with others?

9. What's wrong with her? Is she retarded or something?

Response: She's a person, just like you and me, and she has a disability.

Response: Nothing is "wrong" with her — she just thinks differently than we do.

10. Why can't she understand what I'm saying? Is something wrong with her?

Response: Maybe she didn't hear you, or she needs you to explain it differently.

Response: She's Deaf/hard of hearing. I can help her to understand you, or we can find an interpreter. Perhaps if you use pictures or writing, that will help.

Response: She needs time to process what you're saying. Let her think a minute.

11. Why can't this woman understand the paperwork I'm trying to get her to sign?

Response: She uses pictures to communicate instead of written words. Why don't you explain to her what the paperwork says in everyday language, without big words?

Response: She doesn't understand all the legal jargon. Could you please explain it?

Response: The print is too tiny for her to read. Do you have a large-print format?

12. This woman is legally adjudicated incompetent. Why should she be a witness?

Response: Just because she has a guardian, that doesn't mean she can't tell what happened. Listen to her, because guardianship doesn't cover one's right to speak.

Response: She knows the difference between the truth and a lie. She can tell her own story.

Response: Guardianship does not impede her right to give testimony if she wishes to.

13. She's only having a "behavior," and she's "making stuff up to get attention."

Response: I don't think we should assume that when someone says they have been assaulted.

Response: If she wants attention, then pay attention. Listen to her story. Believe her.

Response: All behavior is a form of communication. Let's pay attention to what she is trying to say.

14. This doesn't have to go to court. It'll never get a conviction if this case does go to trial.

Response: All people have a right to due process and equal protection under the law.

Response: We need to do what's right for the survivor, even if it means going to court.

Response: The perpetrator needs to be held accountable, conviction or no conviction.

15. Why can't this woman give a coherent narrative? It's all jumbled up and out of order.

Response: Some women with disabilities can't do clocks or calendars very well, but they know their schedules. If you focus on her activities, you will learn a lot.

Response: She has difficulty understanding time. Talk about the people involved, herself and what happened, such as "What did John do? What did you do? What did John do then? What did you do?" Focus on the incident itself, not the time-frame.

Response: She's trying to process a lot right now. Give her time to think/calm down.

16. Help! I said something that made the woman upset, and I didn't mean to!

Response: Tell her you're sorry, and see if you can figure out what it is that upset her.

Response: Let's all take a break for a minute and talk things through. You may have brought up some part of the incident she may not have remembered before.

Response: After you apologize, maybe you and I can talk to her together about it.

17. Why is that woman flapping her arms like that? It makes her look really stupid.

Response: She has autism. She does that to calm herself down sometimes.

Response: By focusing on the flapping, it helps get her mind off the pain and confusion she's feeling right now. Let her flap, and then let her continue her story.

Response: She may be feeling uncomfortable, overloaded, or overwhelmed right now. Let's take a break, or talk about something else for a minute. We can come back.

18. Whom should I be talking to here? This woman has a guardian and she's incompetent.

Response: Even though she has a guardian, she still has the right to speak for herself.

Response: "Incompetent" is a legal term. It doesn't mean she can't express herself.

Response: Let's ask her who her guardian is, and what kind of information they want.

19. **This woman's guardian won't release the information/rape kit/evidence, etc.**

Response: Illinois law states that the survivor or law enforcement can release the kit.

20. **She says she has a guardian. What does that mean?**

Response: When someone has a guardian, a judge has decided they need help making decisions. There are different types of guardians. Let's find out what decisions her guardian has the power to make.

Response: A guardian is appointed by a judge to make decisions on someone else's behalf. A plenary guardian makes most major life decisions. A limited guardian only makes the decisions the court has determined they can make. Either way, we want the person to express what they think, too.

THE TOP TEN THINGS I'D LIKE TO TELL RAPE CRISIS CENTERS ABOUT PREVENTION OF SEXUAL VIOLENCE AGAINST PEOPLE WITH DISABILITIES

By Shirley Paceley

When I was asked to write this article about prevention of sexual violence against people with disabilities, many ideas came to mind. I could summarize the data on prevalence and review the many risk factors for sexual violence. I could talk about successful collaborative models or the three-year prevention project that I led in Illinois. Or perhaps I could outline specific skills to teach and effective teaching strategies. As I reflected on the possibilities, the answer came clearly as many faces and voices appeared in my memories. What would the people I have supported in prevention of and response to sexual violence want me to share? The answer was a bit too much, so I limited it to the top ten. I hope you find the list inspiring, motivating and challenging. Most importantly, I hope it leads you to action.

1. We need you. People with disabilities experience sexual violence more often than people without disabilities. From a prevention perspective, people with disabilities have many more risk factors, mostly due to social and environmental factors. We are sometimes isolated, often taught to be very compliant, not given critical information, overprotected, marginalized, segregated, and sexually assaulted at alarming rates. We may be denied basic human rights. We need your help. But first,

2. We want you to know the truth. There are many myths about us…or more correctly called lies. Some people think because we are different, we aren't equal and that we can't make contributions to others and our communities. Some people think we have less value, that we don't feel pain, and that we can't learn. Those are lies. We have feelings like everyone else. Each of us has talents and abilities and preferences. We are more like you than we are different. Get to know us and you will learn the truth. However,

3. You may have to look for us. If you are teaching bullying classes or relationship classes or any type of violence prevention classes in the schools, we may not get to learn from you. Many times we are segregated from the other students in different classrooms or even different buildings. In our world, special means separate so you may have to ask for the Special Education classes. Please ask. Don't let them tell you we can't learn, because we can. For those of us out of school, you can contact disability service organizations. Some professionals may focus on our deficits but…

4. We are not our labels. Don't worry about learning everything there is to learn about people with disabilities before you work with me. A label doesn't tell you who I am. I want to be defined by my likes, dislikes, hopes, dreams, accomplishments, and unique personality. While my label might help you understand something about how I learn, I am a person first. Remember this, I am a person first! Some labels are very hurtful and I prefer not to be labeled anymore. Just ask me if you want to know something about me. I am the expert on myself. Please remember,

5. Sticks and stones may break my bones but words will break my heart. A woman once told me, "Being called retarded is a pain I will take to my grave." Don't tell us to ignore those who call us names and treat us bad. Words hurt. Words leave asting scars. Work with us to change those attitudes. Use respectful, people first language. Speak out when you hear cruel words spoken about us. Help others to see our abilities. When we need an advocate or a counselor, encourage your colleagues to support us. Healing begins with relationships, and relationships begin with communication so…

6. Listen carefully because everyone communicates. We may not communicate the same way that you do so you might think you can't understand us. This isn't true. You can understand us. But don't just listen with your ears; listen with your eyes as our bodies have a lot to say. And most importantly, listen with your heart. When you do, you will most likely understand what I am trying to say. Together, we can figure out lots of things. Please give me time and I will help the best I can. If you don't understand something,

7. Ask lots of questions. When you enter our classrooms, workshops and residences, you may have questions about how things are set up. You might notice some rules that don't make sense. You might be told to ignore someone or to not talk to someone. If something makes you uncomfortable, please ask about it. It could make a huge difference in our lives. If you follow the golden rule, then we know you see us as equal citizens. It is good to burst the bubble of implied agreement. We are counting on you to do the right thing and to…

8. Teach my family and support staff about the effects of trauma. When I am having a hard time, people say I am having a ‘behavior,’ or that I just want attention. I don’t understand why people without disabilities can have difficult times but I am not allowed to. Can you help them understand that I still remember my abuse and it hurts my heart? No medicine or behavior plan will make the memories go away. Teach them to believe and support me. I need to feel safe to express what has happened to me. I need help in finding my strength and moving forward. I don’t want to be managed; I want to feel able to manage myself. Please also…

9. Encourage others to empower us. If you teach us to be assertive and tell us we can say no to unwanted touch, we may be confused. Some of us are NEVER allowed to say no. If we can’t say no to food or an activity, how can we possibly say no to someone who wants to hurt us? Keep teaching us how to be safe, but encourage and teach our families and staff also. If the people we trust the most give us permission to say no, then we will be free to say no to others. And lastly,

10. Thank you. Thank you for understanding about oppression and privilege. Thank you for understanding about power and control and for believing in empowerment. Thank you for being patient as I learn to trust you. Thanks for knowing the truth and for finding me. Thanks for believing in me. Thanks for caring enough to help me find my inner strength. Thanks for honoring me as your equal. Thank you for knowing that my safety is important…that my life is important. Thanks for helping me to find my voice and speak up.

For more information, go to www.bluetowertraining.com or read the following article: Paceley, Shirley and Sandra Laesch. “Sexual Abuse Prevention for People with Developmental Disabilities,” Sexual Assault Report, Vol. 12, No. 4, (2009) 53-54, 56, 58-59.

SECTION 5

TOOLS

Tools

- ○ **Tool 1** **Disability Responsiveness Assessment Tool**
- ○ **Tool 2** **Sample Action Plan**
- ○ **Tool 3** **Sample Policies**
- ○ **Tool 4** **Disability Resources**

DISABILITY RESPONSIVENESS ASSESSMENT TOOL

ASSESSMENT DATE: ____________________

AGENCY NAME: ____

ADDRESS: ____

TELEPHONE: ________________ **E-MAIL:** ______________________________

STAFF INTERVIEWED: ____

INTERVIEWERS: ____

SEND REPORT TO: _______________________________

CONNECTION AND READINESS SECTION

1. How does your agency recruit employees, volunteers and board members who have disabilities? How is agency composition representative of the demographics of the service area (per census data)?

2. How is the agency environment welcoming and accessible to clients, staff, board and volunteers with disabilities (e.g., art work and other décor, magazines and books in public areas, arrangement of furniture)?

3. How do agency materials indicate that accommodations (e.g., interpreters, adapted communication) will be provided for women with disabilities?

4. How does your collaboration with disability service agencies improve your readiness to serve women with disabilities and the broader community (e.g., hospital, police, court)?

5. How would a disability service agency know that your agency welcomes women with disabilities as clients? Describe any specific awareness/outreach/ networking efforts.

6. How would a woman with a disability who experienced sexual violence know she could receive services from your agency? Describe any specific awareness/outreach efforts.

7. Describe staff development opportunities regarding serving women with disabilities. How are women with disabilities and/or disability service providers included as trainers? Describe approaches that enhance staff comfort and confidence in working with women with disabilities.

Training Topics		**Number of Hours Per Year**
Women with disabilities and sexual violence incidence/impact/general information	☐ Yes ☐ No	
Types of disabilities	☐ Yes ☐ No	
Accommodations for different abilities	☐ Yes ☐ No	
Service planning and delivery with women with disabilities	☐ Yes ☐ No	
Crisis response to disclosure of sexual violence	☐ Yes ☐ No	
Agency capacity to serve women with disabilities	☐ Yes ☐ No	
Agency policies & procedures guiding service to women with disabilities	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

CONNECTIONS AND READINESS SUMMARY

○ Strengths:

○ Challenges:

○ Resources Needed:

POLICIES AND PRACTICES SECTION

1. How do agency policies, practices and the budget demonstrate commitment to serving women with disabilities?

2. How do current policies and practices accommodate the various needs of women with disabilities (e.g., communication tools, service animals, physical access)?

3. How do emergency evacuation procedures ensure the safety of women with disabilities?

4. How do policies and practices create challenges in serving women with disabilities?

5. How does the agency serve women with disabilities who request off-site services? Describe the challenges associated with providing off-site services.

6. How would/do women with disabilities know that off-site services are available?

7. How does staff advocate for and/or arrange transportation and accommodations for individual women with disabilities in both agency and community settings?

8. Are there particular intake questions that invite survivors to disclose and/or discuss any disability and need for accommodation? How would staff know a woman has a disability, if not obvious, and her particular needs in relation to any disability?

9. What specific guidance and supervision do staff receive regarding victim-centered service planning and delivery for a woman with a disability (e.g., communication techniques, empowering the survivor, working with guardians)?

10. How are client materials/paperwork (e.g., intake form, service plan, evaluation of services) made available in alternative formats such as large print, pictures, simplified language?

POLICIES AND PRACTICES SUMMARY

❍ Strengths:

❍ Challenges:

❍ Resources Needed:

PHYSICAL ACCESS SECTION

1. Does your agency have a parking lot?

   ☐ Yes ☐ No ______ number of spaces

   Does at least one parking space have at least 8' of clearance on each side of the space (e.g. for a van). ☐ Yes ☐ No

   Are accessible spaces identified with signage? ☐ Yes ☐ No

2. If you do not have a parking lot, is there accessible parking nearby? Are the accessible parking spaces closest to the accessible entrance?

   ☐ Yes ☐ No

3. Is at least one entrance to the building accessible without using stairs?

   ☐ Yes ☐ No

4. Does the accessible entrance provide direct access to the main floor or lobby?

   ☐ Yes ☐ No

5. If the building has ramps to entrances, is the grade no steeper that 1 inch of slope for every 12 inches of ramp?

   ☐ Yes ☐ No

6. Do all doors used by clients have at least a 32-inch clear opening (include restrooms and offices)?

   ☐ Yes ☐ No

7. Is there a threshold edge on each door that is less than 1/4 inch high, or a beveled edge no more than 1/2 inch high?

   ☐ Yes ☐ No

8. Are door handles no more than 48 inches from the floor?

   ☐ Yes ☐ No

9. Can doors be opened without having to grasp, twist, or turn a door handle?

   ☐ Yes ☐ No

10. Can doors be opened without too much force
    (8.5 lb for exterior and 5 lb for interior)?

    ☐ Yes ☐ No

11. Are all pathways to service areas at least 36 inches wide?

    ☐ Yes ☐ No

12. If there are stairs between any essential public areas, are there also ramps or elevators to those areas?

    ☐ Yes ☐ No

13. If there is an elevator in the building, is the call button no higher than 42 inches from the floor?

    ☐ Yes ☐ No

14. Do the buttons in the elevator cab have raised/Braille lettering?

    ☐ Yes ☐ No

15. Are restroom doors and stall doors operable from both sides without grasping, twisting or turning?

    ☐ Yes ☐ No

16. Is there an accessible stall with a clear area of at least 5ft X 5ft from the door swing? Is there a stall that is less accessible, but offers more space than a standard stall?

    ☐ Yes ☐ No

17. Are there grab bars secured onto the wall behind the toilet and on the side wall nearest to it in the accessible stall?

    ☐ Yes ☐ No

18. Is there clearance space beneath at least 1 sink for someone using a wheelchair to roll safely up to the sink?

    ☐ Yes ☐ No

19. Can the faucets be operated without grasping, twisting or turning?

    ☐ Yes ☐ No

20. Are soap dispensers, hand dryers or towel dispensers no more than 48 in. from the floor and operable without grasping twisting or turning?

    ☐ Yes ☐ No

21. During times of inclement weather, are ice and snow removed from sidewalks, curb cuts and building entrances?

    ☐ Yes ☐ No

22. How do you accommodate clients with environmental sensitivities (e.g., florescent lighting, chemicals, fragrances)?

PHYSICAL ACCESS SUMMARY

○ Strengths:

○ Challenges:

○ Resources Needed:

ADDITIONAL RESOURCES

1. What resources do you need to enhance agency response to women with disabilities who experience sexual violence?

2. COMMENTS:

SAMPLE ACTION PLAN TO ACHIEVE DISABILITY RESPONSIVENESS

WHAT	WHO	WHEN
Participate in local collaboration team to improve service system for women with disabilities who experience sexual violence.	Executive Director	Monthly meeting throughout fiscal year
Establish working agreement with local disability service agency	Executive Director	February
Assess policies and procedures and revise policies that present barriers to serving women with disabilities.	All staff in collaboration, with representatives of Illinois Imagines (including women with disabilities).	July-September
Conduct half-day training on disability competence and disability humility with all staff.	Executive Director of rape crisis center and Executive Director of ARC and women with disabilities	March
Train receptionist and hotline workers on use of TTY	Advocate	March 1
Purchase and hang art work depicting women with disabilities in the waiting area and counselor's offices.	Counselor and Executive Director	March 30
Create posters specific to serving women with disabilities. Deliver and post new posters in all local disabilities agencies.	PR firm with allies from collaboration, including women with disabilities	March 15 – May 30
Add rail to two bathroom walls. Replace faucet and door knobs with easy-turn knobs and handles.	Maintenance Worker	February 1

SAMPLE POLICY ON RESPONDING TO WOMEN WITH DISABILITIES

This agency strives to create a safe and welcoming environment for all people with disabilities. The staff will respond to women with disabilities who contact the center as follows:

1. Communicate to the client that she is believed and that she will receive as much support as needed.

2. Invite every client to share information about any disability or need for adaptation to provide services as effectively as possible.

3. Communicate using people first language and engage with clients from a disability humility perspective, assuming the woman with disabilities is the expert on her disability and any needs related to her disability.

4. Adhere to required reporting requirements.

5. Work with the survivor to develop a safety plan that limits contact between the victim and the abuser. This may mean helping to find alternative living arrangements, moving activities to other, safer spaces, and/or helping find other personal assistants.

6. Provide the client with information on reporting the abuse to local law enforcement and on how to access medical treatment and what medical services are available. Assist the client in obtaining these services.

7. Provide the client with information about rights and options. Support client decisions about what to do in response to the experience of sexual violence. Do not make any decisions for the client.

8. Communicate regularly to ensure that the client is feeling safe and supported and that services continue to meet expressed needs.

9. Incorporate activities and other support measures into the service plan to facilitate the client's healing and recovery from the trauma of sexual violence.

SAMPLE POLICY ON SUPPORTING HEALTHY RELATIONSHIPS

Interpersonal relationships are an integral part of human development. Sexuality is an important part of some interpersonal relationships, and it is important to acknowledge that this is as true for people with disabilities as for anyone. People with disabilities are sexual beings and have sexual desires.

RIGHTS

The agency will ensure that clients are empowered to exercise their rights, including, but not limited to the following

People with disabilities have the right to

- engage in consensual sexual activity;
- use birth control;
- marry;
- have children;
- masturbate in private;
- discuss their feelings about sex and sexuality;
- fall in love;
- have loving relationships;
- partner with someone of either sex;
- terminate a pregnancy;
- a private space where they can engage in sexual behavior, either alone or with a consenting partner.

EDUCATION

Education about sexuality reduces a person's vulnerability to assault and abuse, helps her gain confidence and self esteem, and helps her foster healthy sexual relationships. Therefore, this agency will promote sexual education and healthy relationships for all clients. All clients will receive education on the following topics:

Sexuality and Healthy Relationships. Sexuality education will be matched to the client's developmental stage and learning style.

Consent. How to give and ask for consent to sexual activity.

Body Parts. Information on body parts and how they function.

Contraception. Information on methods of contraception.

Sexually Transmitted Disease. Information on sexually transmitted diseases including how to prevent them, and how to access medical care for them.

Sexual Assault and Sexual Abuse. What constitutes sexual assault and abuse, where to seek help if it happens, how to report it and how to access medical care.

Privacy. Information about privacy, modesty, and the appropriate places and times to engage in intimate behavior.

Boundaries. Information about establishing and observing boundaries with peers, staff and others.

Adapted from "Creating Balance: Promoting healthy relationships and preventing sexual assault of people with cognitive disabilities. Wisconsin Coalition Against Sexual Assault, 2003.