WV S.A.F.E. TRAINING & COLLABORATION toolkit

SERVING SEXUAL VIOLENCE VICTIMS WITH DISABILITIES

A project of the

West Virginia Sexual Assault Free Environment (WV S.A.F.E.) Partnership

WV S.A.F.E. Partners:

West Virginia Foundation for Rape Information and Services (WVFRIS)

West Virginia Department of Health and Human Resources (WVDHHR)

Northern West Virginia Center for Independent Living (NWVCIL)

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A. Collaboration 101

Funding was provided by Grant No. 2006-FW-AX-K001 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this toolkit are those of the authors and do not necessarily reflect the views of the U.S. Department of Justice, Office on Violence Against Women.

Forward

Service providers are finally recognizing the intersection of two issues: the prevalence of persons with disabilities who are sexually victimized and the prevalence of sexual violence victims who have disabilities. Although one in the same, the response to sexual violence victims who have disabilities may differ depending on their point of entry into the service delivery system. Sexual violence service providers have not been adequately trained in serving victims with disabilities. Disability service providers have not been trained in responding to sexual violence. There has been a lack of recognition that a coordinated community response is needed to ensure that the social service system (collectively comprised of the local, regional and state agencies that serve victims on the local level) effectively and equally meets the needs of these individuals. In West Virginia, through this project, we are bringing together service providers who aid sexual violence victims with those who serve persons with disabilities. Our goal is to increase the access victims with disabilities have to services. It is important to acknowledge that "getting to this place" did not happen overnight; rather, it required consciousness-raising and community organizing by dedicated activists. In essence, "getting to this place" is the story of two social movements—the anti-sexual violence movement and the disability rights movement—maturing into a "second wave" of activism and joining together to address needs of previously underserved populations.

The beginnings for both movements grew from the 1950s to the 1970s when minority groups—most notably African Americans, gays and lesbians, women and people with disabilities—began ardently fighting to secure their civil rights. Early in the women's rights movement, women began to speak out about their personal experiences of sexual violence. In the decades to follow, tremendous progress was made toward supporting sexual violence victims. Rape crisis programs were established in counties throughout the United States to offer crisis intervention, support and advocacy for victims, as well as community awareness and prevention. A significant body of literature and research emerged that increased public concern about sexual violence. Legislative changes—including the enactment of state laws to ensure victim rights and federal laws such as the Rape Control Act in 1975 and the Violence Against Women Act of 1994—were enacted that have increased the efficacy of the criminal justice and medical community responses to sexual violence.[1]

Encouraged particularly by the civil rights and women's rights movements, large-scale cross-disability rights activism began in the late 1960s with the goal of ending social oppression. That oppression kept children with disabilities out of the public schools and sanctioned discrimination against adults with disabilities in employment, housing and public accommodations. As part of this movement, the independent living movement emerged to support the choice of living in the community for people with even the most severe disabilities. The first independent living center opened in 1972; by the beginning of 2000, there were hundreds of such centers across the country and the world. In the meantime, a series of landmark court decisions and legislative changes—including the enactment of the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act of 1975 and the Americans with Disabilities Act of 1990—secured for individuals with disabilities unprecedented access to their civil rights.[2]

These victories for the two movements, as critical as they were, have not ended sexual violence or discrimination against persons with disabilities.[3] There is still a great need for continued activism. By coming together in localities across the country, as we are beginning to do in West Virginia, these movements are able to take the important next steps of educating one another and combining their resources to create positive systems change for sexual assault victims with disabilities. We hope you find the *West Virginia S.A.F.E. Training and Collaboration Toolkit: Serving Sexual Violence Victims with Disabilities* to be a useful resource to facilitate this cross-training and improve the response and partnerships across agencies and movements in your community.

Acknowledgements

The work of creating a toolkit involves the expertise and assistance of numerous individuals. The WV S.A.F.E. partnership is grateful to the individuals listed below for their contributions in the creation of this toolkit.

Project Partners and Primary Authors

Each of the three project partners coordinated the writing of the modules (in conjunction with the Project Consultant) within the sections pertinent to their disciplines. Each partner reviewed all of the modules during the development and pilot phases of the project. After each module was piloted and then reviewed and approved by the Office on Violence Against Women, the modules were then edited by the Toolkit Project Coordinator and Project Consultant.

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- Russell Nesbitt Services
- Sexual Assault Help Center
- Task Force on Domestic Violence, "HOPE", Inc.
- Rape and Domestic Violence Information Center
- Northern West Virginia Center for Independent Living
- West Virginia Department of Health and Human Resources (Marion, Ohio and Preston counties)

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WV S.A.F.E. Training and Collaboration Toolkit—Serving Sexual Violence Victims with Disabilities[4]

This toolkit offers guidance for service providers on working collaboratively to integrate accessible services for sexual violence victims with disabilities into the existing social service delivery system. *The purpose is to provide the information and resources needed to begin the process of collaborating and cross-training among relevant agencies. Using the tools in the toolkit, agencies can build their capacity to offer responsive, accessible services to sexual violence victims with disabilities.* The toolkit's focus is on adult and adolescent victims with disabilities.

The concept for and contents of this toolkit evolved over a four-year period from the work of a project coordinated by several West Virginia statewide/regional agencies and piloted by local agencies from three counties. Although the toolkit is written for a West Virginia audience, other states and communities are welcome to adapt the materials to meet their needs.

This *User's Guide* explains the toolkit's features and organization as well as the pilot project.

Toolkit Features

The toolkit's main feature is a collection of educational modules intended to:

- **Facilitate dialogue and collaboration among partnering agencies** to improve the accessibility and appropriateness of services across systems for sexual violence victims with disabilities (see the *Collaboration 101* modules);
- **Build individual providers' knowledge** related to fundamental issues in providing accessible and responsive services to sexual violence victims with disabilities (see *Disabilities 101* and *Sexual Violence 101* modules); and
- **Provide tools to facilitate assessment and planning by individual agencies** to improve the accessibility and appropriateness of their services for sexual violence victims with disabilities (see the *Tools to Increase Access* modules).

The toolkit was developed with the recognition that both individual and partnering agencies will adapt the toolkit materials to assist them in providing accessible and appropriate services to sexual violence victims with disabilities. NOTE:

- Individuals and agencies can use all of the modules and materials or select only the modules and materials that address their specific needs.
- Individuals and agencies can decide the sequencing of the modules that meets their needs, depending on factors such as the types of services each agency provides, who will be trained (designated or all staff, volunteers, students, board members), etc.
- Collaborative groups can decide the selection and sequencing of the modules to utilize based on the partnering service providers, strengths and gaps in the current response, level of existing collaboration among service agencies, issues that need to be addressed, etc.
- Individual agencies and partnerships may wish to add information and discussions on other pertinent issues not addressed through the modules.

Because the toolkit is available online, those using it can benefit from new material that may periodically be added. The toolkit can be accessed at http://www.fris.org/ to check for updates.

Background: Toolkit Development

In 2006, the West Virginia Foundation for Rape Information and Services (FRIS) received a grant from the U.S. Department of Justice, Office on Violence Against Women (OVW) to examine and implement changes to local and state systems that respond to women with disabilities and deaf women who are victims of sexual assault. Entitled *West Virginia Sexual Assault Free Environment* (WV S.A.F.E.), the resulting collaboration consists of three core team partner agencies: FRIS, the West Virginia Department of Health and Human Resources (DHHR) and the Northern West Virginia Center for Independent Living (NWVCIL).[5]

This collaborative's broad mission is to identify and address state and local gaps and barriers in services and policies that impede the provision of effective, accessible and seamless services to survivors of sexual assault among women with disabilities and deaf women. The shared vision is:

> *".. [C]reating permanent systems change at all levels of the sexual assault and disability systems and state policy in which effective services for women with disabilities and deaf women are fully integrated into the existing structure of victim services and advocacy."*

The statewide partnership, and subsequent participation of their counterparts in three counties (Marion, Ohio and Preston counties), conducted needs assessments and developed a strategic plan. The plan included the following short-term goals and objectives:

1. Foster collaboration among local service providers who interact with survivors with disabilities (to overcome fragmentation of services). Objectives: Coordinate and implement on-going partnership meetings and formalize collaborative processes among pilot site partners.
2. Build a sustainable common knowledge base among local service providers and among statewide partnering agencies. Objectives: Develop and implement a capacity building plan to strengthen the knowledge base and sustainable practices.
3. Ensure services and supports are accessible and responsive to the needs of women with disabilities and deaf women. Objectives: Assess accessibility with pilot site and state partners and implement prioritized components of accessibility transition plans.

The toolkit is the result of the sustainable cross-training component of this four-year project. Note that the materials are applicable to serving all adult/adolescent victims of sexual violence (recognizing the vast majority are women) and that the term "persons with disabilities" became inclusive of deaf persons, unless otherwise indicated.

Note also that while a limited number of agencies officially partnered in this pilot project, the benefit to victims can increase when the partnership is welcoming of any agency that might provide services to victims with disabilities. To that end, longer-term goals include: expanding local pilot site partnerships to include all points of entry into the service delivery system for victims with disabilities; improving the accessibility of those points of entry; providing ongoing capacity building opportunities; and replicating this systems-change model in additional counties in West Virginia.

Toolkit Organization

Toolkit Components. The toolkit offers a set of four separate components: *A. Collaboration 101, B. Sexual Violence 101, C. Disabilities 101* and *D. Tools to Increase Access*. Each component is comprised of a series of informational modules.

Structure of the modules within each component. The individual modules within these components are primarily organized into two main sections: *Core Knowledge* and *Discussion*. Some modules include both sections while others include only the *Core Knowledge* or the *Discussion* section. Several of the *Tools to Increase Access* use a checklist, rather than a narrative format. All of the remaining modules include a cover page featuring a brief overview and the key points. Each also includes an introduction describing the purpose, objectives and any preparation needed.

- ***Core Knowledge:*** Depending on the content, the *Core Knowledge* section provides basic information on the topic. It may also include *Test Your Knowledge* questions to evaluate what was learned. These can be useful both for the reader and for supervisors who may choose to use the questions to gauge the knowledge of staff and volunteers.

  The *Core Knowledge* section is intended for individual use—e.g., for self-paced learning, one-on-one training of employees such as agency orientation or continuing education, volunteer trainings, review prior to an agency or multi-agency discussion, etc.

- ***Discussion:*** The *Discussion* section is designed for use in a group setting, either within an agency or with outside partnerships. Each *Discussion* section indicates the estimated time frame for the dialogue and the preparation needed, if any; describes suggested activities and questions (targeted to create a common knowledge base, improve agency response and build collaboration); and ends with a closing assessment of what was learned during the discussion and changes providers/agencies plan to make as a result of the discussion.

- ***Resources:*** Some modules also include related forms and/or other sample materials.

The modules were developed to maximize agencies' finite resources for in-house and multi-agency training. To that end, an effort was made to offer *Core Knowledge* sections that simplified complex topics as much as possible. It is a delicate balance to find a format in which the information provided can be easily understood but that provides enough detail to assist the reader in offering responsive assistance to victims with disabilities. As appropriate in each *Core Knowledge* and *Discussion* section, guided probes and case scenarios are included to assist service providers in applying the information to impact service delivery changes both within their own agencies and their communities.

Cross-referencing of modules. The modules were generally developed so they can be used independently of one another; however, a few make reference to other modules as prerequisites. Reference to other modules is also made throughout the modules so the reader can easily gain further knowledge on a particular topic.

Terminology used. Across all modules, the following should be noted:

- Agencies that interact with sexual violence victims and persons with disabilities typically refer to the individuals they serve as "clients," "consumers" and/or "victims." For convenience, "victims" and "clients" are primarily used.

- The terms "sexual violence" and "sexual assault" generally will be used to encompass sexual assault, sexual abuse and other forms of sexual violence.

- In recognition that the vast majority of victims of sexual violence are female and the vast majority of offenders are male,[6] individual victims are often referred to using female pronouns and individual offenders are often referred to using male pronouns. This use of pronouns in no way implies that males are not victims of sexual violence or that females are not offenders; it is written in this format solely for the ease of reading the material.

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Project partners welcome the non-commercial use of this toolkit to increase knowledge about serving sexual violence victims with disabilities in any community, and adaptation for use in other states and communities as needed, without the need for permission. We do request that any material used from this toolkit be credited to the West Virginia Sexual Assault Free Environment (WV S.A.F.E.) project, a partnership of the West Virginia Foundation for Rape Information and Services, the Northern West Virginia Center for Independent Living and the West Virginia Department of Health and Human Resources (2010). Questions about the project should be directed to the West Virginia Foundation for Rape Information and Services at www.fris.org.

[1]This paragraph was drawn primarily from California Coalition Against Sexual Assault, *A vision to end sexual assault—The CALCASA strategic forum report* (2001), as well as J. Meyers, *History of sexual assault prevention efforts* (Colorado Coalition Against Sexual Assault, 2000) and P. Poskins, *History of the anti-rape movement in Illinois*. All can be accessed through http://new.vawnet.org/category/index_pages.php ?category_id=576.

[2]This paragraph was drawn from University of California Berkley, *Introduction: The disability rights and independent living movement* (last updated 2010), through http://bancroft.berkeley.edu/collections/drilm/index.html.

[3]Adapted from University of California Berkley.

[4]Note that the format used in this *User's Guide* was in part modeled after the Office for Victims of Crime's *Sexual assault advocate/counselor training, trainer's manual* (Office of Justice Programs, U.S. Department of Justice), https://www.ovcttac.gov/saact/index.cfm.

[5]An additional partner, the West Virginia University Center for Excellence in Disabilities, participated in the first two years of the project.

[6]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (C. Rennison, Rape and sexual assault: Reporting to police and medical attention, 1992–2000 (Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2002), 1, http://bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=92; and P. Tjaden & N. Thoennes, *Prevalence, incidence and consequences of violence against women: Findings from the National Violence Against Women Survey* (Washington, DC: National Institute of Justice, Office of Justice Programs, U.S. Department of Justice, 1998), 2–4, http://www.ojp.usdoj.gov/nij/publications/welcome.htm. Regarding sex offenders, males make up the vast majority, but females also commit sexual crimes. In 1994, less than 1 percent of all incarcerated rape and sexual assault offenders were female (L. Greenfeld, *Sex offenses and offenders: An analysis of data on rape and sexual assault, U.S. Department of Justice, Bureau of Justice Statistics* (Washington, DC: 1997). As cited in R. Freeman-Longo, *Myths and facts about sex offenders* (Center for Sex Offender Management, 2000), http://www.csom.org/pubs.

Forming a Collaboration Among Service Providers: An Initial Meeting Activity

After identifying the agencies that should be involved in collaborating to improve access to services for sexual violence victims with disabilities and completing the preparations to bring a group together, the content of the first meeting of the collaboration must be considered.[1] This module offers a starting point for dialogue for these agencies. It is designed to help service providers from partnering agencies do the following: (1) build a shared knowledge about each of their agencies; (2) learn about each agency's history in this work and in their current roles; and (3) lay the foundation for a local collaboration.

Key Points

- A collaboration is a well-defined relationship entered into by two or more organizations to achieve common goals.[2] Collaboration involves agencies coming together to accomplish something that they cannot do alone.[3]
- Collaboration is critical to providing a seamless, service-delivery system for all victims of sexual violence. Victims have many potential points of entry into the service delivery system: advocacy organizations, the criminal justice system, health care organizations and school systems, just to name a few. It is important that these systems are accessible and work together to meet all of the needs of all victims of sexual violence.
- When forming this collaboration to improve access to services for sexual violence victims with disabilities, planners should bring together agencies in their communities that represent the various points of entry for victims seeking services. They should also consider when and how to include the voices of consumers, as appropriate to the established goals of the collaborative.

A1. Forming a Collaboration Among Service Providers: An Initial Meeting Activity

Purpose

This module focuses on planning for the first meeting of a newly forming collaboration. By this time, service providers have identified a need or purpose for the group and identified potential partners. It is important that the organizers who are convening the meeting critically consider if they have identified and included all potential stakeholders. Potential stakeholders should include both those who will be impacted by the work of the group and those who will be needed to successfully carry out the work. Potential stakeholders could include service providers, policy makers, funders and consumers—depending on the goals of the collaboration.

After identifying stakeholders to involve and completing the preparations for bringing a group together (e.g., date, time, place and invitations to individuals and organizations), the structure and intended outcomes of the first meeting need to be considered. This meeting offers a starting point for dialogue for agencies interested in collaborating to improve services. For clarity, agencies should understand that a collaboration is a well-defined relationship entered into by two or more organizations to achieve common goals.[4] These organizations come together to accomplish something that they cannot do alone.[5] Collaborations can be short-term to focus on time-limited projects or long-term to address more in-depth challenges.

COLLABORATION 101

Collaboration is critical to providing a seamless, service-delivery system for victims of sexual violence. In West Virginia, an estimated one in six women will be the victim of an attempted or completed sexual assault.[6] These victims have many potential points of entry into the service delivery system: advocacy organizations, the criminal justice system, health care organizations and school systems, just to name a few. It is important that these agencies and systems are accessible and work together to meet all of the needs of all sexual violence victims.

This module's purpose is to help service providers from partnering agencies do the following: (1) build a shared knowledge about each of their organizations; (2) learn about each agency's history in this work and in their current roles; and (3) lay the foundation for a local collaboration.

Objectives

Those who complete this module will be able to:

- Describe their agency's services and the services of partnering agencies;
- Discuss the status of the existing service system for sexual violence victims with disabilities; and
- Come to agreement about basic components of the local collaboration process.

Note that this module, along with other modules in *Collaboration 101,* is intended to be used by two or more agencies to facilitate collaboration rather than for individual agency training purposes.

DISCUSSION

Projected Time for Discussion
2 to 3 hours

Preparation

Note that **this discussion section is intended to serve as an outline for organizers to plan the initial meeting of a collaboration. The purposes of collaborations will differ, so the questions that will be asked of the participants will differ.** For illustration purposes, the examples given are for planning the first meeting of a sexual assault response team (SART).

Also note that preparation for this initial meeting discussion is more involved than most other discussions in the toolkit.

- Prior to the meeting, carefully consider whether all key stakeholders have been invited to participate. The composition of any collaboration should be reflective of the local community and representative of those being impacted by the decisions that will be made. Therefore, each collaboration will be unique. For example, in creating a SART, it would be logical to include representatives of all first responders to sexual assault and others who may eventually be in contact with the victim throughout the criminal justice or healing processes. However, the composition of this team will differ based on the community. In a large city, key members of a SART might be the law enforcement officer from the special sex crimes unit, sexual assault nurse examiners, the rape crisis center's advocate, the prosecutor from the Violence Against Women unit, a disability service provider and the sexual violence prevention/services coordinator on the local college campus. In a rural community, none of those entities may even exist. Emergency medical services may be a first responder and, with no hospital, the local health department may be a resource for victims. In rural areas, victims may enter the service delivery system in different ways, such as through the faith-based community or by contacting the one law enforcement officer for the municipality. For a collaboration's work to be effective, the participants have to be knowledgeable about and committed to the issue (e.g., improving the coordinated response to sexual assault victims).

- The initial collaboration meeting may be the first time that participants discuss the issue of sexual violence outside of their work setting and it is possible that a participant could disclose victimization. Therefore, take steps to ensure that the group environment is safe and responsive to its members. Prior to the meeting, identify and arrange for the necessary supports in the event that a member should require self-care. (For example, have a private office or room available or access to an advocate.) Plan at the beginning of the meeting to do the following: (1) acknowledge the sensitive nature of discussing sexual violence; (2) stress the importance of self-care for survivors; and (3) advise the group of the supports that are available.
- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations, and if so, work with them to secure those accommodations.
    - Encourage participants to review a resource developed by the National Association of State Directors of Developmental Disabilities Services, *The Guide: NASDDDS Handbook on Inclusive Meetings and Presentations* (through http://www.nasddds.org/Publications/special.pubs.shtml). Since the collaboration will be working to improve the accessibility of services, a starting point is to ensure that the meetings themselves are accessible to all potential participants.
- Prior to the discussion, request that participants from within an agency work together to prepare a *10 to 15 minute* informal presentation on the following:
    - Agency philosophy and mission;
    - Agency services (including types of services, area served, staff size, service hours, brief history and definition of terms/acronyms used); and
    - Services specific to the issue the collaboration is going to address. (For this example, a description of these services might include the number of victims served, the training the staff receives and how referrals are made.)

If the participants are volunteers or consumers who do not represent an agency, they might be asked to share their personal work and/or interest in this field. If participants are invited to attend the meeting as consumers, they should not be identified as such without their permission.

NOTE: The information discussed should be pertinent to the purpose of the collaboration. In forming a SART, it would be important to know the roles and services of existing partners. If the purpose of the collaboration were to exclusively examine services for sexual violence victims with disabilities, some information the participants might share could include how victims with disabilities currently access services, screening processes that are in place, and how staff members are trained on this issue. It is anticipated that in the course of discussing existing services, gaps will be identified. Participants should be encouraged to engage in an open discussion of service and training limitations within their agencies.

- Encourage participants to bring any printed materials (e.g., agency brochures and business cards) to the meeting to share with other participants.
- Select a discussion facilitator and note taker.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Since this is the first meeting, it would be helpful to have name badges or table tents.

COLLABORATION 101

Activities and Questions

1. **Briefly explain that this meeting is meant to be a starting point for a dialogue** for agencies and individuals interested in collaborating on your selected purpose area (e.g., to develop a SART or to improve services for victims of sexual violence with disabilities). *(5 minutes)*

   Then ask participants to introduce themselves and share their work and/or personal journey that brought them to their current role. *(Up to 5 minutes for each participant)*

2. **Invite participants to identify discussion ground rules to promote open communication**. Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.
- Acknowledge the sensitive nature of discussing sexual violence and stress the importance of self-care for survivors. Advise the group of the supports that are available during the meeting and in the community.

3. **Ask a representative from each partnering agency to spend *10 to 15 minutes* providing an agency overview**, as described in the *Preparation* section.

4. **Ask participants to discuss the questions below**. *(10 minutes for a. and b.)*

   a. What did you learn about existing services that you did not know?

   b. What gaps and challenges exist (e.g., for victims in general or for victims with disabilities in accessing the services of the partnering agencies)? Record in the meeting minutes any gaps and challenges identified so that partnering agencies can address them at future meetings.

   c. Is there information or insight gained from the discussion that you will take back to your agency that will impact the agency's service delivery system? *(10 minutes)*

5. **Ask participants to come to an agreement on the following**: *(20 minutes)*

   a. What do you see as the initial purpose of this collaboration? What are some of the outcomes that can be achieved? (NOTE: These are important questions and enough time should be allotted for a thorough conversation. If time does not permit such a discussion, at a minimum develop a consensus on when the goals of the group will be established.)

   b. How do you want to structure these meetings (e.g., whether to have a chairperson, if the role of meeting facilitator will be rotated, etc.)?

   c. How do you want to record the notes from these meetings (e.g., format and level of detail of the notes, rotation of note takers, etc.)?

   d. What are the expectations regarding confidentiality of what is shared at these meetings?

   e. What decision-making process should be used (e.g., to vote, come to agreement on issues, etc.)?

f. How will agencies communicate with each other between meetings?

6. **Schedule meetings and meeting sites** through the next quarter and establish an agenda for the next meeting. *(10 minutes)*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the terms "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]P. Mattessich, Can this collaboration be saved? 20 factors that can make or break any group effort, *Shelterforce Online, #129*, May/June 2003, National Housing Institute, at http://www.nhi.org/online/issues/129/savecollab.html. Note that all online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]Mattessich.

[4]Mattessich.

[5]Mattessich.

[6]West Virginia Bureau for Public Health, Health Statistics Center, 2008 *Behavioral Risk Factor Surveillance System Survey*.

Examining Your Collaboration

This module is designed to support the process of developing and sustaining a joint initiative among partnering agencies to improve access to services for sexual violence victims with disabilities. It encourages representatives from these agencies to do the following: (1) learn more about collaboration in general; (2) examine their current collaboration, identifying strengths and areas where changes are needed; and (3) begin to develop a plan to strengthen the collaboration.[1]

Key Points

- "Collaboration goes beyond informal cooperation or the occasional coordination of efforts. It is a long-term, well-defined relationship entered into by two or more organizations to achieve common goals. It involves the genuine sharing of authority, accountability, resources and rewards. There is [always either] a need, a crisis or an opportunity. Partners come together to accomplish something that they cannot do alone."[2]
- Communities use different approaches to facilitate collaboration—their approaches often build upon related efforts already underway.
- When agencies successfully collaborate to improve access to local services for sexual violence victims with disabilities, it can benefit victims (e.g., better and more accessible services), partnering agencies (e.g., more networking and coordination to meet the needs of victims) and the community (e.g., increased knowledge of services and more confidence in service providers).
- To begin to develop a clearer sense of factors that influence partnering agencies' efforts to collaborate, this module encourages agencies to think about and jointly discuss questions and considerations related to the following:
  - Which agencies are/should be involved in this effort;
  - The history of collaboration among the partnering agencies;
  - Relationships among the partnering agencies;
  - The collaborative's vision and a work plan to incrementally implement the vision;
  - Whether the collaboration is guided by the self-identified needs of victims;
  - The level of support for the collaboration from agency administrators, the community and community leaders;
  - Resources available to facilitate the collaboration;
  - Leadership and staffing for the collaborative;
  - Operating procedures of the collaborative; and
  - Methods used to evaluate the effort.

A2. Examining Your Collaboration

Purpose

Collaboration 101. Forming a Collaboration Among Service Providers: An Initial Meeting Activity, suggested activities for an initial meeting to begin a dialogue among the partnering agencies on improving local services for sexual violence victims with disabilities. The next step, as discussed in this module, is for staff at these agencies to learn more about collaboration and examine their current collaboration. Examining their collaboration involves identifying strengths in their joint efforts to serve sexual violence victims with disabilities, as well as areas where changes are needed. Such an exploration can help build relationships and increase communication among the partnering agencies—outcomes which not only benefit these agencies, but also the clients they serve.

Objectives

This module seeks to:

- Facilitate a dialogue on how agencies can collaborate to improve access to services for sexual violence victims with disabilities;
- Develop a basis for understanding how each participating agency perceives the collaboration in general;
- Identify potential barriers to effective collaboration; and
- Develop a prioritized plan for strengthening the collaboration.

Also note that other modules in this toolkit focus more on assessing the agency-specific and community-wide accessibility issues related to serving sexual violence victims with disabilities (as opposed to general collaboration issues).

Part 1: CORE KNOWLEDGE

What is collaboration?

The definition of collaboration was discussed briefly in *Collaboration 101. Forming a Collaboration Among Service Providers: An Initial Meeting Activity.* In review:

> "*Collaboration goes beyond informal cooperation or the occasional coordination of efforts. It is a* ***long-term, well-defined relationship*** *entered into by two or more organizations to achieve common goals. It involves the genuine* ***sharing of authority, accountability, resources and rewards.*** *There is [always either] a need, a crisis or an opportunity.* ***Partners come together to accomplish something that they cannot do alone.***"[3]

For partnering agencies that seek to increase the accessibility of local services for sexual violence victims with disabilities, collaboration is a tool they can use to facilitate this common goal. While each agency can strive to make internal improvements, it is only by working together that they can offer a streamlined and coordinated response to victims with disabilities.

Are there different approaches to facilitate collaboration?

Communities use different approaches to facilitate collaboration—their approaches often build upon related efforts already underway. For example, there may be a local council on violence against women that includes representation from agencies that serve sexual violence victims and persons with disabilities. A subcommittee could be formed to address the issue of increasing access to services for sexual violence victims with disabilities. An existing coordinating team, such as a sexual assault response team (SART), might be willing to explore how to better respond to victims with disabilities. Agencies may already engage in informal partnering on this or other

areas that could pave the way for more formal efforts to strengthen accessibility to services for sexual violence victims with disabilities. For instance, they may form a task force with subcommittees or a less formal working group to accomplish the tasks of the collaboration. Agencies may collectively seek funding to support their collaboration.

What are the benefits of collaboration?

When collaboration is successful, it can benefit victims with disabilities, the partnering agencies and the community. For victims, for example, collaboration can increase their options for protection, healing and justice; facilitate prompt referrals and connections to services; and lead to services that accommodate their needs. For partnering agencies, collaboration can increase the effectiveness of their staff in assisting clients in addressing their full range of needs and heighten the awareness of their staff of community resources. For the community, collaboration among partnering agencies can lead to a greater public knowledge of services available to sexual violence victims with disabilities and increased confidence in those agencies' abilities to collectively provide assistance. Collaborations should publicize the potential benefits so everyone who is involved or affected understands how their self-interests are served by supporting the collective efforts.

What factors might impact the success of your collaboration?

Many factors could impact the success of collaboration among partnering agencies to improve access to services for sexual violence victims with disabilities. For example, in *Collaboration 101. Forming a Collaboration Among Service Providers: An Initial Meeting Activity,* we discussed how understanding each other's agency-specific roles in working with victims with disabilities is a first step for providers to be able to assist one another in connecting victims with the comprehensive services they need. We also began to explore the gaps and challenges for victims with disabilities in accessing the services of the partnering agencies. This knowledge can help service providers to determine what is needed to improve accessibility.

To begin to develop a clear sense of the factors that influence your collaboration, think about the questions and considerations below.[4] These questions and considerations are the focus of *Part 2: Discussion* of this module. Exploring these questions and considerations, first on your own or in conjunction with other staff from your agency and then with representatives from partnering agencies, can help promote a common understanding of how individual partners perceive the collaboration, areas of agreement/disagreement, and what issues need to be addressed to strengthen it.

FYI Answers to these questions will likely be different if partnering agencies are just beginning to collaborate to improve access to local services for sexual violence victims with disabilities versus if they already have some history of collaborating on this issue. If the collaboration is just starting, these questions can be reference points for guiding the development of the collaboration.

Directions: Each themed section below begins with a "rated" question, meant to encourage respondent objectivity and subsequently facilitate equal input and participation across agencies during discussions. Use the following rating scale for those questions:

1=Strongly Disagree **2**=Disagree **3**=Not Sure/Need More Information **4**=Agree **5**=Strongly Agree

The remaining questions in each themed section ask respondents to further describe how the collaborative addresses the theme.

COLLABORATION 101

1. Participating Agencies

Rate the following statement on the above scale of 1 to 5 and explain your rating:

All relevant agencies (that interact with sexual violence victims with disabilities in the community) are participating in this collaboration. Score: _____

a. What agencies should be part of the collaborative, but are not yet involved?

b. What current barriers might prevent a particular agency from being active in this collaborative (e.g., agency X has lost significant funding and lacks the resources to participate)?

c. Describe whether each partnering agency (1) has a representative who participates in the collaborative who has the authority to make decisions for her/his agency when needed; and (2) has representatives who participate who provide services as well as develop and implement policies.

2. History of Collaboration

Rate the following statement on the above scale of 1 to 5 and explain your rating:

Partnering agencies already work together on other initiatives. Score:_____

a. Describe how they have worked together in the past.

b. What factors have contributed to the success/failure of these initiatives?

c. What would you have changed to enhance these collaborative efforts?

3. Relationship Among Agencies

Rate the following statement on the above scale of 1 to 5 and explain your rating:

There is respect and trust among partnering agencies. Score:_____

a. What are the existing strengths that support mutual respect and trust, as well as barriers that detract from mutual respect and trust?

   (One key to mutual respect and trust is building awareness among those involved in the collaborative of each agency's general mission, services and role in serving victims with disabilities. See *Collaboration 101. Forming a Collaboration among Service Providers: An Initial Meeting Activity.*)

4. Vision of the Collaborative

Rate the following statement on the above scale of 1 to 5 and explain your rating:

Partnering agencies have a shared vision of what they wish to accomplish through this collaborative. Score:_____

a. What is that shared vision? (See *Collaboration 101. Forming a Collaboration Among Service Providers: An Initial Meeting Activity.*)

b. Are agencies equally invested in achieving that vision? Why or why not?

5. Work Plan for Collaboration

Rate the following statement on the above scale of 1 to 5 and explain your rating:

Our collaborative's vision is achievable in increments over a defined time period. Score:_____

a. Has/will a written work plan been developed and agreed upon by the partnering agencies to implement this vision?

b. Is the work plan to be reviewed periodically to evaluate whether circumstances or goals have changed, and if so, then revised? (See *Tools to Increase Access. Developing a Transition Plan*.)

6. Collaboration Guided by Self-Identified Needs of Victims

Rate the following statement on the above scale of 1 to 5 and explain your rating:

Partnering agencies collectively make a sufficient effort to ensure that the voices of sexual violence victims and persons with disabilities guide the collaboration. Score:_____

a. What strategies are/will be used to ensure that the self-identified needs of sexual violence victims and persons with disabilities guide the collaboration? What additional strategies may be useful?

7. Support for Collaboration

Rate the following statement on the above scale of 1 to 5 and explain your rating:

The current level of support from agency administrators and the community for this collaborative initiative is sufficient. Score:_____

a. Describe if and how leadership of each agency supports the collaboration.

b. Describe if and how the community/community leaders support the collaboration.

c. Describe strategies that are being/will be used to gain additional support.

8. Resources to Facilitate Collaboration

Rate the following statement on the above scale of 1 to 5 and explain your rating:

There are sufficient resources available across partnering agencies to support the work of this collaborative. Score:_____

a. Describe the resources that partnering agencies are willing to share/make available to support this effort—personnel time, expertise, training, money, meeting space, etc. (See *Collaboration 101. Creating a Community Resource List*.)

9. Leadership

Rate the following statement on the above scale of 1 to 5 and explain your rating:

There is an individual(s) designated as responsible for leading and/or coordinating our collaborative effort. Score:_____

a. Is this person(s) a paid administrator hired for this purpose or employed by one of the partnering agencies, with this role incorporated into her/his existing work?

b. Do you think the collaboration would continue without that person(s)? Why or why not? If not, is there a way to structure the collaboration to ensure sustainability?

10. Staffing

Rate the following statement on the above scale of 1 to 5 and explain your rating:

The work of the collaboration is shared appropriately across agencies. Score:_____

a. What are the roles of each of the partnering agencies in carrying out the work of the collaboration?

b. Describe if there are different ways/levels that agencies can be involved or contribute to the collaborative.

11. Operating Procedures

Rate the following statement on the above scale of 1 to 5 and explain your rating:

Partnering agencies have agreed upon the operating procedures that aid them in carrying out the collaborative's vision. Score:_____

a. Describe if your collaborative has formal or informal operating procedures. Have there been purposeful discussions to develop operating procedures or did they just evolve over time? How would someone new to the collaborative learn about its operating procedures? (See *Collaboration 101. Forming a Collaboration Among Service Providers: An Initial Meeting Activity.*)

1. Do participating agencies *meet regularly* to discuss expectations, plan for activities and problem-solve? Are collaborative meetings held often enough, not enough or too often? Are meetings sufficiently productive given the time invested? Why or why not?

2. How are *decisions* facilitated and *consensus* reached among agencies?

3. How does your collaborative *deal with conflicts* that arise among agencies?

4. How do agencies *communicate* with one another regarding the collaborative, outside of regular meetings?

5. What strategies are used, if any, during meetings and other communications to (1) facilitate an *environment of mutual respect and trust*; and (2) support all collaborative members in *feeling comfortable* to express their opinions and feelings on the various topics?

6. Describe the expectations for *confidentiality* related to information shared during meetings and in other communications. Describe if and how consensus about these expectations was reached.

12. Evaluation of Efforts
Rate the following statement on the above scale of 1 to 5 and explain your rating: Our collaborative has an effective plan to evaluate our incremental successes in achieving our shared vision. Score:_____
a. How does/will your collaborative evaluate the effectiveness of its efforts? b. How often does the evaluation occur? c. What is done with the evaluation findings?

Test Your Knowledge
Refer to the pages in this module as indicated to find the answer to each question.

1. Define collaboration. *See page A2.2.*
2. What are some examples of how communities might use different approaches to facilitate collaboration to improve access to services for sexual violence victims with disabilities? *See pages A2.2–A2.3.*
3. What are examples of potential benefits of effective collaboration for victims, partnering agencies and communities? *See page A2.3.*
4. What factors might influence and impact the effectiveness of partnering agencies' efforts to collaborate to improve access to services for sexual violence victims with disabilities? *See pages A2.3–A2.7.*

Part 2: DISCUSSION

Projected Time for Discussion
Up to 2.75 hours

Planning

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator. It would be useful for the facilitator to have expertise and/or experience in building community partnerships, particularly for the specific purpose of serving sexual violence victims with disabilities. Also, consider looking outside of your circle of collaborating agencies for a facilitator. Use of a neutral facilitator may help promote more open dialogue among participants.
- Select a note taker to record potential steps to strengthen the collaboration. A flip chart(s) and markers will also be needed.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify the discussion ground rules to promote open communication.** Utilize the following principles: *(5 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable to express their opinions and feelings on the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among the participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and the expectations for confidentiality in the context of this partnership.

2. **Ask participants to work either individually or with other staff from their agencies to review/discuss the questions/considerations posed in *Part 1: Core Knowledge* of this module and to write down their answers/comments for each themed section**. Encourage them to answer the questions honestly and be prepared to discuss the reasoning for their responses. *(Allow up to 45 minutes. Note that some or all of this activity could be completed prior to this discussion.)*

3. **Ask participants to share with the large group the highlights of the individual and agency-specific answers/comments as discussed above**. Record the highlights on flipcharts. *(Up to 60 minutes)*

4. **Facilitate a large group conversation about common themes**, based on the questions below. Record themes on flipcharts. *(20 minutes)*

   a. Did the discussion of the questions identify common or obvious areas of strength and/or weakness that exist within the collaboration?

   b. In what areas, if any, did partners agree?

   c. In what areas, if any, was there disagreement or incongruence?

5. Based on the conversation above, **develop a written list in priority order of potential steps to strengthen the collaboration.** Record the list on flipcharts. Ask for participant feedback on the following: *(20 minutes)*

   a. What specific steps should be taken for each identified area of need?

   b. What resources, information and/or training are needed to implement these steps?

   c. What existing community resources are available to help address each area of need?

   d. Are there areas where we will need to seek out additional resources or technical assistance?

6. **Closing.** Ask each participant to write down how the information gained from this discussion will promote change in their agency's policies, practices or training programs. Then facilitate a large group discussion on this topic. *(15 minutes)*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]Excerpted from P. Mattessich, Can this collaboration be saved? 20 factors that can make or break any group effort, Shelterforce Online, #129, May/June 2003, National Housing Institute, at http://www.nhi.org/online/issues/129/savecollab.html. Note that all online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]Excerpted from Mattessich.

[4]The questions build upon the authors' experiences doing collaborative work, as well as concepts from P. Mattessich, M. Murray-Close & B. Monsey, *Collaboration: What Makes It Work*, as cited in C. Lucas & R. Andrews, *Four Keys to Collaborative Success,* http://www.fieldstonealliance.org/articles/Article-4_Key–Collab–Success.cfm; and M. Carter with M. Griffin & K. Littel, *The Collaborative Approach to Sex Offender Management, Center for Sex Offender Management,* 2000, through http://www.csom.org. If agencies wish to delve more into assessing their capacity and planning for collaborative community work, two online resources include the publications of the Fieldstone Alliance (in particular, see link for free tools), through http://www.fieldstonealliance.org/index.cfm; and the University of Kansas, *The Community Tool Box: Do the Work* (2010), through http://ctb.ku.edu.

Changing Social Systems

This module helps to increase service providers' understanding of social systems in general and encourages them to consider how they can create social change in their local social service delivery systems.[1]

Key Points

- A social system is "the people in a society considered as a system organized by a characteristic pattern of relationships."[2] In the social service field, a social system could be comprised of individuals and agencies that are either formally or informally networked because of the varying needs of the clients they serve.
- For the purposes of this module, social change will focus on how the acts of an individual or group of individuals can result in a sustainable change in the social service delivery system for sexual violence victims with disabilities.
- Social systems can change on a variety of levels. Some individuals' efforts to create social change will have broad impact, while others' efforts will have a more targeted impact. Below are some concrete ways to work toward social change:
  - Examine the vision and mission statements of your organization, especially as they apply to serving sexual violence victims with disabilities.
  - Provide an honest critique of your agency's progress in meeting that vision and mission.
  - Identify action steps that you and your agency need to take to improve the agency's service delivery system.
  - Assess how collaborative efforts can assist your organization in achieving its vision and mission.

A3. Changing Social Systems

Purpose

Service providers can have a major impact on the recovery of sexual violence victims with disabilities when they assist them in identifying and addressing their needs and wishes. To have this impact, service providers must not only provide services, but "go the extra mile" on behalf of victims when advocating within their own agencies and when accessing services from other community agencies.

However, social service providers often are so overwhelmed with maintaining services that they do not look outside of their own agencies to view how their services interface with other organizations to address their clients' needs in the larger, more complex service delivery system. This module is designed to do the following: (1) develop service providers' understanding of social systems in general; and (2) encourage service providers to consider how they can create social change in their local social service delivery systems to improve services to sexual violence victims with disabilities.

NOTE: Ideally, service providers engage in two kinds of advocacy: advocacy to promote positive systems change for their clients, as discussed in this module; and advocacy with individual clients to empower them to have their self-identified needs met. For a discussion on promoting client self-advocacy, see *Disabilities 101. Self-Advocacy and Victims with Disabilities*.

COLLABORATION 101

Objectives

Those who complete this module will be able to:

- Define a social system;
- Define social change;
- Identify their agency's role and vision for creating social change; and
- Identify ways they can impact social change, both individually and collaboratively.

Preparation

- If your agency has conducted an accessibility assessment of its services for sexual violence victims with disabilities using *Tools to Increase Access. Programmatic and Policy Accessibility Checklist* and *Tools to Increase Access. Physical Accessibility Checklist for Existing Facilities,* review a copy of the findings.
- If your agency and other community agencies have begun to draft a transition plan to address the barriers identified in their assessments, review of copy of that plan. (See *Tools to Increase Access. Developing a Transition Plan.*)

Part 1: CORE KNOWLEDGE

What is a social system?

A social system is "the people in a society considered as a system organized by a characteristic pattern of relationships."[3] In the social service field, a social system could be comprised of individuals and agencies that are either formally or informally networked because of the varying needs of the clients they serve. (In this module, this social system is also referred to as a social service delivery system.)

A social service delivery system for serving sexual violence victims will vary depending on the resources within a given community. However, it will most likely include advocacy organizations (rape crisis centers, disability services, etc.), the criminal justice system (including law enforcement agencies, prosecutors' offices and the courts), medical care providers and any other points of entry that victims might use to access services. In some communities, that system could include a college campus; in others, it might include emergency medical services and yet in others it could include the faith-based community. (See *Collaboration 101. Creating a Community Resource List.*)

The overarching system includes practices and protocols—both written and unwritten—for serving sexual assault victims as well as policies that may facilitate or impede the service delivery process. Each of these components could impact victims' experiences after a sexual assault.

What is social change?

Social systems are continuously evolving. Changes to those systems can benefit many members of society and can be caused by different sources. Some changes have a very obvious, far-reaching impact that affects most members of society. For example, the invention of electricity changed how people live and interact; the automobile helped change where people work and how they access goods and services. Other changes impact fewer people, but can be equally as dramatic—such as policies affecting immigration, voting privileges and basic civil rights.

Social change is a general term which refers to:[4]

- Change in social structure—the culture, social institutions, social behavior or social relations of a society, community of people, etc.
- A change in the behavioral pattern of large numbers of people that is visible and sustained. Once there is a deviance from culturally-inherited values, rebellion against the established system may result, causing a change in the social order. Historical examples range from African Americans boycotting buses to protest segregation in the southern United States in the 1950s and early 1960s to the current trend of healthier eating habits in some cities, resulting in restaurants changing menus and posting nutrition values.
- An event or action that affects a large group of individuals who have shared values or characteristics and causes a united, sustained result.
- Acts designed to change in ways that are viewed as positive.

For the purposes of this module, social change will focus on how the acts of an individual or group of individuals can result in a sustainable change in the social service delivery system for sexual violence victims with disabilities.

Why me?

The famous American anthropologist Margaret Meade once said, "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."[5] You are reading this module because your agency is part of a community team—the "small group of thoughtful, committed citizens"—that is working to collectively improve access to local services for sexual violence victims with disabilities.

If your agency has conducted a programmatic accessibility assessment of its services for sexual violence victims with disabilities using *Tools to Increase Access. Programmatic and Policy Accessibility Checklist,* it has already identified existing access barriers. With this knowledge, you and your agency are uniquely positioned to address those barriers and ultimately improve access for all who need your services. You and your agency can also work with partnering agencies to address barriers in coordination and communication across agencies.

Some agency and system changes will require approval from the agency's administrators. Depending on your role in the agency, you may be limited in your ability to influence policy change. But agency/system change also entails changing how a policy is interpreted and implemented at a local level. While you may feel you do not have the ability to change policy, realize that you can influence how that policy is implemented locally. Policies should always be implemented for their intended purposes; this module is not suggesting that rules be bent or violated. Sometimes, however, the interpretation of a policy can have unintended consequences that create barriers for persons with disabilities, and the practices for implementing a policy could be modified or expanded.

Consider the following scenario: It is your agency's policy that all those seeking services must independently complete an application form prior to accessing services. You walk through the waiting room and see someone struggling to read the form because it appears the print is too small. You could do nothing or you could ask if you could be of assistance, providing the form in larger print if available or taking the time to read the form to the person. The policy is in place to ensure that applicants' answers are indeed in their own words. As long as you read the questions as written and do not influence the answers, you are still following the policy. In this scenario, although you may not have the authority to re-write that policy to specify that all forms be available in an alternate format, it is within the scope of your role to interpret agency policy in a way that allows equal access to services for all clients. (See *Disabilities 101. Accommodating Persons with Disabilities* and *Tools to Increase Access. Readiness to Serve Victims with Disabilities: A Review of Intake Practices.*)

COLLABORATION 101

How do you change social systems?

Social systems can change on a variety of levels. Some individuals will witness the broad impact of their advocacy work, such as the creation of the Americans with Disabilities Act and the Violence Against Women Act. Others will have a more targeted impact, such as ensuring that the Americans with Disabilities Act has created accessible services in a specific community or that sexual violence victims are not polygraphed as outlined in the Violence Against Women Act. Below are some concrete ways to work toward social change:

- **Examine the vision and mission statements of your organization, especially as they apply to sexual assault victims with disabilities.**

  How specific are these statements? Most tend to be rather lofty, with few targeted action steps for achieving them. Do they accurately reflect the work of your organization? Does your agency have a plan for achieving them?

- **Provide an honest critique of your agency's progress in meeting that vision and mission.**

  Is your agency falling short in achieving its goals? Who is not being served effectively? How do your current services for sexual violence victims with disabilities measure up to your vision for those services? (NOTE: Utilize *Tools to Increase Access. Programmatic and Policy Accessibility Checklist* as a component of measuring your agency's capability to effectively serve victims with disabilities.)

- **Identify action steps that you as an individual and as an agency need to take to improve your agency's service delivery system.**

  Changing the service delivery system in a sustainable way creates systems change. There are many opportunities to facilitate change. For example, you can be a role model for co-workers by using person first language and assisting others in learning how to better communicate with people with disabilities. (See *Disabilities 101. Person First Language* and *Disabilities 101. Tips for Communicating with Persons with Disabilities*.) Perhaps your agency does not have a method of training new staff on communicating with sexual assault victims with disabilities. If not, you could suggest that *Disabilities 101. Tips for Communicating with Persons with Disabilities* become a mandatory part of staff orientation. Maybe your agency does not routinely ask clients if they need accommodations or if they are safe. If not, then *Disabilities 101. Accommodating Persons with Disabilities*, *Sexual Violence 101. Safety Planning* and *Tools to Increase Access. Readiness to Serve Victims with Disabilities: A Review of Intake Practices* could be presented/discussed and intake forms changed. If your agency is developing a transition plan for improving access for sexual assault victims with disabilities, you could volunteer to serve on the transition planning team. (See *Tools to Increase Access. Developing a Transition Plan*.) You can help increase awareness of the barriers facing sexual assault victims with disabilities by sharing your concerns and ideas with your co-workers and supervisor. Engaging colleagues in your agency who are interested in an issue is also a way of heightening your capacity to impact change.

  These seemingly small actions can enable services to reach more victims and potentially save lives. The key is in taking the time to identify what needs to be changed, determining what realistically can be changed in the short and long-term, and then taking the initiative to make the changes happen. (See the modules in *Tools to Increase Access*.)

FYI When planning changes, you should always consider the history of existing policies and practices. That history can influence your co-workers' responses to your concerns. Long-term employees have reasons for doing things the way they do and making changes can be threatening to some, or may be seen as devaluing their experiences with the agency. Understanding the underlying reasons for a policy can be critical to gaining support for changing a policy or practice that no longer meets the mission or vision of the agency.

4. **Assess how collaborative efforts can assist your organization in achieving its vision and mission**.

   Changing the question changes the focus. Move past "What is wrong?" to "What can we do about it?" Broader social change occurs when agencies move beyond their own doors and engage colleagues in their efforts.

   The discussion section of this module is designed to encourage collaborative efforts among organizations toward social change.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer for each question.

1. What is a social system? *See page A3.2.*
2. What individuals and agencies comprise the social service delivery system for victims with disabilities in your community? *See page A3.2.*
3. What is social change (specifically in regard to this module)? *See pages A3.2–A3.3.*
4. What are some specific ways that service providers can work towards social change? *See pages A3.4–A3.5.*

Part 2: DISCUSSION

Projected Time for Discussion

2 hours (may vary depending on group members' experiences with social change)

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part I: Core Knowledge* of this module to their collaborative work with sexual violence victims with disabilities. The discussion could be incorporated into forums such as agency staff meetings, meetings of an agency's board of directors, as well as multi-agency meetings or trainings. Anticipated discussion outcomes include an increased understanding of the barriers and challenges experienced by victims with disabilities in accessing the current service delivery system; identification of ways to enhance accessible and victim-centered services through responsive agency policies, procedures and resources; and a plan to create changes in the current service delivery system through collaborative efforts.

Refer to the learning objectives at the beginning of this module for specific outcomes for this module on changing social systems.

Key Points for the Group to Consider

Social change efforts can seem overwhelming to staff with already large workloads. It is important for the group involved in this discussion to understand that systems change is a process and can occur on many levels. Seemingly small changes can have a major impact on services. Changing intake procedures, improving training content and creating a list of interpreters—these types of activities can, with minimal efforts, drastically improve the service delivery system for victims with disabilities. Other projects, such as challenging the accessibility of transportation or the court system in a community, may take a larger work group and an extended period of time to achieve. It is important for members of a collaboration to take on work that they have the capacity to handle. For larger projects, it is essential that the workload and time frames established be completed in doable increments. Small

steps still achieve the same end results, just over longer periods of time. A group should not avoid addressing major service barriers in its community solely because it cannot resolve the issues quickly.

Planning

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator. The facilitator should be familiar with social and systems change and be able to assist the group in thinking through the potential unintended consequences when considering social/systems change. Vigilante efforts to force changes versus planned, thoughtful efforts that work within systems can yield different results. The facilitator may need to research the concepts of social and systems change to provide more foundational information to the group, depending on her/his expertise.
- Select a note taker.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module prior to the discussion.
- Each participant should bring to the meeting:
  - A copy of vision and mission statements for their agency;
  - A copy of any strategic plan that their agency may have related to working toward achieving their agency's vision; and
  - If completed, a copy of findings from their agency assessment using *Tools to Increase Access. Programmatic and Policy Accessibility Checklist* and any transition plans related to addressing identified barriers.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: *(5 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2. **Ask a representative from each partnering agency to share their vision and mission statements and their agency's plans for addressing that vision as it pertains to serving sexual violence victims with disabilities.** They could also share the summary of their accessibility assessments and transition plans. *(10 minutes)*
3. As a large group, **discuss the following questions**: *(1.5 hours)*

a. What common themes are shared among the vision and mission statements of the agencies present? List the themes on a flipchart.

b. What challenges are agencies presently facing in achieving their vision as it pertains to serving sexual violence victims with disabilities? (If *Tools to Increase Access. Programmatic and Policy Accessibility Checklist* was completed, it may have identified these challenges.) List the challenges on the flipchart.

c. What, from the list, are some common challenges that the group is experiencing? Highlight those from the chart.

d. Which of those challenges can be met by changing policies and practices from within the individual organizations? List those on a separate page.

e. Which of those challenges must be met by changing policies and practices outside of the individual organizations? List those on a separate page.

f. How will input from persons with disabilities be sought to ensure that any challenges identified are in fact actual barriers to services? How will their suggestions for solutions be sought?

g. As a group, answer the following questions for each item on the two lists (i.e., showing the common challenges that can be met by changing policies and practices inside *and* outside the individual organizations).

   1. Is this change achievable?
   2. What specific steps need to be taken to facilitate this change?
   3. Who must be involved in that process?
   4. Do we have the resources and capacity to make this change? If not, is there a way to access those resources?
   5. Can we commit the time and resources for initiating this change? If so, create a time frame and plan for meeting again to begin the process.

4. **Closing.** Ask each participant to write down how the information gained from this module discussion will promote change in their agency's policies, practices or training programs and their next steps in the process of initiating that change. Then facilitate a large group discussion on this topic. *(15 minutes)*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" generally are used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]WordWeb Online (international dictionary and word finder) (accessed 7/12/09), http://www.wordwebonline.com/. This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]WordWebOnline.

[4]Adapted from *The Psychology Wiki* (accessed 7/12/09), http://psychology.wikia.com/wiki/Social_change.

[5]Well-known quote attributed to M. Meade (1910-1978), although when and where it was said is unknown.

Creating a Community Resource List

This module helps service providers to do the following: (1) develop an understanding of the benefits of having a community resource list for sexual violence victims with disabilities; (2) understand the process for creating a list of local resources;[1] and (3) gain insight into the process of resource mapping.

Key Points

- Identifying community resources, also known as resource mapping, is a strategy for improving services to communities. It can be achieved by compiling a list of resources and/or by mapping out the resources, their physical locations, contact information and linkages with other resources.
- To help guide the work of identifying community resources and assets, the following questions should be addressed: What is the purpose of the asset assessment and how will the results be used? What is the size/scope of the community being assessed? What people are available to do the work? How much time do you have for the task or how much time can you allow? How much money and other resources are available for incidental expenses?
- There are two basic complementary approaches to identifying resources, with one approach focusing on the resources of groups that offer services in the community for sexual violence victims with disabilities and the other focusing on the resources offered by individuals in the community.
- Once you have collected resource information, it can be helpful to put it on a map. Maps are good visual aids—when data creates a picture, understanding and insight often increase. There are several possible approaches to creating a map: Mark the resources on a large community street map, use a computer program to create a more flexible and sophisticated map, or even diagram resources on a chart, rather than an actual map, to show linkages among the different categories of resources.

A4. Creating a Community Resource List[2]

Purpose

Resources available to sexual violence victims with disabilities are not always readily identifiable. For example, some services may not be widely advertised and instead be provided by an agency only upon request. Therefore, service providers must be aware of all of the available resources that sexual violence victims with disabilities might potentially need. Compiling a list of those available resources creates a tool to help provide victims with efficient, seamless service delivery, regardless of their point of entry into the system.

This module is designed to help service providers to do the following: (1) develop an understanding of the benefits of having a community resource list for sexual violence victims with disabilities; (2) understand the process for creating a list of local resources; and (3) gain insight into the process of resource mapping.

Objectives

Those completing this module will be able to:

- Define resource mapping and identify the benefits of creating a community resource list;

- Understand the basic issues to consider when creating a resource list;
- Identify the different approaches for creating a resource list; and
- Convene a work group and create a resource list.

NOTE: Agencies may be concerned about the time required to create and maintain a comprehensive resource list for sexual violence victims with disabilities. Keep in mind that this resource list can first be created on a small scale and incrementally expanded in scope. *Part 2. Discussion* in this module provides participants with an opportunity to begin working collaboratively to create such a list. Also, you most likely are not starting from scratch—not only does your agency probably have a general resource list, but in the process of completing other modules in this toolkit, you may have already begun to gather information about resources for victims with disabilities and have initiated relationships with agencies that provide relevant services.

Part 1: CORE KNOWLEDGE

What is resource mapping?

Identifying community resources, also known as *resource mapping*, is a strategy for improving services to communities. It can be achieved by compiling a list of resources and/or by mapping out the resources, their physical locations, contact information and linkages with other resources (see below for more on different kinds of maps). The resulting "map" can be an excellent visual of what resources are available to the community and how to connect victims with those resources.

To help guide the work of identifying resources, the following questions should be addressed:

- What is the *purpose* of resource mapping and *how will the results be used*? Consider whether the list/map will be shared with other agencies and professionals or be available for in-office use only. Will it be used to initiate some type of action, and if so, what and how? Will it be used to improve services? Do you want to narrow the scope of the resource list to a specific group of victims (e.g., victims with cognitive disabilities) or establish criteria for including a resource on the list (e.g., only affordable housing options rather than all housing options in a community)? The answers to these questions will provide structure and direction for the mapping process.
- What is the *size/scope of the community to be assessed for resources*? It might be a specific housing development, a local neighborhood, a town or city, a region or the state. It might be necessary to identify resources outside of a particular community if victims living there seek services in a neighboring county or state due to the lack of local services and programs. The answer to this question can not only provide focus to your information-gathering efforts, but also help you estimate the time commitment involved in the process. Obviously, with a larger size/scope, more work will be involved.
- What *people* are available to do the work? Is this a project achievable by one staff person or a collaborative project involving multiple agencies? Is it possible to engage local government support or a college class for such a project, since knowing the community's resources is in the entire community's interest?
- How much *time* is available and allowable for the task?
- How much *money*, if any, and other supports are needed/available for incidental expenses?

Additional time and money to do resource mapping may enable you to increase the scope and depth. However, even with limited time and funds, much can be accomplished in identifying resources that will be helpful to victims with disabilities in the community.

What are the potential benefits of resource mapping?

The benefits of the resource mapping process to you and your agency can potentially include:

- Faster identification of relevant programs and services for victims;
- Increased interagency collaboration to serve victims;
- More networking and streamlined resources to allow better support for victims;
- Greater awareness of the community's strengths and gaps in serving sexual violence victims with disabilities, allowing agencies to work together to increase the frequency, duration, intensity and quality of existing services and supports in the community; and
- Ultimately, more flexibility and choice for victims, more victim support in navigating the system, and a more accessible and welcoming environment for victims.

Are there different approaches to identifying resources?

Two basic approaches to identifying resources complement each other, with one approach focusing on the resources of groups and the other focusing on individuals.

1. **Identify the resources of key GROUPS within a community**. The central task here is to take an inventory of the groups (agencies, organizations and institutions) that offer services in the community for the targeted group: sexual violence victims with disabilities. This process begins with creating a work group and generating a list.

- Organize a brainstorming session to develop an initial list of community resources. First, *identify and involve key people*, including consumers, who have knowledge of the relevant systems and the community. For the identified target population, input should be sought from persons with disabilities, agencies providing services to sexual violence victims, disability service providers and key community organizations that serve either victims or persons with disabilities in other capacities, such as health care providers and the criminal justice system. Other possible points of entry into the service delivery system should be considered and input sought from those entities, such as the faith-based community or schools. Next, *establish a time and place for a meeting* (it might be face-to-face or via a phone conference call). Allow for at least an hour, depending on the scope of the information-gathering needs, the scope of the community being served and the momentum of the group. Determine if accommodations are needed to make the meeting accessible to all participants (e.g., a physically accessible building, large print written materials, an American Sign Language interpreter). Be sure to *clearly define the objective(s) for the discussion, the information being sought and how it will be used.*

  NOTE: See *Part 2: Discussion* of this module for a process to follow to conduct the first meeting of the work group.

- Use other sources of information to add to the list. For example:

  - The *Internet* contains information about a variety of resources. Try using different key words to search for information (the name of the community or state, "disabilities services" and "sexual assault victim services," etc.) or go to the websites of state level organizations as they often include links to additional resources.
  - The *yellow pages* are free, comprehensive and often excellent sources.
  - Town *directories*, published specifically for your community.
  - Lists of *businesses*, available from the local chamber of commerce.

- *Existing lists of organizations*. Check with your library, ministerial association, Family Resource Network, Senior and Community Services, rape crisis centers, etc. Also see West Virginia 211, a general information and referral resource for community services (call 304-376-3102 or go to http://www.wv211.org).
- *Lists of organizations that are not generally published.* For example, the local United Way may have a list of non-profit agencies.
- The *local newspaper* may contain information, or provide a contact for other media outlets that may have an otherwise unpublished list of resources.
- *Bulletin boards and other community-calendar type listings* that might be found on the local cable television.
- *Friends and colleagues* may know of resources that are not on other lists.

- Think about how to categorize the list: alphabetically, geographically, type of services, size, free/fee for services, or other possible categories.
- Consider increasing the usefulness of the list by including a brief summary of the types of services provided and the process for accessing the services. A summary will enable anyone using the list to quickly determine the appropriateness of each resource for the specific victim being served.
- Periodically refine and revise the list.

*The following are **examples of community resources as they might be listed** in the local yellow pages or by city/county planning departments, the chamber of commerce and volunteer placement agencies. The resources are organized by sector.*[3]

- **Community-based organizations**
  - Community service providers, including victim service agencies and agencies serving persons with disabilities
  - Advocacy groups for victims, persons with disabilities, drug abuse reduction, etc.
  - Food kitchens and distribution centers
  - Housing organizations
  - Emergency housing shelters, halfway houses, substance abuse homes, domestic violence shelters, transitional housing, etc.
  - Residential/day programs for persons with disabilities
  - Churches offering community services
  - Mental health treatment/counseling centers
  - Transportation services
  - Legal services
- **Grassroots or citizens' associations**
  - Local neighborhood organizations
  - Coalitions

- Community centers
- Groups for seniors
- Advocacy groups
- Political and leadership organizations

- **Institutions**
  - Educational institutions
  - Hospitals and health clinics
  - Short- and long-term care facilities
  - State or federal agencies
  - Medical facilities
  - Law enforcement agencies and other agencies providing emergency services
- **Private sector**
  - Chamber of commerce
  - Business associations
  - Local businesses
- **Specific populations**
  - Persons with disabilities
  - Victims of sexual assault
  - Senior citizens
  - Ethnic/racial groups
  - Recipients of public assistance, food stamps, Medicaid or Medicare or MR-DD Waivers
  - Youth
  - College students

*The following are **sample questions you might ask when gathering information to create a list of organizational resources.** The extent of information you choose to gather on each organization may depend on factors such as the purpose of the resource list, the size/scope of the community being assessed, and the time and resources you have to conduct this inventory.*[4]

- What is your contact information? Seek the name of the person being interviewed, occupation, address, phone number/e-mail and organizational name, brief description and website.
- How many people make up your organization (e.g., staff, volunteers, members or contributors, board members and clients)?

- Is your organization non-profit or for profit?
- What services, products and supports does your agency provide? What are the hours of operation? How do clients access your services (e.g., drop in, call, etc.)?
- How does your organization make its services, products and support known to the public?
- What written media materials/newsletters does your organization publish? How does your organization keep its members/clients up to date on organizational activities and changes?
- What type of equipment and adaptive technology does your organization use for information dissemination/exchange or client support (e.g., computer, audio, audio-visual or video, mechanical and other)? (See *Disabilities 101. Accommodating Persons with Disabilities*.)
- What costs are associated with your services and products for clients/community members?
- Are there eligibility criteria for becoming a client/using your organization's services, products and supports?
- What other organizations do you work with/are you associated with? What other organizations does your group sponsor events with, share information with or share resources or equipment with?
- What other projects does your organization participate in that involve persons with disabilities and/or victims of sexual violence?
- What new projects would your organization be interested in taking on, directly or indirectly, related to your mission?
- What changes would you like to see in the community in the next five years related to serving victims of sexual violence with disabilities? How would you affect these changes?

2. **Identify the INDIVIDUALS within a community who could be considered resources.** Another approach to identifying community resources is to compile a list of individuals who are resources. Particularly in rural communities, individuals (in addition to organizations) may be viewed as assets. Identifying these individuals might be challenging because there are many more people than groups in a community and surveying them all is time intensive. Talking directly to persons representing specific populations can also take a great deal of time and energy. For example, you would need to talk with people who are deaf in your community to find out if they might contact specific individuals within their community (such as a sexual assault survivor who is a therapist and is deaf) as a resource for support.

   Because of these challenges, identifying individual resources often (but not always) takes place in smaller areas within a community—a neighborhood, for example, where the task is more manageable. But regardless of the size of the targeted area, the information gained from individuals can be valuable. Below is a process for identifying individual community resources.

- Answer the five questions in the "What is Resource Mapping?" section on page A4.2 of this module. (Purpose? Size? People? Time? Money?)
- Determine how many people you want to gather input from in the community. Everyone? A specific sub-population? A few representatives that can speak to a specific population's needs rather than the entire population?

- Draft questions that elicit the information you need. Are you interested in skills or roles within the community? If it is skills, which ones? If it is roles, what specific roles are you looking for? These too come in many and varied types.
- Design a method by which these questions can be asked. For example:
  - Will you use a survey? How will the survey be administered (mailed paper or electronic survey, face-to-face or telephone interview, etc.)?
  - Will you use interviews of key community leaders and/or community members?
  - Will you meet people in groups (e.g., by creating focus groups, attending a parents' meeting of the local Special Olympics organization, etc.)?
  - Will you use a combination of the above?
- Test your questions on a sample group to make sure they actually obtain the data being sought. Based on the sample group's answers and suggestions, revise your questions accordingly.
- Add the information gathered about individual resources to the information from the inventory of group resources to create a comprehensive resource list.

How do you visually map community resources?

Once you have collected resource information, it can be helpful to put it on a map. Maps are good visual aids—when data creates a picture, understanding and insight often increase. There are several possible approaches to creating a resource map.

- **Use a large community street map with few other markings**—sometimes available from your city or county planner. Mark with a dot/tag/push-pin (maybe color-coded by type of resource) the geographic locations of the services and resources you have found. The patterns that emerge may surprise you. You may see, for example, that certain locations have varying numbers or types of resources. Those areas where few assets exist may require additional research to learn where community members go for help. (For example, are clients accessing resources outside of the community or perhaps do individual resources exist?)
- **Use a computer program to create a more flexible and sophisticated map.** This process enables the creation of "overlays"—visually placing one category of map over another, and changing the visual patterns. This type of mapping can visually show areas where different services may be clustered in a community and clearly identify where few resources exist.
- **It is also possible to diagram your resources on a chart,** rather than an actual map, to clearly show the linkages among different categories of resources.

FYI To stay focused when developing your resource list and map, ask yourself the following questions: Why am I collecting this information and what am I going to use it for? What might be some of the specific needs of a sexual assault victim with disabilities (accessible transportation, an interpreter, forensic medical care, crisis intervention, etc.) that will cause me to broaden my search for resources?

FYI Once an extensive community resource list for service providers is developed, it can be transformed into resource material for victims. However, consider the scope of information to include on such material as too much data may overwhelm some victims and lead them to feel that getting help is too complicated or difficult.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer for each question.

1. What is another phrase for identifying community resources as a strategy for improving services to communities? *See page A4.2.*
2. What are important questions to ask to help guide the work of identifying resources? *See page A4.2.*
3. What are the potential benefits to service agencies of creating a community resource list? *See pages A4.2–A4.3.*
4. What are the two basic complementary approaches to identifying resources? How do these approaches differ from one another? *See pages A4.3–A4.7.*
5. What are some approaches to creating a map of community resources? *See page A4.7.*

Part 2: DISCUSSION

Projected Time for Discussion
2 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in the *Part 1: Core Knowledge* of this module to their collaborative work with sexual violence victims with disabilities. Specifically, it facilitates the first meeting of a work group tasked with developing a list of community resources for victims with disabilities. The anticipated discussion outcomes include an increased understanding of the benefits to agencies of creating a resource list for sexual violence victims with disabilities, a commitment to creating such a list, and a first draft of a community resource list.

Refer to the learning objectives at the beginning of this module for specific outcomes for this module.

Preparation

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator. The facilitator should be familiar with resources in the community and any existing resource lists.
- Select a note taker.
- Make sure that the work group includes plans for obtaining input from consumers, either through representation on the work group or through focus groups, interviews or surveys. Persons with disabilities and victims of sexual violence are the true experts in identifying effective local resources.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion.
- Participants should review and bring to the meeting copies of any resource list(s) their agencies utilize in providing services in the community.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

These activities and questions are designed to guide participants (the work group) in creating a resource list. The product can be further developed through a series of work group meetings and activities. Participants' responses to the questions and suggestions should provide the foundation for creating a work plan to complete the resource list.

1. **Using a flipchart to record the responses, have the group answer the following questions.** *See Part I: Core Knowledge* for an explanation of each question. *(20 minutes)*

   a. What is the purpose of the asset assessment and how will the results be used?

   b. What is the size/scope of the community being assessed?

   c. What people are available to do the work?

   d. How much time do you have for the task or how much time can you allow?

   e. How much money and other resources are available for incidental expenses?

2. **Determine the types of resources that will be included:** groups/agencies, individuals or both. Discuss the types of resources that are most commonly accessed by sexual violence victims with disabilities in your community and the benefits of including them on your list. See *Part 1: Core Knowledge* for a discussion of the types of resources and specific considerations when gathering the information for each type. *(20 minutes)*

3. **Identify the process that will be used to create the resource list.** Consider the following options: *(20 minutes)*

   a. Will the work group provide the only input for the list?

   b. Will surveys be used to gather information from other agencies and individuals?

   c. Will focus groups be conducted with consumers?

   d. Will work group members individually generate lists, collaboratively review and add to those lists, and then compile them into one master resource list? Or will one member be identified to compile a master list, review for duplications and then send the compiled list out to the group?

   e. Does the group want to create a visual resource map? See *Part 1: Core Knowledge* for a discussion of different types of maps.

4. **Identify pertinent existing lists of community resources**, such as the Internet, phone book, chamber of commerce listings, Family Resource Network directories, lists already developed by the rape crisis center and disability service providers, United Way agency listings, and statewide resources serving the target population. *Note that many agencies actually offer their services statewide through outreach efforts but do not have local offices, particularly in the disability field.* See the examples provided in *Part 1: Core Knowledge* for categories of community resources as they might be listed in the yellow pages and other published listings and for sample questions to ask each organization. *(20 minutes)*

5. **Determine how the resource list will be distributed and regularly updated.** *(10 minutes)*

6. **Identify someone to serve as the coordinator of the project. Establish a timeline and identify the next steps in the process.** *(20 minutes)*

7. **Taking the extra step:** Through this process you probably identified areas of need that sexual violence victims with disabilities have that are unmet by your community's current service delivery system. As a group, discuss the impact each of these unmet needs has on a victim's ability to access services and heal from the trauma of sexual violence. Examine the possibility of partnering to meet those needs. *(See Collaboration 101. Creating Social Change.) (10 minutes)*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]This module was adapted from the following resources: University of Kansas, *Community tool box: Identifying community assets and resources,* http://ctb.ku.edu; K. Crane & B. Skinner, Community resource mapping: A strategy for promoting successful transition for youth with disabilities, *National Center on Secondary Education and Transition Information Brief*, 2(1) (2003), through http://www.ncset.org/default.asp; and National Center on Secondary Education and Transition, *Essential tools: Improving secondary education and transition for youth with disabilities* (3rd edition) (Institute on Community Integration, University of Minnesota, 2005), through http://www.ncset.org/default.asp. These and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]Adapted from University of Kansas.

[4]Adapted from University of Kansas.

Formalizing a Collaboration

This module discusses taking the step of formalizing your collaboration and institutionalizing changes across partnering agencies that will facilitate increased access to services for sexual violence victims with disabilities.[1] One useful tool in this process is a formalized agreement among the partnering agencies. Crafting such an agreement is the focus of this module.

A document that formalizes an agreement among agencies might be called a memorandum of understanding, memorandum of agreement, an interagency agreement, a working relationship agreement or another term altogether. These documents may differ in areas such as level of detail, whether they are open-ended or time specific, etc. It is up to each collaborative to determine which type of formalized agreement best meets its purpose.

Key Points

- For the purpose of this module, a formalized agreement is a written document that identifies the common purposes and goals of two or more organizations.[2] It spells out the partnering organizations' understanding of their working relationship.[3] A formalized agreement can:
  - State what resources and services will be shared between/among the partnering organizations to meet their common goals;
  - Define each agency's roles and limitations in service provision and in the collaboration; and
  - Identify agency-specific and cross-agency policies, procedures and training that will be utilized to assist victims with disabilities.
- Formalized agreements are jointly developed, agreed upon by a partnership and subsequently signed by agency administrators.[4]
- Periodically, formalized agreements can be evaluated for usefulness in carrying out the goals of the collaborative. They can be revised and re-signed as needed to ensure that all of the professionals and agencies involved are aware of related policies and practices and committed to carrying out the agreement.

A5. Formalizing a Collaboration

Purpose

The *Collaboration 101* series of modules offers information and guidance on how to create the foundation for a successful collaboration among agencies in order to increase access to services for sexual violence victims with disabilities. Module topics include forming a collaboration, examining current partnerships and developing a plan to enhance collaboration, identifying the community resources available to victims with disabilities, and facilitating the necessary social change that a collaboration can create. This module discusses taking the next step of formalizing a collaboration and institutionalizing changes that facilitate increased access to services for victims. One useful tool in this process is a formalized agreement among the partnering agencies. Crafting such an agreement is the focus of this module.

COLLABORATION 101

A document that formalizes an agreement among agencies might be called a memorandum of understanding, memorandum of agreement, an interagency agreement, a working relationship agreement or another term altogether. These documents may differ in areas such as level of detail, whether they are open-ended or time specific, etc. It is up to each collaborative to determine which type of formalized agreement best meets its purpose.

For the purpose of this module, a formalized agreement among agencies is a written document that identifies common purposes and goals of two or more organizations.[6] It spells out the partnering organizations' understanding of their working relationship.[4] A formalized agreement can:

- State what resources and services will be shared among the partnering organizations to meet their common goals;
- Define each agency's roles and limitations in service provision and in the collaboration; and
- Identify agency-specific and cross-agency policies, procedures and training that will be utilized to increase access to services for victims with disabilities.

A formalized agreement is jointly developed and agreed upon by the partnering agencies and, subsequently, signed by agency administrators.[8] While the development of such an agreement takes time, many of the details can be decided upon at earlier stages in the collaboration process and then reaffirmed when the agreement is being drafted. Periodically, a formalized agreement can be evaluated for usefulness in carrying out the goals of the collaborative, then revised and re-signed as needed. Periodic revision and re-signing can help ensure that all of the professionals and agencies involved are aware of related policies and practices and committed to carrying out their agreements.[9]

Objectives

Those who complete this module will be able to:

- Develop a draft of a formalized agreement among partnering agencies to increase access to services for sexual assault victims with disabilities in their communities; and
- Identify steps to finalize the agreement and implement it across agencies.

DISCUSSION

Projected Time for Discussion
Allow two (2) hours

Developing a formalized agreement among agencies is a process and may involve a series of meetings and/or follow-up activities (e.g., seeking authorization from the administrators of the participating agencies to support the details proposed in the agreement). This discussion is designed to provide the framework for developing a draft agreement and the planning process necessary to finalize and implement it.

Preparation

NOTE: This discussion includes questions that partnering agencies can consider to generate the content for a formalized agreement. Because each community and each collaborative is different, discussion facilitators should consider whether additional questions need to be asked and additional issues need to be addressed when establishing their agreement.

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.

- Select a facilitator. The facilitator should be familiar with how to develop a formalized agreement among agencies.
- Select a note taker.
- Prior to the discussion, participants and the facilitator should review the sample formalized agreement provided at the end of this module. This review will provide context for the discussion and the creation of a collaborative-specific agreement.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions[10]

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: *(5 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality.

2. **Identify who will develop the written draft of the formalized agreement and be responsible for coordinating with other agency representatives in finalizing it.** This discussion will provide the text to insert into the agreement; the next step will be to bring it all together into one document. It is helpful to identify the drafter prior to the remainder of the discussion, so that person can be particularly focused on making sure the draft accurately reflects decisions made during the discussion.

   For Suggested Activities and Questions 3-7, utilize both discussion activities/questions and the Sample Formalized Agreement at the end of the module to aid participants in developing the content for their own agreement.

3. **Develop the introduction of the agreement.**[11] The introduction section provides the reader with an overview of the agreement. It describes the need, the agencies involved, why it is necessary to work together, etc. It is optional to include details about past efforts or to discuss how the agencies reached this level of agreement. To develop this section, ask participants to consider the following:

   a. What agencies are involved in this collaboration?

   b. What are the purposes of this collaboration?

   c. What led them to come together to collaborate for this intent?

   d. What are the goals of this collaboration?

   e. What are the desired outcomes of this collaboration?

   f. Why is it necessary to work together to achieve these goals and outcomes?

   g. Why is this agreement necessary?

h. What agreements are set forth in this document?

i. What level of detail, if any, is desired in this section on the collaborative's background (e.g., the guiding principles for the partnership itself, its service approach to victims with disabilities, etc.)?

After encouraging participants to brainstorm responses to each question, request that they develop concise statements regarding each question that can be inserted into the draft formalized agreement. (Note that some of these questions were discussed in *Collaboration 101. Forming a Collaboration Among Service Providers: An Initial Meeting Activity* and *Collaboration 101. Examining Your Collaboration.*)

4. **Develop the agency description section of the agreement.** This section lists the agencies to be included and provides a brief, general description of their services. It may also include a statement describing any specific services that agencies provide to sexual assault victims with disabilities. Invite participants from each agency to develop concise statements that include this information that can be added to the draft agreement.

   If an organization has multiple departments or programs, consider including a brief overall description of the agency, as well as a description of the specific department involved in the collaboration (e.g., the West Virginia Department of Health and Human Resources and Adult Protective Services). Also, be sure to define any agency- or discipline-specific acronyms and operational or technical terms included. (Note that agency descriptions were discussed to some extent in *Collaboration 101. Forming a Collaboration Among Service Providers: An Initial Meeting Activity* and *Collaboration 101. Examining Your Collaboration.*)

5. **Develop the section that defines the activities of the collaborative and the related roles and responsibilities of the partnering agencies.** This section covers (1) agency roles and responsibilities in maintaining the collaborative itself and (2) roles and responsibilities of specific agencies in carrying out the goals of the collaborative. To develop this section, ask participants to consider the following:

   a. **What *activities* have been established to maintain the collaborative itself?** (E.g., regular meetings and trainings; ongoing development of work plans; identification of how each agency can provide leadership; staff and resources to support the collaborative; sharing of information; periodic community assessments and evaluations of the collaborative; etc.) **What are the *related roles* and *responsibilities of all of the partnering agencies?***

   b. **What *agency-specific activities* have been identified to carry out the goals of the collaborative?** (E.g., coordination of cross-training; self-assessment of the accessibility of agency services for victims with disabilities; coordination with other agencies to serve victims with disabilities; creation/revision of policies, procedures or agency materials; coordination of the initial response to victims with disabilities; coordination of referrals; coordination of public education efforts, etc.) **What are the *related roles* and *responsibilities of each agency?***

After encouraging participants to brainstorm responses to each question, request that they develop concise statements regarding activities and agency roles and responsibilities that can be inserted into the draft formalized agreement. (Note that these questions are discussed to some extent in the other *Collaboration 101* modules, particularly *Collaboration 101. Examining Your Collaboration.*)

6. **Develop the time frame section of the formalized agreement.** This section can identify the dates that the agreement is effective, as well as how it will be reviewed and renewed. If the agreement will be time-specific, ask participants to come to agreement on:

- For what time period should the agreement be effective?
- When should the agreement be reviewed, revised if needed and renewed?

Give your collaborative adequate time to implement its activities before reviewing the formalized agreement and judging its success.[12] Also, keep in mind that revising and renewing the agreement is another time intensive project and is not practical to do too often.

As an alternative to a time-specific agreement, partnering agencies may want to consider having an agreement that has no specified ending date (i.e., it automatically renews), but that can be modified upon the request of any participating agency. There are some benefits to using this strategy: It would prevent the activities identified in the agreement from expiring if the formal collaborative body becomes less active over time or if an activity is a key service to the community. For example, what begins at some point as a new practice may become the standard protocol after a period of years (e.g., law enforcement officers transporting victims to a shelter). A new chief of police, with little background information or history on the protocol, is asked to sign the 18th annual renewal of the agreement—just as gas prices have increased and his department's funds have been cut. By being asked to sign the renewal agreement he has the opportunity to easily opt out of the collaboration and terminate a practice to which he may not have given any consideration up to this point. In this case, the unintended consequence of the process of re-signing the agreement was the termination of the law enforcement practice of transporting victims to a shelter!

Given that abrupt changes in working relationships could significantly impact victim services, the collaborative should consider the importance of continuity when developing agreements. While allowing for the periodic review of roles and responsibilities, consideration should be given to the continuity of any practices created by the partnership and how such practices might be incorporated into each individual agency's policies.

7. **Get the appropriate signatures to "seal" the agreement.** This section includes the signature of a representative from each participating agency. That representative must have decision-making authority. Having agency administrators sign the agreement is a way to hold agencies accountable for upholding their responsibilities as members of the collaborative. Ask participants to consider the following:

   a. Who is the most appropriate administrator from each agency to sign the agreement? Should more than one representative sign?

   b. What is the likelihood that each of the administrators identified will support this initiative and be willing to sign the agreement? Are there suggestions on increasing the likelihood that they will be supportive?

   c. Who will request the signature from each agency administrator?

   d. What is the timeframe for obtaining the signatures?

   e. What process should be used for getting original signatures on one copy of the agreement? Who will coordinate this process?

A key factor to consider in formalizing a partnership is having agency "buy-in" into the collaboration versus having the support of one individual representing that agency. Having the agency versus an individual invest in the project safeguards the continuity of the relationship should there be changes in staff. It guarantees that the collaborative work is supported by the entire agency. Such a commitment by the agency provides more sustainability for the collaborative efforts.

If an agency has numerous departments and/or staff, consider having the agreement signed by the agency administrator and the coordinator of the specific program that will be working directly with the collaborative.

For example, an agreement might be signed by the hospital administrator *and* the emergency department's nurse manager.

8. **Ask participants to review/identify steps to take to develop the agreement, finalize it, obtain the necessary signatures and provide a signed copy to all of the partnering agencies**. Make sure everyone involved in developing the agreement is aware of and agrees to their roles and deadlines for completing their tasks. Ask the participants to identify the specific actions that need to be taken and the parties responsible for each step and then create a time line for completing each step. (Consider recording this information on a simple chart with headings such as the one below. To customize the chart, copy it, then edit the headings if desired and add as many rows as needed.)

Action Step	Responsible Party	Time Line

Also, ask participants to consider activities that can mark the accomplishment of producing the agreement and jumpstart the collaborative's activities. For example, partnering agencies might hold a celebration to publicize the formalization of the collaboration and follow it up with a joint training program. If participants identify and agree upon such an activity, ask them to incorporate coordination of this activity into the above planning process.

9. **Schedule follow-up meetings as necessary** to facilitate the development of the agreement and the completion of the above steps. Identify meeting sites. *(10 minutes)*

<<name of the collaborative >>

Sample Formalized Agreement Among Agencies[13]

Introduction

<<Insert names of the partnering agencies>> have come together to collaborate for the purposes of <<insert purposes, e.g., increasing access to services for sexual assault victims with disabilities>>. These partnering agencies herein desire to enter into a formalized agreement, setting forth the purposes and goals of the collaborative, as well as its activities.

This collaborative developed as a result of <<insert description of why the collaborative was developed, e.g., a survey of local agencies revealed service/policy gaps and barriers that impeded the provision of effective, accessible and seamless services to sexual assault victims with disabilities>>.

The goals of the collaborative are <<insert goals, e.g., collectively build the capacity of partnering agencies to offer appropriate, accessible services to victims with disabilities>>. Ultimately, the desired outcomes are to <<insert desired outcomes, e.g., create permanent change at all levels of the sexual assault and disability systems in which effective services for persons with disabilities are fully integrated into the existing structure of victim services and advocacy>>.

Description of Partnering Agencies

Partnering agencies involved in <<insert name of the collaborative>> offer the following services, in general and specifically to sexual assault victims with disabilities:

- <<Insert a brief agency description of each partnering agency and its work regarding sexual assault victims with disabilities.>>

Roles and Responsibilities

Each partnering agency in the <<insert the name of the collaborative>> agrees to do the following:

- Actively participate as a member of the <<insert the name of the collaborative>>, participate in scheduled collaborative meetings and trainings, share information and resources related to its agency's role in the collaborative, work to implement and monitor the provisions of this agreement, share in/support the leadership, evaluate the effectiveness of collaborative efforts and recommend revisions as needed over time. <<Edit the above or add in any additional roles or responsibilities of all members of the collaborative.>>
- <<Add roles and responsibilities specific to each partnering agency in the collaborative.>>

Time Frame

We, the undersigned, commit to participate in the <<insert the name of the collaborative>> and the roles and responsibilities as described in this agreement. This agreement becomes effective on _____ _____ and will be reviewed and renewed by _____. <<If the agreement will not be time-specific, this section can merely indicate that the agreement can be reviewed at the request of any partnering agency and revised as needed.>>

Signatures

<<Insert signature, typed name, title, agency of each signer and date signed. Ensure each signer has the authority to sign for their agency.>>

Signed: _____
Name:
Title:
Agency:
Date signed:

Signed:_____
Name:
Title:
Agency:
Date signed:

Signed:_____
Name:
Title:
Agency:
Date signed:

Signed: _____
Name:
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Agency:
Date signed:

Signed: _____
Name:
Title:
Agency:
Date signed:

Signed: _____
Name:
Title:
Agency:
Date signed:

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the terms "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.
[2]D. King Akers, Balancing the power: *Creating a crisis center accessible to people with disabilities* (Austin, TX: SafePlace), 115.
[3]King Akers.
[4]U.S. Department of Justice, 126.
[5]The following resources were useful in the development of this module: A. Duke (Ed.), *Creating a memorandum of understanding: A know your rights guide for public housing tenants in Massachusetts* (Massachusetts Law Reform Institute, 2005), based on a booklet originally prepared by the Massachusetts Union of Public Housing Tenants, *How to create memos of understanding: Training materials for public housing tenant organizations in Massachusetts; King Akers,* 97-132; SAFECOM, Writing guide for a memorandum of understanding (Department of Homeland Security, Office for Interoperability and Compatibility), http://www.safecomprogram.gov/NR/rdonlyres/70169F1E-F2E9-4835-BCC4-31F9B4685C8C/0/MOU.pdf; U.S. Department of Justice, *A national protocol for sexual assault medical forensic examination, adult/adolescent* (Washington, D.C., 2004), 30–2, through http://samfe.dna.gov; and *Sample memorandum of understanding* (for applicants of grant programs of the Office on Violence Against Women, U.S. Department of Justice), http://www.ovw.usdoj.gov/docs/sample-mou.pdf. The online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.
[6]King Akers, 115.
[7]King Akers, 115.
[8]U.S. Department of Justice, 126.
[9]Drawn from U.S. Department of Justice, 126.
[10]Activities 3 through 7 in this section are loosely drawn from SAFECOM, 3-8.
[11]Paragraph drawn from SAFECOM, 3.
[12]Drawn from King Akers, 113.
[13]Adapted from Red Wind Consulting, Inc., Sample memorandum of agreement, *Drafting a protocol for sexual assault medical forensic examinations in American Indian and Alaskan Native communities: Recommendations and tools for tribes and federal, state and local agencies* (draft, February 2010).

WV S.A.F.E. TRAINING & COLLABORATION toolkit

SERVING SEXUAL VIOLENCE VICTIMS WITH DISABILITIES

A project of the

West Virginia Sexual Assault Free Environment (WV S.A.F.E.) Partnership

WV S.A.F.E. Partners:

West Virginia Foundation for Rape Information and Services (WVFRIS)

West Virginia Department of Health and Human Resources (WVDHHR)

Northern West Virginia Center for Independent Living (NWVCIL)

Fall 2010

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WV S.A.F.E. Training and Collaboration Toolkit— Serving Sexual Violence Victims with Disabilities

B. Sexual Violence 101

Funding was provided by Grant No. 2006-FW-AX-K001 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this toolkit are those of the authors and do not necessarily reflect the views of the U.S. Department of Justice, Office on Violence Against Women.

Forward

Service providers are finally recognizing the intersection of two issues: the prevalence of persons with disabilities who are sexually victimized and the prevalence of sexual violence victims who have disabilities. Although one in the same, the response to sexual violence victims who have disabilities may differ depending on their point of entry into the service delivery system. Sexual violence service providers have not been adequately trained in serving victims with disabilities. Disability service providers have not been trained in responding to sexual violence. There has been a lack of recognition that a coordinated community response is needed to ensure that the social service system (collectively comprised of the local, regional and state agencies that serve victims on the local level) effectively and equally meets the needs of these individuals. In West Virginia, through this project, we are bringing together service providers who aid sexual violence victims with those who serve persons with disabilities. Our goal is to increase the access victims with disabilities have to services. It is important to acknowledge that "getting to this place" did not happen overnight; rather, it required consciousness-raising and community organizing by dedicated activists. In essence, "getting to this place" is the story of two social movements—the anti-sexual violence movement and the disability rights movement—maturing into a "second wave" of activism and joining together to address needs of previously underserved populations.

The beginnings for both movements grew from the 1950s to the 1970s when minority groups—most notably African Americans, gays and lesbians, women and people with disabilities—began ardently fighting to secure their civil rights. Early in the women's rights movement, women began to speak out about their personal experiences of sexual violence. In the decades to follow, tremendous progress was made toward supporting sexual violence victims. Rape crisis programs were established in counties throughout the United States to offer crisis intervention, support and advocacy for victims, as well as community awareness and prevention. A significant body of literature and research emerged that increased public concern about sexual violence. Legislative changes—including the enactment of state laws to ensure victim rights and federal laws such as the Rape Control Act in 1975 and the Violence Against Women Act of 1994—were enacted that have increased the efficacy of the criminal justice and medical community responses to sexual violence.[1]

Encouraged particularly by the civil rights and women's rights movements, large-scale cross-disability rights activism began in the late 1960s with the goal of ending social oppression. That oppression kept children with disabilities out of the public schools and sanctioned discrimination against adults with disabilities in employment, housing and public accommodations. As part of this movement, the independent living movement emerged to support the choice of living in the community for people with even the most severe disabilities. The first independent living center opened in 1972; by the beginning of 2000, there were hundreds of such centers across the country and the world. In the meantime, a series of landmark court decisions and legislative changes—including the enactment of the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act of 1975 and the Americans with Disabilities Act of 1990—secured for individuals with disabilities unprecedented access to their civil rights.[2]

These victories for the two movements, as critical as they were, have not ended sexual violence or discrimination against persons with disabilities.[3] There is still a great need for continued activism. By coming together in localities across the country, as we are beginning to do in West Virginia, these movements are able to take the important next steps of educating one another and combining their resources to create positive systems change for sexual assault victims with disabilities. We hope you find the *West Virginia S.A.F.E. Training and Collaboration Toolkit: Serving Sexual Violence Victims with Disabilities* to be a useful resource to facilitate this cross-training and improve the response and partnerships across agencies and movements in your community.

Acknowledgements

The work of creating a toolkit involves the expertise and assistance of numerous individuals. The WV S.A.F.E. partnership is grateful to the individuals listed below for their contributions in the creation of this toolkit.

Project Partners and Primary Authors

Each of the three project partners coordinated the writing of the modules (in conjunction with the Project Consultant) within the sections pertinent to their disciplines. Each partner reviewed all of the modules during the development and pilot phases of the project. After each module was piloted and then reviewed and approved by the Office on Violence Against Women, the modules were then edited by the Toolkit Project Coordinator and Project Consultant.

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Pilot Sites

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Participating Pilot Site Agencies in Marion, Ohio and Preston Counties:

- Russell Nesbitt Services
- Sexual Assault Help Center
- Task Force on Domestic Violence, "HOPE", Inc.
- Rape and Domestic Violence Information Center
- Northern West Virginia Center for Independent Living
- West Virginia Department of Health and Human Resources (Marion, Ohio and Preston counties)

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WV S.A.F.E. Training and Collaboration Toolkit—Serving Sexual Violence Victims with Disabilities[4]

This toolkit offers guidance for service providers on working collaboratively to integrate accessible services for sexual violence victims with disabilities into the existing social service delivery system. *The purpose is to provide the information and resources needed to begin the process of collaborating and cross-training among relevant agencies. Using the tools in the toolkit, agencies can build their capacity to offer responsive, accessible services to sexual violence victims with disabilities.* The toolkit's focus is on adult and adolescent victims with disabilities.

The concept for and contents of this toolkit evolved over a four-year period from the work of a project coordinated by several West Virginia statewide/regional agencies and piloted by local agencies from three counties. Although the toolkit is written for a West Virginia audience, other states and communities are welcome to adapt the materials to meet their needs.

This *User's Guide* explains the toolkit's features and organization as well as the pilot project.

Toolkit Features

The toolkit's main feature is a collection of educational modules intended to:

- **Facilitate dialogue and collaboration among partnering agencies** to improve the accessibility and appropriateness of services across systems for sexual violence victims with disabilities (see the *Collaboration 101* modules);
- **Build individual providers' knowledge** related to fundamental issues in providing accessible and responsive services to sexual violence victims with disabilities (see *Disabilities 101* and *Sexual Violence 101* modules); and
- **Provide tools to facilitate assessment and planning by individual agencies** to improve the accessibility and appropriateness of their services for sexual violence victims with disabilities (see the *Tools to Increase Access* modules).

The toolkit was developed with the recognition that both individual and partnering agencies will adapt the toolkit materials to assist them in providing accessible and appropriate services to sexual violence victims with disabilities. NOTE:

- Individuals and agencies can use all of the modules and materials or select only the modules and materials that address their specific needs.
- Individuals and agencies can decide the sequencing of the modules that meets their needs, depending on factors such as the types of services each agency provides, who will be trained (designated or all staff, volunteers, students, board members), etc.
- Collaborative groups can decide the selection and sequencing of the modules to utilize based on the partnering service providers, strengths and gaps in the current response, level of existing collaboration among service agencies, issues that need to be addressed, etc.
- Individual agencies and partnerships may wish to add information and discussions on other pertinent issues not addressed through the modules.

Because the toolkit is available online, those using it can benefit from new material that may periodically be added. The toolkit can be accessed at http://www.fris.org/ to check for updates.

Background: Toolkit Development

In 2006, the West Virginia Foundation for Rape Information and Services (FRIS) received a grant from the U.S. Department of Justice, Office on Violence Against Women (OVW) to examine and implement changes to local and state systems that respond to women with disabilities and deaf women who are victims of sexual assault. Entitled *West Virginia Sexual Assault Free Environment* (WV S.A.F.E.), the resulting collaboration consists of three core team partner agencies: FRIS, the West Virginia Department of Health and Human Resources (DHHR) and the Northern West Virginia Center for Independent Living (NWVCIL).[5]

This collaborative's broad mission is to identify and address state and local gaps and barriers in services and policies that impede the provision of effective, accessible and seamless services to survivors of sexual assault among women with disabilities and deaf women. The shared vision is:

> *".. [C]reating permanent systems change at all levels of the sexual assault and disability systems and state policy in which effective services for women with disabilities and deaf women are fully integrated into the existing structure of victim services and advocacy."*

The statewide partnership, and subsequent participation of their counterparts in three counties (Marion, Ohio and Preston counties), conducted needs assessments and developed a strategic plan. The plan included the following short-term goals and objectives:

1. Foster collaboration among local service providers who interact with survivors with disabilities (to overcome fragmentation of services). Objectives: Coordinate and implement on-going partnership meetings and formalize collaborative processes among pilot site partners.

2. Build a sustainable common knowledge base among local service providers and among statewide partnering agencies. Objectives: Develop and implement a capacity building plan to strengthen the knowledge base and sustainable practices.

3. Ensure services and supports are accessible and responsive to the needs of women with disabilities and deaf women. Objectives: Assess accessibility with pilot site and state partners and implement prioritized components of accessibility transition plans.

The toolkit is the result of the sustainable cross-training component of this four-year project. Note that the materials are applicable to serving all adult/adolescent victims of sexual violence (recognizing the vast majority are women) and that the term "persons with disabilities" became inclusive of deaf persons, unless otherwise indicated.

Note also that while a limited number of agencies officially partnered in this pilot project, the benefit to victims can increase when the partnership is welcoming of any agency that might provide services to victims with disabilities. To that end, longer-term goals include: expanding local pilot site partnerships to include all points of entry into the service delivery system for victims with disabilities; improving the accessibility of those points of entry; providing ongoing capacity building opportunities; and replicating this systems-change model in additional counties in West Virginia.

Toolkit Organization

Toolkit Components. The toolkit offers a set of four separate components: *A. Collaboration 101, B. Sexual Violence 101, C. Disabilities 101* and *D. Tools to Increase Access*. Each component is comprised of a series of informational modules.

Structure of the modules within each component. The individual modules within these components are primarily organized into two main sections: *Core Knowledge* and *Discussion*. Some modules include both sections while others include only the *Core Knowledge* or the *Discussion* section. Several of the *Tools to Increase Access* use a checklist, rather than a narrative format. All of the remaining modules include a cover page featuring a brief overview and the key points. Each also includes an introduction describing the purpose, objectives and any preparation needed.

- ***Core Knowledge:*** Depending on the content, the *Core Knowledge* section provides basic information on the topic. It may also include *Test Your Knowledge* questions to evaluate what was learned. These can be useful both for the reader and for supervisors who may choose to use the questions to gauge the knowledge of staff and volunteers.

  The *Core Knowledge* section is intended for individual use—e.g., for self-paced learning, one-on-one training of employees such as agency orientation or continuing education, volunteer trainings, review prior to an agency or multi-agency discussion, etc.

- ***Discussion:*** The *Discussion* section is designed for use in a group setting, either within an agency or with outside partnerships. Each *Discussion* section indicates the estimated time frame for the dialogue and the preparation needed, if any; describes suggested activities and questions (targeted to create a common knowledge base, improve agency response and build collaboration); and ends with a closing assessment of what was learned during the discussion and changes providers/agencies plan to make as a result of the discussion.

- ***Resources:*** Some modules also include related forms and/or other sample materials.

The modules were developed to maximize agencies' finite resources for in-house and multi-agency training. To that end, an effort was made to offer *Core Knowledge* sections that simplified complex topics as much as possible. It is a delicate balance to find a format in which the information provided can be easily understood but that provides enough detail to assist the reader in offering responsive assistance to victims with disabilities. As appropriate in each *Core Knowledge* and *Discussion* section, guided probes and case scenarios are included to assist service providers in applying the information to impact service delivery changes both within their own agencies and their communities.

Cross-referencing of modules. The modules were generally developed so they can be used independently of one another; however, a few make reference to other modules as prerequisites. Reference to other modules is also made throughout the modules so the reader can easily gain further knowledge on a particular topic.

Terminology used. Across all modules, the following should be noted:

- Agencies that interact with sexual violence victims and persons with disabilities typically refer to the individuals they serve as "clients," "consumers" and/or "victims." For convenience, "victims" and "clients" are primarily used.

- The terms "sexual violence" and "sexual assault" generally will be used to encompass sexual assault, sexual abuse and other forms of sexual violence.

- In recognition that the vast majority of victims of sexual violence are female and the vast majority of offenders are male,[6] individual victims are often referred to using female pronouns and individual offenders are often referred to using male pronouns. This use of pronouns in no way implies that males are not victims of sexual violence or that females are not offenders; it is written in this format solely for the ease of reading the material.

Reproduction of materials. The non-commercial use and adaptation of these modules to increase knowledge about serving sexual violence victims with disabilities is permitted. Please credit any material used from this toolkit to the West Virginia Sexual Assault Free Environment (WV S.A.F.E.) project, a partnership of the West Virginia Foundation for Rape Information and Services, the Northern West Virginia Center for Independent Living and the West Virginia Department of Health and Human Resources (2010).

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[1]This paragraph was drawn primarily from California Coalition Against Sexual Assault, *A vision to end sexual assault—The CALCASA strategic forum report* (2001), as well as J. Meyers, *History of sexual assault prevention efforts* (Colorado Coalition Against Sexual Assault, 2000) and P. Poskins, *History of the anti-rape movement in Illinois*. All can be accessed through http://new.vawnet.org/category/index_pages.php ?category_id=576.

[2]This paragraph was drawn from University of California Berkley, *Introduction: The disability rights and independent living movement* (last updated 2010), through http://bancroft.berkeley.edu/collections/drilm/index.html.

[3]Adapted from University of California Berkley.

[4]Note that the format used in this *User's Guide* was in part modeled after the Office for Victims of Crime's *Sexual assault advocate/counselor training, trainer's manual* (Office of Justice Programs, U.S. Department of Justice), https://www.ovcttac.gov/saact/index.cfm.

[5]An additional partner, the West Virginia University Center for Excellence in Disabilities, participated in the first two years of the project.

[6]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (C. Rennison, Rape and sexual assault: Reporting to police and medical attention, 1992–2000 (Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2002), 1, http://bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=92; and P. Tjaden & N. Thoennes, *Prevalence, incidence and consequences of violence against women: Findings from the National Violence Against Women Survey* (Washington, DC: National Institute of Justice, Office of Justice Programs, U.S. Department of Justice, 1998), 2–4, http://www.ojp.usdoj.gov/nij/publications/welcome.htm. Regarding sex offenders, males make up the vast majority, but females also commit sexual crimes. In 1994, less than 1 percent of all incarcerated rape and sexual assault offenders were female (L. Greenfeld, *Sex offenses and offenders: An analysis of data on rape and sexual assault, U.S. Department of Justice, Bureau of Justice Statistics* (Washington, DC: 1997). As cited in R. Freeman-Longo, *Myths and facts about sex offenders* (Center for Sex Offender Management, 2000), http://www.csom.org/pubs.

Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors

This module helps service providers build their knowledge of the prevalence of sexual victimization among persons with disabilities; understand risk factors that contribute to the prevalence; identify barriers that perpetuate those factors and prevent reporting; and discuss what agencies and communities can do to help reduce those risks.

Key Points

- In the overall U.S. population, one in six women and one in 33 men have been the victims of an attempted or completed rape in their lifetimes.[1] Additionally, the stark reality has been that persons with disabilities may be at a significantly higher risk for victimization than those without a disability.
- In West Virginia, about one in six women (ages 18 and over) and one in 21 men (ages 18 and over) reported having been the victims of an attempted or completed rape. Sexual victimization among state residents with disabilities is significantly higher (14 percent) than among residents without disabilities (9.6 percent).[2]
- It is not the disability itself that increases the risk of sexual victimization, but societal and situational factors. Commonly cited risk factors for sexual victimization for people with disabilities include the following: negative public attitudes towards persons with disabilities; social isolation; lack of accessible transportation; reliance on others for care; communication barriers; lack of knowledge about healthy intimate relationships; type of disability; lack of resources/lack of knowledge of existing resources; poverty; lack of control of their personal affairs; perceived lack of credibility when they disclose sexual victimization; lack of caregiver support; and alcohol and drug abuse by perpetrators.
- Service providers also need to be aware of related barriers that may prevent reporting by sexual violence victims with disabilities, such as accessibility, situational factors, fear and educational/socialization factors.[3]
- Communities must counter attempts at victim-blaming by holding offenders fully accountable for their behavior and seeking to prevent sexual victimization of persons with disabilities. Increasing protective strategies for at-risk individuals has proven to be one way to help reduce the risk of victimization. Risk reduction is also the responsibility of service providers, as they can proactively identify resources and address obstacles to reporting and accessing services. This can be done by developing policies that provide increased protection or by increasing access that persons with disabilities have to services. Community leaders and service providers can challenge the factors that contribute to vulnerability to sexual victimization rather than complacently accept that the victimization of many persons with disabilities is inevitable.

B1. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors

Purpose

This module is designed to help service providers build their knowledge of the prevalence of sexual victimization among persons with disabilities; understand the risk factors that contribute to the prevalence; identify barriers that perpetuate those factors and prevent reporting; and recognize what agencies and communities can do to help reduce those risks.

SEXUAL VIOLENCE 101

In order to provide a sense of the scope and nature of the problem of sexual violence against persons with disabilities, this module presents a significant number of statistics. An effort has been made to include very concise summaries of pertinent points from statistical studies and encourage discussion of the implications of this research data for service providers.

Objectives

Those completing this module will be able to:

- Understand, in general, the prevalence of sexual victimization among persons with disabilities;
- Discuss demographics specific to West Virginia that contribute to the prevalence of sexual victimization for persons with disabilities;
- Identify factors that contribute to the risk of sexual victimization among persons with disabilities;
- Identify barriers to reporting sexual victimization for persons with disabilities; and
- Identify specific strategies that agencies and communities can initiate and support to reduce the sexual victimization of persons with disabilities.

Part 1: CORE KNOWLEDGE

What does vulnerability to sexual victimization mean?

In an effort to understand and prevent sexual violence, numerous studies have been conducted on incarcerated sex offenders to determine how they select their victims. This body of research—inherently flawed because it only studied offenders who were actually caught and convicted, which would tend to be the more violent offenders—offered the first "window" into the minds of perpetrators of sexual violence. Studies conducted in the late 1970s by Dr. Nicholas Groth and H. Jean Birnbaum identified three categories of offenders, two of which targeted victims based on *availability or vulnerability.*[4]

The perspective that sex offenders target those whom they perceive as vulnerable makes sense on many levels. For example, a burglar will choose the house without the dog or the alarm system—whatever reduces his chances of getting caught and increases his likelihood of success. However, the issue of vulnerability to sexual victimization needs to be raised, if not challenged, particularly in terms of victims with disabilities. It may be perceived that there is little hope that persons who are vulnerable due to a disability can prevent becoming another rape statistic. Communities must counter such a misconception by placing blame for sex offenses on the offenders and holding them fully accountable for their behavior. In addition, community leaders and service providers can proactively seek out ways to decrease vulnerability to victimization for people with disabilities. They can challenge the factors that are contributing to vulnerability rather than complacently accepting that victimization is inevitable. This can be done by developing policies that provide increased protection (e.g., mandatory screening of care providers) or by increasing access that persons with disabilities have to services. *For the purposes of this module, the term "vulnerability" is used to indicate increased risk due to the situation, not a person's disability.*

What is the risk of sexual victimization for persons with disabilities?

In the overall U.S. population, one in six women and one in 33 men have been the victims of an attempted or completed rape in their lifetimes.[5] Statistically, an additional reality has been that, depending on the type of disability, persons with disabilities may be at a significantly higher risk for victimization than persons without disabilities.

- The 2007 National Crime Victimization Survey for the first time detailed crimes specifically against persons with disabilities. The survey found that persons with a disability had an age-adjusted rate[6] of victimization that was more than twice the rate of persons without a disability.[7]
- One study estimated that approximately 49 percent of people with developmental disabilities who are victims of sexual violence will experience 10 or more abusive incidents.[8]

Data on sexual victimization in West Virginia indicates a high risk for sexual victimization based on the demographics of the state. The West Virginia Bureau for Public Health, Health Statistics Center, 2008 *Behavioral Risk Factor Surveillance System* (BRFSS) survey found the following:[9]

- About one in six women (ages 18 and over) and one in 21 men (ages 18 and over) reported having had sex or someone attempted to have sex with them without their consent.
- Sexual violence victimization among residents with disabilities is significantly higher (14 percent) than among residents without disabilities (9.6 percent).

With the estimated high victimization rate for people with disabilities, many residents in West Virginia are at risk. The 2000 census demographics showed that *West Virginia had the highest percentage of population of persons with disabilities of all 50 states.*[10] In addition, West Virginia has many other factors that contribute to increased risk of sexual victimization. (See the section below on risk factors.)

What do we know about the reporting of sexual victimization?

Historically, sexual victimization has been vastly underreported. On the national level, the *National Crime Victims Survey* found that most sexual assaults go unreported. Rape/sexual assault and simple assault were the violent offenses least likely to be reported to law enforcement.[11] In 2003, the *National Crime Victimization Survey,* a survey conducted annually by the U.S. Department of Justice, showed that only 39 percent of sexual assaults were reported to law enforcement—not a large increase from the 32 percent reported in a similar study in 1994. *The Rape in America* survey, conducted as a part of the National Women's Study, found that only 16 percent of rapes were reported to law enforcement or other authorities.[12] Data from the National Survey of Adolescents indicated that only 14.3 percent of sexual assaults had been reported.[13] Collectively these national studies indicate that only about 14 to 39 percent of all sexual assaults or rapes are ever reported to law enforcement.[14]

The reporting of sexual victimization by persons with disabilities is even less frequent. One study found that only 3 percent of sexual abuse cases involving people with developmental disabilities were reported.[15] A study conducted in Canada found that almost 75 percent of sexual abuse cases involving victims with disabilities were not reported.[16] In a 2005 survey of people with disabilities in the Tucson area, 60 percent reported having been sexually victimized, yet almost half never revealed the assault. When a disclosure was made, it was most often to friends (58 percent) or family members (54 percent), rather than Adult Protective Services (APS), law enforcement or a social service agency.[17]

In West Virginia, the low rate of reporting of sexual violence against persons with disabilities is evidenced in data provided by APS. For example, the total number of APS reports in 2009 for sexual abuse *for the entire state* was only 78, despite the significant population of persons with disabilities. This statistic indicates a disconnect between persons identified or estimated to be at risk and those actually reporting victimization and being served. Service providers can help bridge this disconnect by assisting persons with disabilities in (1) identifying the risks for victimization and barriers to reporting, (2) addressing those risks and (3) increasing accessibility for reporting and obtaining services.

What risk factors for sexual victimization exist for persons with disabilities?

Commonly Cited Risk Factors for Sexual Victimization of Persons with Disabilities[18]
Negative public attitudes toward persons with disabilities—While social and legal reform since the 1960s has improved public attitudes towards individuals with disabilities, this population still faces considerable prejudice and discrimination. Society still has a tendency to devalue and dehumanize people with disabilities and suppress their voices. Some people believe that people with disabilities receive unnecessary "special" treatment, such as favored parking spaces and priority in affirmative action hiring, while ignoring how such treatment enables persons with disabilities to remain independent. (See *Disabilities 101. Self-Advocacy* and *Victims with Disabilities.*) Too frequently considered physically weak, emotionally unstable and/or intellectually incompetent, persons with disabilities may be viewed by perpetrators as easy targets for victimization. Perpetrators may trust that first responders won't believe these victims or know how to help them. Perpetrators may also think it unlikely that a conviction would be pursued, especially if it might disrupt an agency's current practices (e.g., cause an investigation of a nursing home staff person at a time when staffing is already limited), challenge an agency's policies (e.g., not screening home health care workers), or require an agency to make costly changes in its policies or practices.
Social isolation—Sexual assaults most often occur in the homes of victims or perpetrators. The assaults usually are at times when victims are isolated from other people, particularly if the family culture is heavily self-reliant and closed. Persons with certain disabilities often may be socially isolated, with limited access to outside communications and interactions.
Lack of accessible transportation—One reason people become socially isolated is the lack of accessible transportation. Many communities do not have public transportation or transportation with a chair lift. Even if transportation options are available, they may be difficult to access.
Reliance of people with disabilities on others for care—Individuals with disabilities sometimes depend on others for assistance with their personal needs. This reliance on others may increase their vulnerability and exposure to sexual violence. One study found that, *for victims with disabilities, 33 percent of their abusers were acquaintances, 33 percent were natural or foster family members, and 25 percent were caregivers or service providers.*[19] Many also may lack control of their personal affairs, which can contribute to learned helplessness.
Communication barriers—A person with a disability that creates communication challenges may have difficulty reporting sexual victimization. Lack of an interpreter or assistive technology, difficulty articulating thoughts or having a limited vocabulary can all contribute to an individual's inability to disclose sexual victimization. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
Learned compliance of people with disabilities—Persons with disabilities, particularly in group homes or institutional settings, are often taught to be compliant, passive and quiet to meet the expectations of a "good" resident/client. Inherently, many persons with developmental disabilities or mental retardation are very trusting, desire to please others and seek acceptance—factors that can increase their risk for sexual victimization.
Lack of knowledge about healthy intimate relationships—If persons with disabilities have not experienced healthy intimate relationships, they may be unclear about the differences between healthy relationships and sexual exploitation. Some individuals with disabilities may also lack knowledge about their

own bodies and how to reduce their risk of sexual violence. Programs for persons with disabilities seldom provide adequate information about sexual assault prevention and sexuality education.

Nature of the disability—The risk for sexual victimization may in part depend upon the type of disability. Persons with disabilities who do not require caregivers have a lower risk than those who require assistance with their daily needs. One study found that, *among adults with developmental disabilities, as many as 83 percent of females and 32 percent of males were victims of sexual assault.*[20] In another study, *40 percent of women with physical disabilities reported sexual assaults.*[21] Persons with cognitive disabilities also tend to have a higher risk for victimization.

Gender—Just as females without disabilities are more likely to be sexually victimized than males without disabilities, females with disabilities have a higher risk of victimization than males with disabilities. Overall, one study estimated that 83 percent of women with disabilities will be sexually victimized in their lifetime.[22] Another study found that males with disabilities were twice as likely as males without disabilities to be sexually victimized in their lifetime.[23]

Lack of resources and/or lack of knowledge of existing resources—Victims with disabilities often remain in unsafe or abusive situations because they are unaware of alternatives or feel they have no safe alternatives.

Poverty—Limited finances can result in limited alternatives and resources (options to change caregivers, enhance home security, flee from a perpetrator, relocate, call for help, etc.). Data from the Disability Statistics Center (www.dsc.uscf.edu) indicates that about *30 percent of working-age adults who are limited in their ability to work live in poverty.*

Lack of control of their personal affairs—When caregivers, family members or others have power over individuals with disabilities (through controlling their finances, transportation, what they eat or how they bathe, their access to communication, etc.) then the potential for the misuse of power exists. Those who sexually perpetrate against persons with disabilities often take advantage of this imbalance of power. (See *Disabilities 101. Guardianship and Conservatorship* and *Disabilities 101. Working with Victims with Mental Illnesses.*)

Perceived lack of credibility of people with disabilities when they disclose sexual violence—Criminal justice system professionals sometimes hesitate to pursue cases in which a victim's credibility can be challenged. Offenders often target persons whom they may perceive as lacking credibility (as mentioned earlier), including those with certain developmental disabilities and mental illnesses. One study noted that 45 percent of female psychiatric outpatient clients reported being sexually abused during childhood.[24] (See *Disabilities 101. Working with Victims with Mental Illnesses.*)

Factors regarding perpetrators—Some research on the victimization of people with disabilities has noted the stress experienced by caregivers and emphasized that attention should be given to providing caregivers the support they need. While caregiver stress is a concern, professionals in the sexual violence field are quick to point out that stress on the part of caregivers does not cause perpetration and certainly never justifies it.

Alcohol and drug abuse by perpetrators are frequently factors in sexual violence. *"Half of all sexual assault perpetrators are under the influence of alcohol at the time of the assault, with estimates ranging from 30 percent to 75 percent."*[25] It is important to note that alcohol or drug use does not cause sexual violence perpetration, but may reduce the inhibitions of offenders.

FYI When reviewing the above list with victims, emphasize **it is not a specific disability that creates the risk, but the situation that the person with a disability is in that creates the risk.** Unfortunately, someone with a disability is more likely to be in a situation where they have limited finances/resources, are isolated, have a caregiver who wasn't screened, etc.

FYI Although increased risk for victimization may exist for some persons with disabilities, the opportunity also exists to increase the protective factors and services that can minimize or eliminate that risk.

What barriers perpetuate the risk of sexual victimization and prevent reporting by victims with disabilities?

Service providers should be aware of related barriers, as listed below, that may perpetuate the risk of sexual victimization and prevent reporting by persons with disabilities.

Examples of Barriers that May Perpetuate Risk and Prevent Reporting
Accessibility for persons with disabilities—for example: • Reliance on caregiver to access resources/services • Lack of transportation/lack of access to transportation • Communication challenges • Lack of physical accessibility of services
Situational factors—for example: • Programmatic barriers (lack of needed services, lack of information about available services, negative attitudes of agency staff towards people with disabilities, etc.) • Financial dependency or reliance on caregiver for access to finances
Fear—for example: • Fear of perceived consequences (retaliation by offender, loss of caregiver, loss of independence, etc.) • Fear because of negative past experience • Fear of not being believed
Educational/socialization factors—for example: • Manipulated to feel blame • Lack of knowledge regarding sexuality • Lack of knowledge regarding rights • Socialized to be compliant • History of being protected by others inhibits accessing resources for protection • Inhibited from being self-directed

How can the risk of sexual victimization for persons with disabilities be reduced?

Individuals should never be blamed or held responsible for their own victimization. As a society, we do not prevent murders by teaching people how to dodge bullets; similarly, we cannot prevent sexual violence by focusing on avoiding offenders. However, increasing protective strategies for at-risk individuals has proven to be one way to

help reduce the risk of victimization. Risk reduction is also the responsibility of service providers, as they can proactively identify resources and address obstacles to reporting and accessing services.

See the chart below for examples of actions that both individuals with disabilities and service providers can take to reduce risk and increase access to services.

Strategies to Reduce the Risk of Sexual Victimization for Persons with Disabilities

Examples of protective strategies that at-risk individuals can use (implementation may require the help of service providers):

- Ensure access to communication methods (phone, Internet, etc.) if help would be needed. (See *Sexual Violence 101. Safety Planning.*)
- Maintain access to assistive devices. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- Minimize financial dependency on one person; include more than one person in financial arrangements (e.g., assisted living staff and a family member, or a guardian and a service provider).
- Receive and understand basic information on sexual violence, personal boundaries, personal safety and community resources. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault and Abuse, Sexual Violence 101. Safety Planning* and *Collaboration 101. Creating a Community Resource List.*)
- Require that a caregiver and/or guardian be screened (including a background check with regular evaluations that include input from the consumer and support persons), undergo training on healthy sexuality and develop stress management skills.
- Inform all caregivers and service providers that sexual violence will be reported to law enforcement and then follow through with reporting. (See *Sexual Violence 101. Mandatory Reporting.*)
- Reduce isolation through multiple, unscheduled social connections (family, friends, church, neighbors, social networks, etc.) that occur in person or via the phone or Internet. Also maintain regular conversations with someone other than the caregiver (a doctor, advocate, family member, APS worker, clergy, etc.) to verify personal safety.
- Have an individualized safety plan. (See *Sexual Violence 101. Safety Planning.*)

Examples of ways that organizations can increase access to their services:

- Advertise services in accessible formats in venues utilized by persons with disabilities.
- Provide services at no or low-cost.
- Partner with agencies serving victims with disabilities to provide education about available resources, their rights, sexuality, and healthy sexual relationships versus sexual violence.
- Have the necessary resources available to communicate with victims seeking services, such as a picture board, capacity to hire an interpreter, etc. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- Identify accessible resources to meet the needs of victims of sexual violence and persons with disabilities (related to safety, housing/safe shelter, green space for service animals, transportation, etc.). (See *Collaboration 101. Creating a Community Resource List.*)
- Ensure the facility is accessible or arrange to provide equivalent services at an alternate site. (See *Disabilities 101. Accommodating Persons with Disabilities,* as well as the *Tools to Increase Access* modules.)

- Train staff to appropriately respond to disclosures from victims with disabilities, provide crisis intervention and safety planning, support victims and quickly connect them with the resources they need. (See *Sexual Violence 101. Crisis Intervention.*)

Examples of ways service providers can work on a systemic level to reduce risk:

- Change policies that limit victims' access to services. (See *Disabilities 101 modules.*)
- Support projects, such as affordable and accessible housing, that increase safe, independent living opportunities for persons with disabilities. (See *Collaboration 101* modules.)
- Encourage policies and practices that will increase the safety of individuals with disabilities, such as screening policies for personal care attendants and guardians. (See *Sexual Violence 101. Safety Planning, Disabilities 101. Accommodating Persons with Disabilities,* and *Tools to Increase Access. Readiness to Serve Victims with Disabilities: A Review of Intake Practices.*)
- Increase awareness of the risk of sexual victimization to create a supportive social environment that encourages victims to speak out.
- Provide cross-training to all disciplines involved in the service delivery system (including law enforcement officers, medical providers and prosecutors) to ensure that victims with disabilities will be well served at all points of entry into the system.

FYI The above suggestions can help change the situation, not the disability. However, the risk for victimization can be reduced if local agencies and communities eliminate barriers to accessing services for persons with disabilities, increase protective resources available to persons with disabilities, and support persons with disabilities in taking steps to protect themselves.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. One out of how many women and one of how many men in the United States have been victims of an attempted or completed rape in their lifetimes? What are the comparable rates for women and men in West Virginia? Is the risk for sexual victimization lower, equal to or greater for persons with disabilities—nationwide and in West Virginia? *See pages B1.2–B1.3.*
2. What factors increase the risk of sexual victimization for persons with disabilities? *See pages B1.4–B1.5.*
3. What barriers exist that may prevent reporting by sexual violence victims with disabilities? *See page B1.6.*
4. What can be done to challenge the factors contributing to victim-blaming and the vulnerability of persons with disabilities to sexual violence? *See pages B1.6–B1.8.*

Part 2: DISCUSSION

Projected Time for Discussion
2 hours

Purpose and Outcomes

Part 2: Discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their collaborative work with sexual violence victims with disabilities. The discussion could be incorporated into forums such as agency staff or board meetings as well as multi-agency meetings or trainings. Anticipated discussion outcomes include increased understanding of the risk for victimization faced by persons

with disabilities, the barriers to reporting victimization, and ways service providers and communities can address those issues.

Refer to the learning objectives at the beginning of this module for specific outcomes for this module.

Preparation

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator for the discussion as well as a note taker.
- Participants and the facilitator should review the power and control wheels in *Abuse of People with Developmental Disabilities by a Caregiver,*[26] included at the end of this module.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, blank attendance sheet, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify the discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2.a. **Utilizing the list of barriers to reporting in *Part 1: Core Knowledge*, review each item and ask each participant to identify if it would be a barrier for a victim with a disability seeking services from their specific agency.** (For example, if a victim with a physical disability had a caregiver who was the offender and the victim contacted your agency for help, would you have the capacity to fully serve her?[27] What if she lacked transportation? What if she needed an interpreter?) Identify whether each barrier is a result of the disability (which cannot be changed) or the lack of accessible services. *(15 minutes)*

2.b. **As a group, brainstorm possible ways to overcome any identified barriers.** *(Up to 30 minutes)*

3.a. Make sure each participant has a copy of *Abuse of People with Developmental Disabilities by a Caregiver.* These power and control wheels address various types of intimidation and abuse that a victim of sexual violence may experience. **As a group, review each of the eight categories on the wheels and identify where victims with developmental disabilities who are experiencing that type of mistreatment by their caregivers could easily access services in your community.** Then expand your assessment to include victims with various types of disabilities (physical, sensory and cognitive).

Be realistic in your assessment. For example, under intimidation, if the victim has a pet and her caregiver is abusing the pet, is there emergency housing that would allow the victim either to bring her pet or is there somewhere

to board the pet? Would the lack of a "pet-friendly" living environment or lack of finances to board a pet be barriers that might cause someone in your community to remain in an abusive situation? Under financial abuse, if a person with a cognitive disability was living in a group home and a staff person was stealing her money, is there a place she could report the theft and would be believed, or would she have to endure the misconduct just to have a place to live?

3.b. **Create a list of barriers that need to be addressed in your community and possible strategies for engaging additional partners** to assist in addressing those barriers. *(up to 1.25 hours)*

FYI If you work with clients with developmental disabilities who are experiencing or are at risk for abuse perpetrated by their caregivers, the power and control wheels provided in *Abuse of People with Developmental Disabilities by a Caregiver* might be useful tools for explaining the dynamics of abuse to them and/or their non-offending support persons. One suggestion is that you first discuss with clients what they can expect in a healthy, nonviolent relationship with their caregivers, using the wheel that says "nonviolent" on the outer rim. Then you can compare that wheel with the other wheel that discusses tactics used against victims by abusive caregivers (the wheel that says "violence" on the outer rim) and ask clients to identify tactics their caregivers may already be using. Next, you, the clients and their support persons can discuss options for responding to the abuse and do safety planning. Keep in mind your responsibilities regarding mandatory reporting of abuse. (See *Sexual Violence 101. Mandatory Reporting.*)

The Wisconsin Coalition Against Domestic Violence also offers an *Abuse in Later Life Power and Control Wheel* that may be helpful if you are working with older clients—see http://www.ncall.us/resources.html.

4. **Closing.** Ask each participant to write down how the information gained from this discussion will promote change in their agency's policies, practices or training programs and their next steps in the process of initiating that change. Then facilitate a large group discussion on this topic. *(15 minutes)*

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[1]P. Tjaden & N. Thoennes, Prevalence, incidence and consequences of violence against women survey: Findings from the National Violence against Women Survey (National Institute of Justice and Centers for Disease Control & Prevention, 1998), http://www.ncjrs.gov/pdffiles/172837.pdf. For the full report, published in 2000, go to http://www.ncjrs.gov/pdffiles1/nuj/183781.pdf or http://www.ojp.usdoj.gov/nij/pubs-sum/183781.htm. Note that all online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[2]Paragraph from West Virginia Bureau for Public Health, Health Statistics Center, 2008 Behavioral Risk Factor Surveillance System (BRFSS) survey (2008),

[3]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the term "victims" is primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" generally are used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[4]For an overview of their more comprehensive research, see N. Groth & H.J. Birnbaum, Men who rape: *The psychology of the offender* (Da Capo Press, 2001).

[5]Tjaden & Thoennes.

[6]Age-adjusted rates are used in this report to "account for variations in age and risk of victimization among those with and without disabilities." M. Rand & E. Harrell, Crime against people with disabilities (Bureau of Justice Statistics Special Report, Office of Justice Programs, U.S. Department of Justice, 2009), 2, http://bjs.ojp.usdoj.gov/. For more explanation, see the report.

[7]See Rand & Harrell.

[8]D. Valenti-Heim & L. Schwartz, *The sexual abuse interview for those with developmental disabilities* (1995).

[9]West Virginia Bureau for Public Health, Health Statistics Center.

[10]www.census.gov.

[11]M. Rand, Criminal victimization 2008, *Bureau of Justice Statistics Bulletin* (2009), http://bjsdata.ojp.gov/content/pub/pdf/cv08.pdf.

[12]D. Kilpatrick, C. Edmonds & A. Seymour, *Rape in America: A report to the nation* (Arlington, VA: National Crime Victims Center, 1992).

[13]D. Kilpatrick & B. Saunders, *National survey of adolescents in the United States* (Ann Arbor, MI: Inter-University Consortium for Political and Social Research, 1995), http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/02833.

[14]D. Kilpatrick, *Rape and sexual assault* (National Violence Against Women Prevention Research Center, 2000).

[15]D.Valenti-Heim & L. Schwartz, *The sexual abuse interview for those with developmental disabilities* (Santa Barbara, CA: James Stanfield Company, 1995).

[16]D. Sobsey & C. Vamhagen, *Sexual abuse, assault and exploitation of people with disabilities: A study of victims* (Ottawa: Health and Welfare Canada, 1988).

[17]M. Mandel, *A survey on the prevalence of sexual assault among people with disabilities in the Tucson area* (unpublished raw data) (Tucson, AZ: Southern Arizona Center Against Sexual Assault, 2005). As cited in Office for Victims of Crime, Promising practices in serving victims with disabilities (Washington, D.C.: Office of Justice Programs, U.S. Department of Justice) http://www.ovc.gov/publications/infores/ServingVictimsWithDisabilities_bulletin/crime.html.

[18]M. Ticoll, *Violence and people with disabilities: A review of the literature* (Ontario: L'Institut Roeher, National Clearinghouse on Family Violence, Family Violence Prevention Unit, Health Canada, 1994), http://www.phac-aspc.gc.ca/ncfv-cnivf/publications/fvdisabliterature-eng.php; and Day One: The Sexual Assault and Trauma Resource Center, Rhode Island Coalition Against Domestic Violence and PAL: An Advocacy Organization for Families and People with Disabilities, *Is your agency prepared to ACT? Conversation modules to explore the intersection of violence and disability* (Advocacy Collaboration Training Initiative, 2004).

[19]D. Sobsey, Sexual offenses and disabled victims: Research and practical implications, *Visa Vis,* 6(4) (1988).

[20]I. Johnson & R. Sigler, Forced sexual intercourse among intimates, *Journal of Interpersonal Violence,* 15(1) (2000).

[21]M. Young, M. Nosek, C. Howland, G. Chanpong & D. Rintala, Prevalence of abuse of women with physical disabilities, *Archives of Physical Medicine and Rehabilitation,* 78 (suppl) (1997), s34-s38.

[22]L. Stimpson & M. Best, *Courage above all: Sexual assault against women with disabilities* (Toronto: DisAbled Women's Network, 1991).

[23]Statistics Canada, Centre for Justice Statistics, 1994, as cited in Harm's Way: The many faces of violence and abuse against persons with disabilities (Ontario: L'Institut Roeher, 1995).

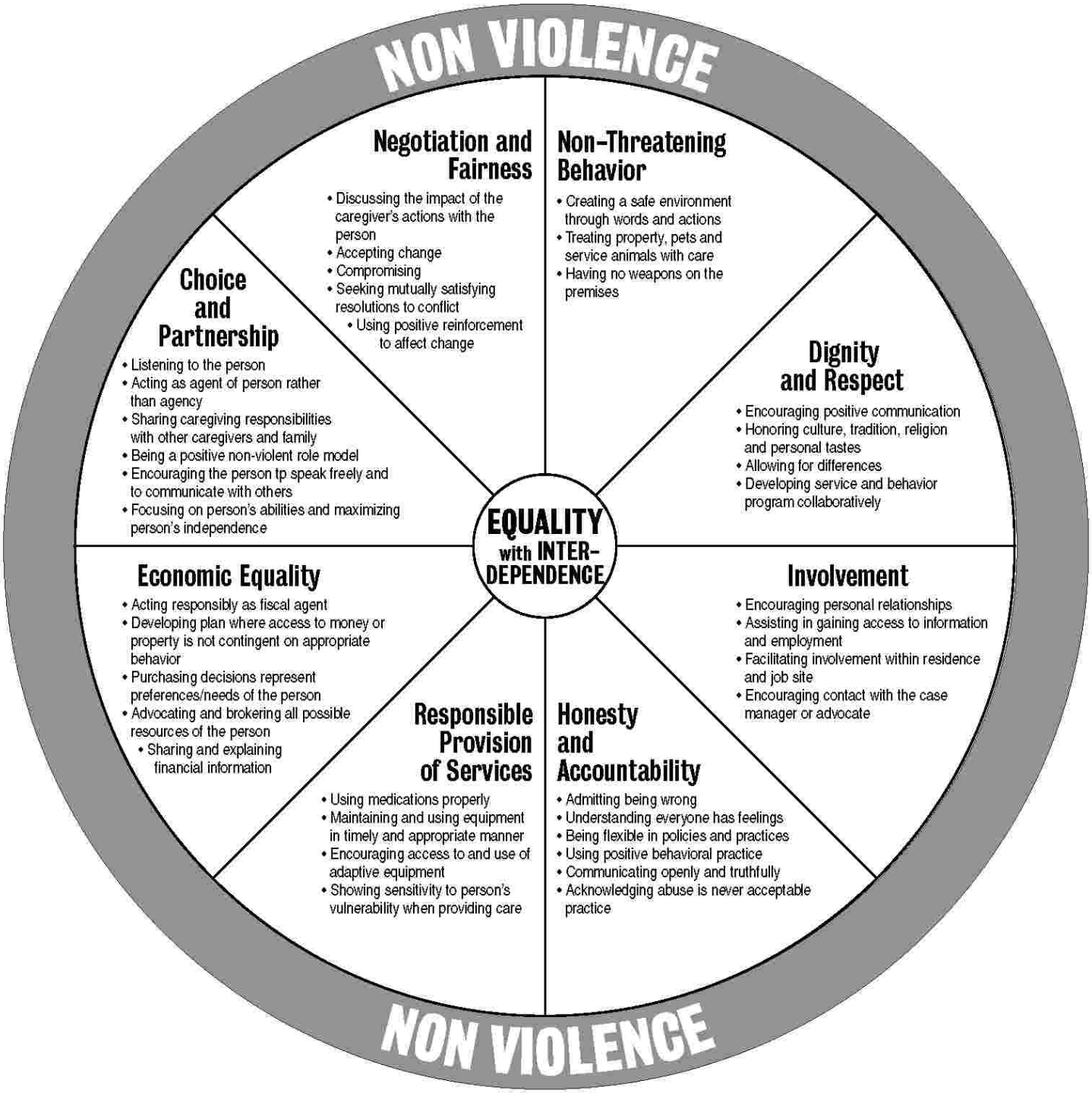
[24]K. Muenzenmaier, I. Meyer, E. Struening & J. Ferber, Childhood abuse and neglect among women outpatients with chronic mental illness, *Hospital Community Psychiatry,* 44(7) (1993), 666-670.

[25]A. Abbey, Alcohol and sexual violence perpetration (National Online Resource Center on Violence Against Women 2008), www.vawnet.org.

[26]Used with permission from Wisconsin Coalition Against Domestic Violence, available through http://www.ncall.us/resources.html#NCALLPUBS.

[27]Although males and females are both victims of sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims/clients are often referred to as female.

Abuse of People with Developmental Disabilities by Caregivers



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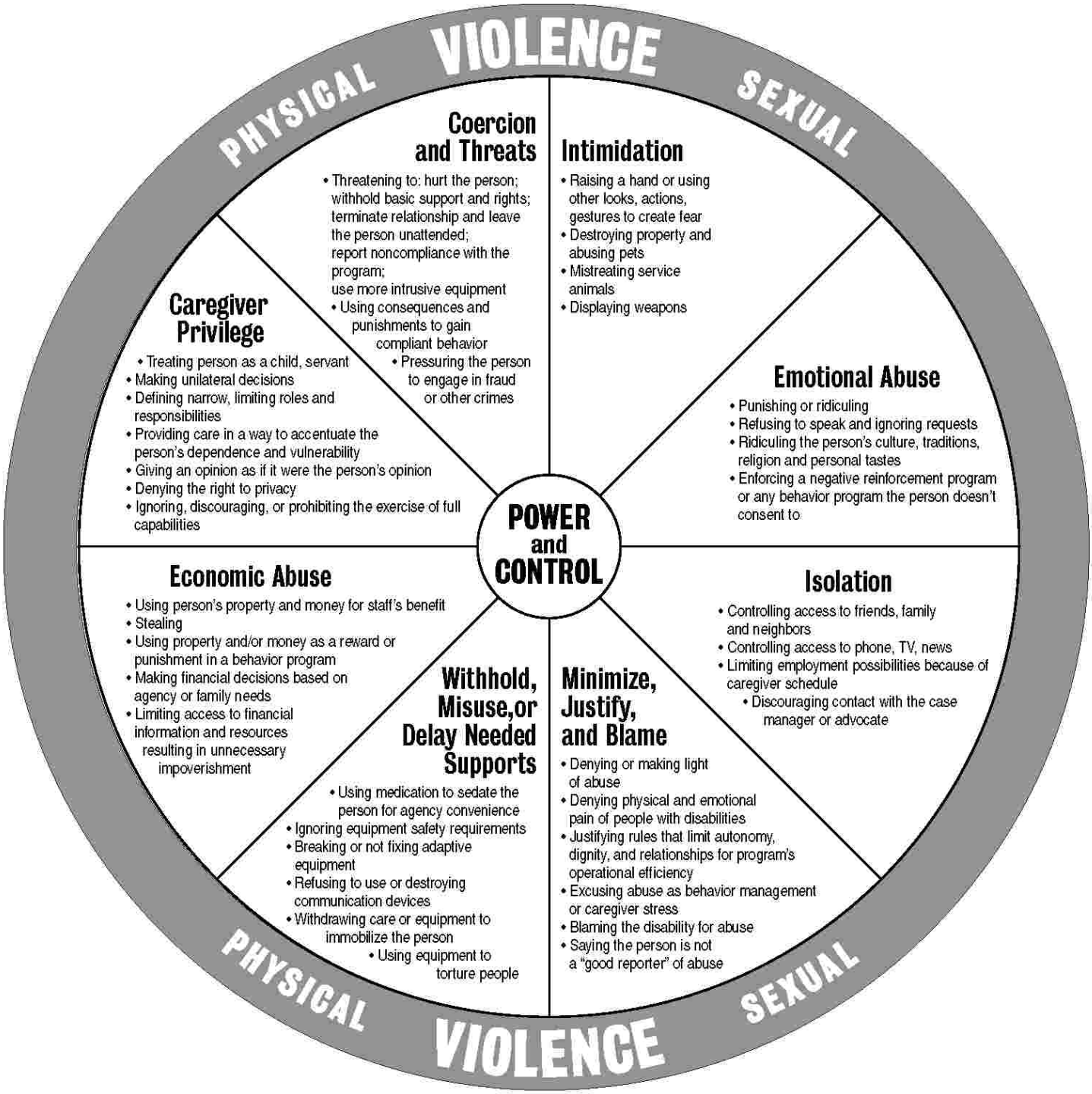
307 S. Paterson St., Suite 1, Madison, WI 53703
(608) 255-0539 / FAX: (608) 255-3560

This diagram is based on the Power and Control/Equality wheels developed by the Domestic Violence Intervention Project, Duluth, MN

Abuse of People with Developmental Disabilities by a Caregiver



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Indicators of Sexual Violence

This module identifies physical and behavioral indicators of sexual violence. It includes strategies to consider if victimization is suspected but no disclosure is made.[1] It offers a limited discussion of the emotional indicators of sexual violence, as this topic is examined in *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*

Key Points

- Sexual assault can have many physical, behavioral and emotional consequences and manifestations for victims.[2] Many victims will never seek or receive services to help them heal from the trauma of the assault.
- Unless excessive physical force is used, most victims will not have visible physical injuries from the sexual assault. Coercion, intimidation and the threat of force all can be contributing factors to why excessive force is not used in many assaults. The absence of physical evidence in no way correlates with the level of fear that victims may have experienced during the assault.
- The most common physical signs of a sexual assault include bruising (on the inner thighs or on the arms where the offender restrained the victim) and trauma to the genital area. Some physical signs are obvious, such as bleeding, and might require medical attention. Other physical indicators, such as pregnancy or a sexually transmitted infection, may be detected days or even weeks after the assault.
- Sexual victimization can result in short-term or long-term behavioral changes and coping responses. These include self-harming behaviors (drug/alcohol use, a suicide attempt, etc.); changes in social interactions and behaviors (withdrawal, running away, sexual promiscuity, etc.); and changes in individual behaviors (sleep disturbances, shifts in eating patterns, bed-wetting, etc.). Neither the presence nor absence of any of these behaviors confirms that sexual assaults did-or did not-occur.
- If clients' behaviors change, service providers need to be open to all possible causes of those changes and explore them as appropriate. Unless service providers are law enforcement officers or designated investigators (e.g., Adult Protective Service (APS) workers or long-term care ombudsmen), their focus in seeking information is solely to insure the health and safety of their clients, not to determine whether or not a crime was committed. It is never appropriate to probe or pressure someone into disclosing victimization.

B2. Indicators of Sexual Violence

Purpose

Sexual assault can have many physical, behavioral and emotional consequences and manifestations for victims. Because this crime is underreported, knowing the potential indicators of sexual violence can assist service providers in understanding and identifying victimization even when victims are reluctant to disclose. This knowledge can be particularly important for those service providers who work with persons with cognitive and communication disabilities who may not have the ability to understand or disclose their victimization.

NOTE: There is a limited discussion of the emotional indicators of sexual violence in this module, as this topic is examined in *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*

SEXUAL VIOLENCE 101

Objectives

Those who complete this module will be able to:

- Identify physical indicators of sexual violence; and
- Understand what behavioral changes might indicate sexual victimization.

Part 1: CORE KNOWLEDGE

What is the impact of sexual violence?

In West Virginia, one in six women and one in 21 men will become victims of sexual assault, but only a very small percentage of those victims will ever report the assault to law enforcement.[3] (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors*.) Many victims will never seek or receive services to help them heal from the physical and emotional trauma of the assault. Service providers who are tuned into physical, behavioral and emotional changes their clients are experiencing may find that those changes are the result of sexual victimization. In no way are the indicators listed below a confirmation that a sexual assault occurred; each of them could be a symptom of other injuries, trauma or unrelated life experiences. A skilled service provider will be able to assess whether unexplained indicators warrant further inquiry and concern regarding potential sexual victimization.

PHYSICAL INDICATORS OF SEXUAL ASSAULT

Will most sexual assault victims have physical injuries?

No. Unless excessive physical force is used, most victims will not have physical injuries from the sexual assault. Coercion, intimidation and the threat of force all can be contributing factors to why excessive force is not used in many assaults. The absence of physical evidence in no way correlates with the level of fear and terror that victims may have experienced during the assault.

Who is most likely to sustain physical injuries?

Physical injuries are more common in sexual assaults in which the offender is a stranger. Male victims who report the assault and older victims are more likely to sustain injury.

What are the most common physical injuries?

Physical signs of a sexual assault are most likely to include bruising (on the inner thighs or on the arms where the offender restrained the victim) and trauma to the genital area. A forensic medical examination can document trauma and any tearing of the genital and/or anal areas through the use of devices, such as a colposcope, that magnify and photograph the injured area. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

Some physical signs are obvious, such as bleeding, and might require medical attention. Other physical indicators, such as pregnancy or a sexually transmitted disease, may be detected days or even weeks after the assault. (Research has found that postmenopausal women are at a higher risk for contracting a sexually transmitted infection.)

BEHAVIORAL INDICATORS OF SEXUAL ASSAULT

What are behavioral indicators of sexual assault?

There are no "normal" responses to rape. Each victim is unique and her response to the trauma is unique.[4] Because sexual assaults often have no visible physical indicators, service providers can sometimes identify that

a sexual assault occurred based only on a change in the victim's behavior. That change may be because the assault occurred recently or it could be that memories of a prior assault were triggered by a recent event. (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma* and *Sexual Violence 101. Crisis Intervention.*)

Studies have identified numerous potential behavioral indicators of sexual victimization, many of which are listed in the chart below. Neither the presence nor absence of any of the following behaviors confirms that a sexual assault did—or did not—occur.

Self-Harming Behaviors

- Increased drug and alcohol use
- Self-mutilation
- Suicide attempt

Changes in Social Interactions/Behaviors

- Withdrawal
- Sexual promiscuity
- Dressing provocatively
- Wearing many layers of clothing
- Running away
- Aggressive or disruptive behavior
- Regressive behavior
- Sexually inappropriate behavior
- Excessive attachment
- Avoidance of certain individuals

Individual Behavioral Changes

- Sleep disturbances/Insomnia
- Excessive sleeping
- Change in eating patterns
  - o Bulimia
  - o Anorexia
  - o Weight gain
- Bed wetting
- Incontinence
- Aversion to touch
- Frequent bathing
- Avoidance of previously favorite places
- Compulsive masturbation
- Isolation
- Sudden unwillingness to undress or shower in front of trusted persons
- Unexplained sexual knowledge inappropriate for developmental age

EMOTIONAL INDICATORS OF SEXUAL ASSAULT

What are indicators of emotional trauma from a sexual assault?

The emotional trauma caused by sexual violence can manifest itself in numerous ways: depression; spontaneous crying; feelings of despair and hopelessness; anxiety and panic attacks; fearfulness; compulsive and obsessive behaviors; feelings of being out of control, irritable, angry and resentful; emotional numbness; and withdrawal from normal routines and relationships.

A specific type of trauma, rape crisis syndrome, has been identified as a form of post-traumatic stress disorder specific to sexual violence victims. Because responding to the emotional trauma of victims is a critical component of crisis intervention, a separate module addresses this issue. (*See Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

What if sexual assault indicators are present but the client does not disclose victimization?

A person's right to privacy should be protected and respected, with special consideration made in situations that require mandatory reporting. (*See Sexual Violence 101. Mandatory Reporting.*) In those situations, even cases of suspected abuse must be reported.

Service providers should always trust their instincts. If their clients' behaviors change, service providers should be open to all possible causes of those changes and explore them as appropriate. This exploration may require that service providers challenge stereotypes or attitudes they may have regarding sexual victimization (e.g., just because a client is older does not mean she could not have been raped; women age 85 and over are also sexually assaulted.) *Unless service providers are law enforcement officers or designated investigators (e.g., APS workers or long-term care ombudsmen), their focus in seeking information is solely to insure the health and safety of their clients, not to determine whether or not a crime was committed.*

Depending on their role and relationship with their clients, service providers may be in a position to seek additional information. For example, counselors and medical professionals have trusted and confidential relationships where other professionals may not. For those in confidential relationships, one of the best ways to determine whether someone has been victimized is to gently and compassionately ask, using words appropriate to their vocabulary and understanding. For a younger child or someone with a cognitive disability, asking "Has someone touched you/upset you/hurt you?" would be a sensitive inquiry regarding their safety. It is never appropriate to probe or pressure someone into disclosing victimization.

If service providers ask questions about sexual victimization, they must be prepared for a disclosure.[5] (For example: one physician added the following question to her patient intake screening form: "Have you ever been a victim of sexual assault?" She estimated that about a fourth to a third of her female patients responded affirmatively to the question.) In order to assist victims who disclose, service providers need to be knowledgeable of both appropriate supportive responses and possible resources in their communities. (See *Collaboration 101. Creating a Community Resource List* and *Sexual Violence 101. Crisis Intervention*.)

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What are potential physical indicators of sexual assault? *See page B2.2.*
2. What are potential behavioral indicators of sexual assault? *See pages B2.2–B2.3.*
3. What should you do if you suspect victimization but the client does not disclose? *See page B2.4.*

Funding was provided by Grant No. 2006-FW-AX-K001 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this module are those of the authors and do not necessarily reflect the views of the U.S. Department of Justice, Office on Violence Against Women.

[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" generally are used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]The information on indicators in this module is compiled from the following sources: N. Baladerian, *Survivor, book III. For family members, advocates and care-providers* (Baladerian, 1985), 4; Building partnerships for the protection of persons with disabilities, *Protect, report, preserve: Abuse against persons with disabilities* (Massachusetts District Attorneys Association, 2006), 11–12; and Day One: The Sexual Assault and Trauma Resource Center, Rhode Island Coalition Against Domestic Violence and PAL: An Advocacy Organization for Families and People with Disabilities, *Is your agency prepared to ACT? Conversation modules to explore the intersection of violence and disability* (Advocacy Collaboration Training Initiative, 2004), 34, section adapted from Wisconsin Coalition Against Sexual Assault, *Transcending silence: A series about speaking out and taking action in our communities* (2001).

[3]West Virginia Bureau for Public Health, Health Statistics Center (2008).

[4]Although males and females are both victims of sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims/clients are often referred to as female.

[5]R. Baer & M. Hammond (Eds.), *Assisting women with disabilities who are victims of violence, cross training curriculum for disabilities personnel,* (Logan, UT: Centers for Persons with Disabilities, Utah State University and Center for Abuse Prevention Services Agency).

West Virginia Laws on Sexual Assault and Abuse

This module is designed to build service providers' basic understanding of the following: what behaviors under state law would be considered sexual assault and sexual abuse; how sex offense charges are filed; the state's statute of limitations on sex offenses; and when reports to law enforcement can and should be made.

Key Points

- Sexual assault and sexual abuse are the two major classifications of sex offenses in West Virginia. Sexual abuse occurs when a person subjects another person to sexual contact without their consent, and that lack of consent is due to physical force, threat or intimidation. Sexual assault is sexual intercourse or sexual intrusion without consent.
- Two sources for West Virginia laws pertaining to sex offenses are the *West Virginia Criminal Code* and the *West Virginia Protocol for Responding to Victims of Sexual Assault.*
- Law enforcement officers make the initial determination of what charges to file against a suspect. However, at the time an indictment is sought, the prosecuting attorney makes the decision as to what criminal charge(s) should be brought in connection with a case.
- There is no statute of limitations on sexual assault offenses and first degree sexual abuse. There is a one year statute of limitations for 2nd and 3rd degree sexual abuse.
- Adult victims can have a forensic medical exam conducted within 96 hours whether or not they choose to report to law enforcement. If the victim is a child or an incapacitated adult, the crime must be reported to law enforcement and the West Virginia Department of Health and Human Resources by the health care provider.[1]
- The key factor in determining if a sexual act is criminal is whether or not there was consent. Proving lack of consent is the greatest challenge in sexual assault cases because there may be no evidence other than that which shows that sexual contact did take place.

Unless the user of this information is an attorney, the information should not be used to provide legal advice.

B3. West Virginia Laws on Sexual Assault and Abuse

Purpose

In the event that a client discloses sexual victimization, service providers need to have a basic understanding of what behaviors under West Virginia law would be considered sexual assault and sexual abuse. This knowledge will enable them to better assist and refer victims for services, as well as identify situations that activate their legal responsibilities under the state's mandatory reporting requirements. (See *Sexual Violence 101. Mandatory Reporting.*)

SEXUAL VIOLENCE 101

Note that unless the user of this information is an attorney, the information in this module should not be used to provide legal advice.

Objectives

Those who complete this module will be able to:

- Locate and describe West Virginia laws pertaining to sex offenses;
- Explain how sex offense charges are filed;
- Identify the state's statute of limitations on sex offenses;
- Identify when reports to law enforcement can and should be made; and
- Identify how consent is the key factor in sexual offenses.

Preparation

- Review this module online or Sex Crimes—Definitions and WV Laws, of the West Virginia Protocol for Responding to Victims of Sexual Assault, through http://www.fris.org.[2] The laws in this print version were current as of 2010.

Part 1: CORE KNOWLEDGE

What's the difference between sexual abuse and sexual assault?

West Virginia laws are very specific about sexual abuse and sexual assault.[3] Sexual acts which are prohibited by law in a jurisdiction are called sex offenses or sex crimes. The key element of these sex offenses is the lack of consent to the sexual activity. Sexual abuse is intentional touching of a sexual nature. Sexual assault involves sexual penetration—oral, anal or vaginal.

Sexual abuse occurs when a person subjects another person to sexual contact without their consent, and that lack of consent is due to physical force, threat or intimidation. According to West Virginia law, there are three (3) levels of sexual abuse:

- ***1st Degree:*** Sexual contact without the victim's consent due to forcible compulsion, the victim is physically helpless, or the victim is younger than age 12 and the perpetrator is age 14 or older.
- ***2nd Degree:*** Sexual contact with someone who is mentally defective or mentally incapacitated.
- ***3rd Degree:*** Sexual contact with a victim under age 16 without their consent.

Definition of Terms: WV Sexual Abuse and Sexual Assault Laws
Drawn from *WVC§61-8B*

- **Forcible compulsion:** (a) physical force that overcomes such earnest resistance as might reasonably be expected, under the circumstances; (b) threat or intimidation, expressed or implied, placing a person in fear of immediate death or bodily injury to him/herself or another person or in fear that he/she or another person will be kidnapped; or (c) fear by a person under 16 years of age caused by intimidation, expressed or implied, by another person who is at least four (4) years older than the victim. For the purpose of this definition, "resistance" includes physical resistance or any clear communication of the victim's lack of consent.
- **Married:** for the purpose of this article, in addition to its legal meaning, includes persons living together as husband and wife regardless of the legal status of their relationship.
- **Mentally defective:** a person suffers from a mental disease or defect which renders that person incapable of appraising the nature of his/her conduct.
- **Mentally incapacitated:** a person is rendered temporarily incapable of appraising or controlling his/her conduct, as a result of the influence of a controlled or intoxicating substance administered to that person without his/her consent or a result of any other act committed upon that person without his/her consent.
- **Physically helpless:** a person is unconscious or for any reason is physically unable to communicate unwillingness to an act.
- **Sexual contact:** intentional touching, either directly or through clothing, of the anus/any part of the sex organs of another person, or the breast of a female or intentional touching of any part of another person's body by the actor's sex organs, where the victim is not married to the actor and the touching is done to gratify the sexual desire of either party.
- **Sexual intercourse:** any act between persons not married to each other involving penetration, however slight, of the female sex organ by the male sex organ or involving contact between the sex organs of one person and the mouth or anus of another person.
- **Sexual intrusion:** any act between persons not married to each other involving penetration, however slight, of the female sex organ or of the anus of any person by an object for the purpose of degrading or humiliating the person so penetrated or for gratifying the sexual desire of either party.
- **Bodily injury:** substantial physical pain, illness or any impairment of physical condition.
- **Serious bodily injury:** bodily injury which creates a substantial risk of death, which causes serious or prolonged disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily organ.
- **Deadly weapon:** any instrument, device or thing capable of inflicting death or serious bodily injury and designed or adapted for use as a weapon or possessed, carried or used as a weapon.

SEXUAL VIOLENCE 101

Sexual assault is sexual intercourse or sexual intrusion without consent. According to West Virginia law, there are three (3) levels of sexual assault:

- ***1st Degree:*** The perpetrator inflicts serious bodily injury, uses a deadly weapon, or the perpetrator is over age 14 and the victim is younger than twelve years old and is not married to that person.
- ***2nd Degree:*** Sexual intercourse or intrusion without consent and lack of consent is due to forcible compulsion or physical helplessness.
- ***3rd Degree:*** Sexual intercourse or intrusion with someone who is mentally defective or mentally incapacitated, or when someone age 16 or older assaults someone less than 16 who is at least 4 years younger than the perpetrator and not married to him/her.

Sexual abuse and sexual assault are the main categories of sex offenses in the *West Virginia Code*. Additional offenses, including incest, are described in other sections of the *West Virginia Code* (www.legis.state.wv.us) and in the Sex Crimes section of the *West Virginia Protocol for Responding to Victims of Sexual Assault* (www.fris.org).

FYI Some legal terms used in state sex offense laws—"mentally defective" for example—show a lack of sensitivity to victims with disabilities. While these terms would not be our choice of language, they currently define the law and influence charging decisions nonetheless. First responders are urged to avoid use of legal terms such as "mentally defective" in their interactions with victims, as their use could increase a victim's reluctance to seek assistance with safety, healing and justice. (See *Disabilities 101. Person First Language*.)

Test your understanding of state law using the definitions above. Although the criminal justice system determines whether disclosed acts of sexual violence are offenses under state law, it is helpful for all service providers to be aware of general differences in what each offense entails.

1. *A man slipped a drug into your drink without your knowledge, you passed out, and he had sexual contact with you without your consent. Which crime do you think has been committed?*
2. *If someone has sexual contact with a person with a cognitive disability who does not have the capacity to give consent, what crime do you think has been committed?*

3a. *If a 17-year-old male has sexual intercourse with an 11-year-old girl who uses a wheelchair, what crime do you think has been committed?*

3b. *Does the fact that the girl uses a wheelchair affect this classification?*

Answers: *1)* Sexual abuse in the 2nd degree; *2)* Sexual abuse in the 2nd degree; *3a.)* Sexual assault in the 1st degree; and *3b.)* No. However, note that in any of these scenarios a prosecutor may decide on a lesser or different charge (see questions that follow).

How are suspects charged with sexual assault or sexual abuse?

With criminal offenses such as sexual assault and first degree sexual abuse, the county prosecuting attorney makes the decision whether or not to prosecute the case and what level of offense is charged. An offense is considered either a misdemeanor or a felony. With a misdemeanor, the lesser charge is punishable by fines and/or up to one year in a county jail. A felony is a more serious charge, punishable by at least one year in prison. A 1st degree sexual abuse offense is a felony, whereas 2nd and 3rd degree sexual abuse are misdemeanors. All degrees of sexual assault are felonies.

Once a crime of sexual abuse or sexual assault is reported to law enforcement, a criminal investigation may begin. Law enforcement officers make the initial determination of what charges to file against a suspect. However, at the time an indictment is sought, the prosecuting attorney makes the decision as to what charge(s) should be brought in connection with a case. In criminal cases, therefore, once the case is reported to law enforcement, the determination of what charges are made (if any) is not under the victim's control.

FYI **A statute of limitations** is a law that sets forth the maximum period of time, after certain events, that legal proceedings based on those events may be initiated.[4] There is no statute of limitations for felonies in the West Virginia Code, with the exception of the felony offense of perjury which has a three-year statute of limitations and some felony tax offenses which have statute of limitations. Felonies, with these exceptions, can be charged at any time. There is a one-year statute of limitation for misdemeanors, so 2nd and 3rd degree sexual abuse must be charged within a year after the offense was committed (*WVC§61-11-9*).

FYI **There may be many reasons why victims may be reluctant to report sex offenses to law enforcement.** Some of the most common are self-blame, fear of retaliation by perpetrators, fear of rejection by family/friends, and unwillingness to deal with the humiliation, loss of privacy and negativity they perceive would accompany criminal justice system involvement.[5] Victims with disabilities may also be concerned that reporting may lead to a loss of independence or, in cases of caregiver abuse, loss of someone to assist them with their daily needs. (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors.*) Regardless of their decision about reporting, victims need to be aware of any available non-legal assistance to help them recover. Whether or not there are criminal charges filed, civil legal remedies may also be available to sexual assault victims. In civil lawsuits, victims typically seek monetary compensation for damages.

What evidence is needed to support these charges?

To charge a suspect with sexual abuse or sexual assault, sufficient evidence that the crime occurred is needed. During a criminal investigation, law enforcement seeks evidence to help reconstruct details about the event(s).[6] Physical evidence on victims' bodies can be collected for approximately 96 hours after the crime occurred—and potentially longer if evidence has not been washed off and/or there are visible physical injuries (e.g., cuts and bruises). (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*) Evidence may also be found at the crime scene, on the suspect's body/clothes and at other locations (e.g., at the suspect's home). To support evidentiary findings, investigators also seek statements from victims, suspects and witnesses.

Evidence on the victims' bodies can be collected whether or not the crime is reported. Sexual assault victims are encouraged to go to a hospital as soon as possible after the crime occurs to have a forensic medical exam. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*) During this exam, evidence is collected. Adult victims can have this exam conducted whether or not they choose to immediately report the sexual assault to law enforcement. If the victims are children or are adults considered by state law to be "incapacitated," the crime must be reported to the West Virginia Department of Health and Human Resources and law enforcement by the health care provider. (See *Sexual Violence 101. Mandatory Reporting.*) Evidence collected can be stored for up to 18 months. After that 18 month period, victims can still report (since there is no statute of limitations on reporting sexual assault or 1st degree sexual abuse in West Virginia), but any evidence that was collected through the forensic medical exam will have been destroyed.

FYI **The key factor in determining if a sexual act is criminal is whether or not there was CONSENT.** In West Virginia, a person cannot legally consent to sexual activity if under the age of 16, mentally defective, mentally incapacitated or physically helpless. If a sexual assault involves drugs/alcohol (either voluntarily or involuntarily consumed by the victim), there may be a lack of consent if the victim is incapacitated or physically helpless.

How do victims "prove" there was no consent if a situation does not fit into one of the above categories? The burden of proof is on the criminal justice system, not victims. Proving lack of consent is the greatest challenge in sexual assault cases because often there is no evidence other than that which shows that sexual contact did take place. Sometimes, through a forensic medical exam, injuries can be visually documented to show use of force. The medical history can often support the victims' accounts of the assault or abuse through the written documentation of injuries. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

When the criminal justice system is not able to prove the lack of consent, victims may feel a profound lack of validation that others believe the sexual assault or sexual abuse did happen. It is critical, therefore, that service providers offer ongoing support for victims and let them know they are believed, regardless of the outcome of a criminal investigation and prosecution.

In West Virginia, certain professionals (e.g., health care and social services personnel, emergency medical services, religious and school personnel, child care/foster care workers, law enforcement officials, and personnel of nursing home or other residential facilities) are considered **mandatory reporters** in suspected cases of sexual abuse and/or sexual assault against (1) children and (2) adults "who by reason of physical, mental or other infirmity are unable to independently carry on the daily activities of life necessary to sustaining life and reasonable health."[7] (See *Sexual Violence 101. Mandatory Reporting.*)

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. How does West Virginia law define sexual assault and sexual abuse? *See pages B3.2–B3.4.*
2. Where can you find information about West Virginia laws pertaining to sex offenses? *See page B3.4.*
3. When sexual violence is reported, who initially determines what charges, if any, to file against a suspect? What is the prosecuting attorney's role in determining charges when an indictment is sought? *See pages B3.4.–B3.5.*
4. What are the statutes of limitations in West Virginia on sexual assault and sexual abuse offenses? *See page B3.5.*
5. Do adult victims need to report the crime to law enforcement in order to have a forensic medical exam conducted? If the victims are children or are adults considered by law to be "incapacitated," to what agency/agencies does a report need to be made? *See page B3.5.*
6. What is the key factor in determining if a sexual act is a criminal offense? *See page B3.5.*

Part 2: DISCUSSION

Projected Time for Discussion
1.75 hours

Planning

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator for the discussion. The facilitator should have expertise on sexual violence and knowledge of related state law.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion.
- A copy of the law should be available for reference during the discussion. (See the *West Virginia Protocol for Responding to Victims of Sexual Assault* at http://www.fris.org.)

- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify the discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2. **Briefly summarize state law regarding sexual assault, sexual abuse, statute of limitations and mandatory reporting** and discuss any questions. (*5 minutes*)

3. In either a small or large group setting, **ask participants to review the following scenarios and consider the questions** that follow. (*15 minutes)*

Scenario 1

While at the grocery store, Jackie stopped to say hello to several boys from school. Jackie is a friendly 16-year-old who has a developmental disability. The boys asked Jackie if she would smoke cigarettes with them in the alley behind the store. She agreed. While in the alley, the boys touched her breasts.

Scenario 2

Bob, who is physically fragile and uses a wheelchair, lives at home with his caretaker son. The son forces Bob to view pornographic films and has sexual contact with him as he helps him bathe and dress/undress.

Scenario 3

A staff member at the residential treatment center where Rita is a patient comes into her room at night and performs oral sex on her. Rita is heavily sedated at the time.

Scenario 4

Fran, who is deaf, is at a party and meets Kevin, who is not deaf but knows sign language. They both are drinking alcohol. After a couple hours, he offers to walk her home. Once inside her apartment, Kevin forces himself on Fran and has sex with her.

In a **large group discussion**, ask participants to discuss the following questions: (30 minutes)

a. For each scenario, is the act considered a crime in West Virginia? Why or why not? If it is a criminal act, what is the violation/degree?

b. What factors made it difficult to decide upon criminality/violation/degree?

c. What additional information might service providers need to make a determination?

d. What can staff/volunteers working with victims with disabilities do if they need clarity on how the law might apply to a case? What resources are available?

4. **Ask participants to discuss possible reactions of victims** who find out the act committed against them is not considered a crime in West Virginia or that no charges will be made due to insufficient evidence. Are there reactions that may be specific to persons with disabilities? Discuss how service providers/partnering agencies can respond to these victims in a supportive way. (*10 minutes*)

5. **Invite participants to share their general experiences of interacting with victims of sexual violence, especially those with disabilities.** To whom did the victims disclose? Did they report, have evidence collected and have subsequent criminal justice involvement? What were the outcomes? Did they seek support services? What services would have been helpful to them? (*10 minutes*)

6. Most victims do not report their assaults to authorities; many never tell anyone. **If your agency serves persons who may be sexual violence victims who may not have disclosed, in what ways can your agency provide them with information regarding their rights?** (*10 minutes*)

7. **What training might staff at your agency need to be able to provide support and referral services?** (For assistance in meeting your training needs, visit www.fris.org.) (*5 minutes*)

8. **Closing.** Ask participants to write down how the information gained from this discussion will promote change in policies, practices or training programs in each of their agencies and their next steps in the process of initiating that change. Then facilitate a large group discussion on this topic. (*10 minutes*)

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested that you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]West Virginia Code, Chapter 61, Crimes and their Punishment, Article 8B, Sexual Offenses (WVC§61-8B), http://www.legis.state.wv.us/WVCODE/Code.cfm?chap=61&art=8B#08B.

[4]Adapted from Wikipedia (web-based encyclopedia), http://en.wikipedia.org/wiki/Statute_of_limitations.

[5]Adapted from U.S. Department of Justice, *A national protocol for sexual assault medical forensic examinations (adults/adolescents)* (Washington, D.C., 2004), 45, footnote 84, http://www.ncjrs.gov/pdffiles1/ovw/213827.pdf.

[6]Adapted from U.S. Department of Justice, 89.

[7]Rape Abuse and Incest National Network, *Mandatory reporting database* (updated December 2008), http://www.rainn.org/public-policy/legal-resources/mandatory-reporting-database. This link takes you to two West Virginia charts: one for children and one for persons who are elderly/have disabilities.

Sexual Harassment

This module offers basic information on sexual harassment and options in West Virginia for reporting and protection. *Unless the user of this information is an attorney, the information should not be used to provide legal advice.*

Key Points

- Because sexual harassment often involves the misuse of authority for sexual favors by persons in positions of power, persons with certain types of disabilities may be at an increased risk for victimization.
- The two forms of sexual harassment are quid pro quo and hostile environment. In quid pro quo, employment or educational decisions are made on the condition that a person accepts unwelcome sexual behavior. A hostile environment is characterized by pervasive sex-related verbal or physical conduct that is unwelcome or offensive, and has the purpose or effect of unreasonably interfering with work or school performance.
- Sexual harassment is a civil rights violation of federal and state discrimination laws in qualifying settings. Federal laws apply to work sites—local, state and federal government offices, businesses with 15 or more employees, employment agencies and labor organizations—as well as to school and college settings. State law addresses work settings—governmental offices (state and political subdivisions of the state) and businesses with 12 or more employees for more than 20 calendar weeks in the year in which the act took place (excluding private clubs).
- To report sexual harassment, victims should follow the workplace/school complaint policy, reporting the behavior to the proper authority using the site's written procedures.[1] If the harassment continues after a reasonable amount of time following a report, victims may have the right to file a formal complaint with the WV Human Rights Commission (for qualifying workplaces/schools); the State of WV Equal Employment Opportunity Office (for state employees); the U.S. Equal Employment Opportunity Commission (for qualifying workplaces); *or* the Office of Civil Rights, U.S. Department of Education (for schools/colleges receiving federal financial assistance).
- Victims of sexual harassment need support. Encourage them to talk about the harassment with someone they trust. Let them know that you believe them and that the harassment is not their fault. Help them consider their options and identify resources available to stop the harassment and address adverse effects of the harassment on their lives.
- Become familiar with your agency's policies related to sexual harassment of employees and of clients by agency staff. Also, find out if there are agency protocols to assist clients who disclose/request help to deal with sexual harassment.

B4. Sexual Harassment

Purpose

Most professionals know that sexual harassment can occur in the workplace and are aware of their agency's policy for addressing it. However, providers who serve individuals with disabilities may not have considered that sexual harassment is actually a form of sexual violence and their clients may be experiencing it at school or work. While

sexual harassment typically does not result in physical injuries to victims, the emotional trauma that victims may experience from it can leave them unable to adequately function in their daily lives. (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

Because sexual harassment often involves the misuse of authority for sexual favors by persons in positions of power, individuals with disabilities who depend on others for care and assistance may be at considerable risk for this type of victimization. Like many sexual harassment victims, they may not know their options for reporting and protection. To that end, this module provides basic information on sexual harassment and options in West Virginia for reporting and protection. *NOTE: Unless the user of this module is an attorney, the information should not be used to provide legal advice.*

Objectives

Those completing this module will be able to:

- Define sexual harassment;
- Identify forms of sexual harassment;
- Discuss victim reactions to sexual harassment and ways to support victims; and
- Identify resources and criteria for reporting sexual harassment.

Preparation

Participants should review their agency's policies on sexual harassment as well as staff procedures on how to assist clients who disclose sexual harassment.

Part 1: CORE KNOWLEDGE

What is sexual harassment?

Sexual harassment includes unwelcome sexual advances, conduct of a sexual nature, and requests for sexual favors. It must explicitly or implicitly affect a person's employment, unreasonably interfere with work or school performance or create an intimidating, hostile or offensive work or school environment.[2]

Sexual harassment can be *verbal* (e.g., making sexually degrading jokes or sending unwanted sexually harassing e-mails and text messages); *physical* (e.g., standing in someone's way or too close in order to sexually intimidate them); or *non-verbal* (e.g., displaying sexually explicit pictures or making sexual gestures). It can include offering academic benefits or employment advancement in exchange for sexual favors or making threats after a negative response to sexual advances.[3]

Under West Virginia law (*WVC§5-11. Legislative Rule Title 77*), sexual harassment is not necessarily confined to unwanted sexual conduct. Hostile or physically aggressive behavior may also constitute sexual harassment, if it is based on gender.

FYI **What is the difference between sexual harassment and flirting?** The determining factor is the impact it has on the victim. Flirting is enjoyable to both people. If the behavior is sexual in nature, is unwelcome and made one person feel uncomfortable or unsafe, then it is sexual harassment.[4]

What are the two basic forms of sexual harassment?

1. **Quid pro quo (this for that):** In this form of sexual harassment, employment or educational decisions are made on the condition that a person accepts unwelcome sexual behavior. This behavior only needs to happen one time to be sexual harassment.

2. **Hostile environment:** This form of sexual harassment is characterized by pervasive (persistent or all encompassing), sex-related verbal or physical conduct that is unwelcome or offensive, and has the purpose or effect of unreasonably interfering with work or school performance. In order for this conduct to be considered sexual harassment, the hostile environment must be extreme or "sustained and non-trivial."[5]

What are common reactions to being sexually harassed?

Sexual harassment can impact victims in different ways. For example, it may cause victims to feel powerless, angry, anxious, depressed and less self-confident. Victims may blame themselves for the harassment. They may attempt to deny the harassment is occurring. It may cause them to feel isolated, especially if their family and friends don't understand what is happening or try to minimize the harassing behavior. It may affect victims' physical and mental well being (e.g., they may fear the harasser will harm them or they may develop health problems due to related stress).

At school, sexual harassment can lead to an inability to concentrate, lower grades, withdrawal from classes, changing majors, absenteeism and dropping out of school. In the workplace, sexual harassment can lead to decreased productivity, denial of advancement and/or benefits and loss of income or job.[6] (For more on victims' reactions to sexual violence, see *Sexual Violence 101. Indicators of Sexual Violence* and *Sexual Violence 101. Crisis Intervention*.)

What are ways to support victims of sexual harassment?

Encourage victims to talk about the sexual harassment, even if they are uncertain about how to describe what is happening to them. Let them know that you believe them and that the sexual harassment is not their fault. Stress that it is important not to suffer the harassment in silence. Silence protects the harasser and will not end the harassment. Offer to help them consider their options and available resources, plan steps they can take to get help to stop the sexual harassment, create a safety plan, and develop coping skills for any adverse emotional effects of the harassment. If they have a disability, offer to assist them in identifying services that can accommodate their needs. (See *Disabilities 101. Accommodating Persons with Disabilities*.) Tell them you are there for them if and when they need to talk again. Keep what you discuss with them confidential, unless victims indicate you should do otherwise. (See *Sexual Violence 101. Crisis Intervention*.)

If employees or students witness fellow employees or students being sexually harassed, their willingness to provide documentation of what they observed could be useful if the victims decide to report. Similarly, victims may be more likely to report if other colleagues or students who have been sexually harassed by the same harasser come forward and disclose their experiences. Help victims understand that for these individuals, providing support involves personal risk (e.g., the harasser, school or employer may attack their credibility). Encourage victims to respect the decisions of others regarding their willingness to take those risks.

FYI There are no mandatory reporting requirements for sexual harassment in West Virginia. However, certain professionals[7] are required to report to the West

Sexual harassment is never the victim's fault.

Victims do not have to be of the opposite sex of their harassers.

Victims can include those being harassed as well as anyone affected by the offensive conduct.

Sexual harassment is, unfortunately, very common. For example, the American Association of University Women Education Foundation reported that nearly two-thirds of college students experience sexual harassment at some point during college (Drawing the Line: Sexual Harassment on Campus, 2006) and that 80 percent of students in grades 8-11 said they experienced sexual harassment in school (Hostile Hallway, 2001). In 2008, the U.S. Equal Employment Opportunity Commission (EEOC) received 13,867 charges of sexual harassment in work settings.

See the American Association of University Women's website, http://www.aauw.org, research section, to access the two above- mentioned publications.

This sidebar was drawn from FRIS, Sexual Harassment, http://www.fris.org, and EEOC, Sexual Harassment, http://www.eeoc.gov/types/sexual_harassment.html.

Virginia Department of Health and Human Resources (DHHR) sexual harassment that involves sexual abuse or sexual assault of children or of adults "who by reason of physical, mental or other infirmity are unable to independently carry on the daily activities of life necessary to sustaining life and reasonable health."[8] Call your local DHHR or the state 24-hour reporting hotline at 800-352-6513 for more information. (See *Sexual Violence 101. Mandatory Reporting*.)

For victims of sexual harassment, what laws apply?

Sexual harassment is considered a civil rights violation of federal and state discrimination laws in qualifying settings.[9] Different laws apply to different settings and not all settings are covered.

Title VII of the Civil Rights Act of 1964. This act categorizes sexual harassment as a form of sex discrimination. It applies only in the following settings:

- Government offices (local, state and federal);
- Businesses with 15 or more employees;
- Employment agencies; and
- Labor organizations.

WVC§5-11. Legislative Rule Title 77. This state law offers protection from sexual harassment only in the following work settings:

- Government offices (state and any political subdivision of the state); and
- Businesses with 12 or more employees for more than 20 calendar weeks in the year in which the act took place (excluding private clubs).

Title IX of the Education Amendment of 1972. This amendment prohibits sexual harassment only in the following settings:

- Schools; and
- Colleges.

What can victims do if they are sexually harassed?

Victims can include not only those persons being harassed, but also anyone affected by the offensive conduct. It is important to stress that victims are not responsible for the harassing behaviors. They can document and report the behaviors but cannot be held responsible for stopping them. In response to sexual harassment, victims should:[10]

- **Inform their harassers directly that the conduct is unwelcome and must stop.** Often the harassment is done to assert power and induce fear. However, it is not always safe for victims to confront their harassers, for reasons of physical safety, concerns for losing their jobs or for retaliation in a school setting. Victims do not have to inform their harassers that their behavior is unwelcome in order to file a complaint of sexual harassment, if doing so may jeopardize their physical safety, emotional well-being or work/school success.

- **Document the harassing behavior.** Write down specifically what was done or said and if there were other witnesses. In addition to documenting incidences of sexual harassment, also keep notes about negative actions that result from the harassment (e.g., a demotion) and about work/school performance (e.g., evaluations that attest to the quality of their work).[11] Keep a copy of any written communications sent to/from the harasser. Tell someone in authority about the harassment.
- **Become familiar with the school/workplace sexual harassment policies and grievance/complaint procedures,** as well as state and federal resources for filing a complaint.
- **Formally report the harassment to authorities at the workplace/school and, if necessary and applicable, file a complaint with a state or federal entity** (see below).

What are the steps to report sexual harassment?

1. **Victims should follow the workplace/school complaint policy,** reporting the behavior to the proper authority using the site's written procedures. Policies may require that a report be made within a specific time period after the sexual harassment occurred.

   Keep in mind that while all schools are required to have sexual harassment policies, not all employers qualify or can be held accountable under discrimination laws. For those qualifying sites, *both harassers and those in authority* can be held liable when they have knowledge of the harassment and do not take action to stop it.

2. **If the sexual harassment continues after a reasonable amount of time following a report to school/workplace authorities,** victims may have the right to file a formal complaint with one of the state or federal entities listed below. School/workplace policies may or may not indicate what constitutes "a reasonable amount of time."

Where can a complaint be filed?

Where a complaint is filed depends on where the sexual harassment occurred:

West Virginia Human Rights Commission (for qualifying workplaces and schools): 304-558-2616 or 888-676-5546, http://www.wvf.state.wv.us/wvhrc/.
State of West Virginia Equal Employment Opportunity Office (for state employees): 304-558-0400, http://www.eeo.wv.gov.
U.S. Equal Employment Opportunity Commission (EEOC) (for qualifying workplaces): 800-669-4000 or 800-669-6820 (TTY), http://www.eeoc.gov/.
U.S. Department of Education, Office of Civil Rights (for schools and colleges that receive federal financial assistance): 800-421-3481, http://www2.ed.gov/about/offices/list/ocr/index.html.

How do victims file a complaint?

A report of sexual harassment should first be made following the school/workplace reporting policy, as noted above. Subsequently, a complaint should initially be filed with only one entity so an investigative process can begin. A formal complaint is initiated by filing a complaint form provided by one of the entities listed previously. An attorney is not needed to file a complaint.

FYI Victims of sexual harassment may be unclear whether they can file a complaint or with which entity to file a complaint. The West Virginia Human Rights Commission can assist them in determining if and where a

complaint should be filed. For more information on how to file a complaint that falls under a federal jurisdiction, victims can contact the Equal Employment Opportunity (EEO) office at the federal agency where the act occurred.

In some situations, reporting options may be limited. If a business has less than 15 employees and is not a government office, employment agency or labor organization, federal law related to sexual harassment does not apply, but state law may apply. If a business has less than 12 employees and is not a state government office, neither federal nor state law applies. Even if federal and state laws do not apply, a business may have its own sexual harassment policy and related grievance procedures that could be followed. If the sexual harassment includes acts considered unlawful in West Virginia, such as stalking or harassment, it can be reported to law enforcement.

When can a complaint be filed?

Complaints filed with the EEOC must be within 300 days from the date of the sexual harassment.[12] Qualifying complaints filed with the West Virginia Human Rights Commission must be within 365 days.[13] Complaints filed with the U.S. Department of Education, Office of Civil Rights, must be within 180 days.[14]

What happens after the complaint is filed?

The complaint processes for both sexual harassment in the workplace and in schools are similar for when a complaint is filed. First, the employer or school responds to the complaint.

An investigation is conducted where relevant information is gathered in a "discovery" process. The intent of the investigation is to determine if there is reasonable cause to believe sexual harassment occurred. If there is reasonable cause, mediation may be made available to reach a settlement. If a settlement is not reached, the case can go to a civil trial. After the case is presented, the judge makes a ruling. If the judge rules in favor of the victim, various remedies can be ordered.[15] One common remedy is monetary compensation.

While an attorney is not needed to file a complaint of sexual harassment, some victims choose to consult with an attorney to help them through the legal process and/or to file a private civil lawsuit. If victims express an interest in the use of a private attorney, help them identify available resources. The state and federal agencies that handle these complaints, as well as local courts, legal aid agencies and victim advocacy programs, may maintain lists of attorneys who could be of assistance. Another source might be the lawyer referral services operated by state and local bar associations.[16, 17]

Is sexual harassment described in the following scenarios?
If yes, identify which type and what recourses are available.

1. *Emily is a 19-year-old college freshman who is deaf. She is struggling with her introductory algebra course. The professor tells her that if she will babysit his kids this weekend, he'll give her a passing grade.*

   No, this scenario is not sexual harassment. Nothing of a sexual nature was involved.

2. *Emily's English professor tells her that if she will go out on a date with him Friday night, he can make sure that she knows the essay questions for the final.*

   Yes, this scenario describes quid pro quo sexual harassment. If Emily does a favor that is sexual in nature (going on a date), her professor will give her the test questions. Emily is protected under Title IX of the Education Amendment of 1972 because the incident took place in an educational setting that is required to have a sexual harassment policy. She should report the behavior according to school policy. If she is not satisfied with the school's response, she could then file a complaint with the U.S. Department of Education.

Is Emily's deafness a factor in the sexual harassment? It could be, if the professor thinks her disability makes her an easy target for his sexual advances. If Emily also had a cognitive disability, she might be confused or flattered by the professor's request rather than offended. The professor might try to take advantage of Emily's disability to obtain sexual favors from her.

3. *Jennifer is the only female in an office with a staff of fourteen. Sometimes at lunch her co-worker, Joe, makes sexist jokes which Jennifer finds degrading, offensive and embarrassing.*

   This scenario possibly describes sexual harassment. Joe's behavior could be creating a hostile environment. There are several factors in determining whether or not his behavior is sexual harassment. The behavior must be pervasive—meaning that it must be "sustained and non-trivial" or extreme in nature. It also has to unreasonably interfere with her work performance. Not all behavior that is sexist, rude and annoying meets the standard of sexual harassment. However, when it does meet that standard, Jennifer or any of the employees has the right to complain. Jennifer could confront the harasser and/or talk with her supervisor.

4. *Joe forwards e-mails on the staff listserv with degrading jokes about women. Jennifer, who is the only female on staff, has told him to stop, but he just laughs at her, saying she can't take a joke. He has sent one or two of these e-mails every day for at least the past 6 months. She can't tell from the subject line which messages are jokes and which she needs to open. It is disrupting her work.*

   Yes, this scenario describes sexual harassment. Joe is clearly creating a hostile environment, knowing that this behavior is offensive and he's doing it repeatedly. It is interfering with Jennifer's work. She should follow her agency's policies for reporting sexual harassment. Her additional recourses are dependent upon the number of employees in her agency and the type of agency. If her work site qualifies under Title VII of the Civil Rights Act, she could file a complaint with the U.S. Equal Employment Opportunity Commission if she is not satisfied with her employer's response to her report. If her employer does not qualify under Title VII, she could file a complaint with the West Virginia Human Rights Commission.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question

1. What is sexual harassment? *See page B4.2.*
2. What are the two forms of sexual harassment and how are they different? *See pages B4.2–B4.3.*
3. What are common reactions to sexual harassment? How can you support victims of sexual harassment? *See page B4.3.*
4. What laws apply to sexual harassment? In what settings do these laws apply? *See page B4.4.*
5. What are the first steps that victims can take if they are being sexually harassed? *See pages B4.4–B4.5.*
6. How do victims initially report sexual harassment? What if the harassment does not stop after they have reported? *See page B4.5.*
7. With which agencies can victims file a formal sexual harassment complaint? What happens after a complaint is filed? *See page B4.5.*

Part 2: DISCUSSION

Projected Time
2.75 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their collaborative work with victims of sexual harassment. The discussion could be incorporated into forums such as agency staff meetings, orientations and continuing education programs, as well as multi-agency meetings or trainings. Anticipated discussion outcomes include increased understanding of barriers and challenges experienced by victims of sexual harassment, greater knowledge about sexual harassment and the resources available to assist victims; and greater comfort and competency in interacting with and assisting victims who are dealing with this form of sexual violence.

Refer to the learning objectives at the beginning of this module for specific outcomes.

Preparation

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator for the discussion. The facilitator should have knowledge about sexual harassment and related federal and state laws.
- Participants and the facilitator should review P*art 1: Core Knowledge* of this module before the discussion.
- Request that participants bring copies of their agencies' written policies on sexual harassment, as well as staff procedures on how to assist clients who disclose sexual harassment.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, blank attendance sheet, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify/review discussion ground rules to promote open communication.** Utilize the following principles: (*10 minutes*)

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2. **Ask a representative from each agency to summarize the written policies on sexual harassment at their workplace.** Do the policies include only sexual harassment of employees, or does it also have a process for addressing sexual harassment of clients by agency staff? *(15 minutes)*
3. **Facilitate a group discussion.** *(15 minutes)*

a. How often does your agency have clients who disclose sexual harassment (frequently, occasionally, rarely or never)? Does your staff receive training on working with victims of sexual harassment?

b. If your agency rarely or never receives these disclosures, consider why (noting sexual harassment is a fairly common occurrence). Consider the barriers for your clients in reporting sexual harassment (e.g., they don't label what they are experiencing as sexual harassment, they don't know help is available or where to go to get assistance, they don't view your agency as one that can provide guidance on this topic, or they fear the ramifications of disclosing).

c. What would help your staff/co-workers be better positioned to help clients label what they are experiencing as sexual harassment and what support can you provide if clients do disclose?

d. What local resources might be helpful to a person who discloses to you they are being sexually harassed?

4. **Ask participants to review the following scenarios and consider the questions that follow.** (These are the same scenarios in *Part 1: Core Knowledge*.)[18] (*45 minutes*)

Scenario 1

Emily's English professor tells her that if she will go out on a date with him Friday night, he can make sure that she knows the essay questions for the final. Emily is a 19-year-old freshman who is deaf. She is struggling to maintain a passing grade in this course.

Scenario 2

Jennifer is the only female in the office. Sometimes at lunch her co-worker, Joe, makes sexist jokes which Jennifer finds degrading, offensive and embarrassing.

Scenario 3

Joe forwards e-mails on the staff listserv with degrading jokes about women. Jennifer, who is the only female on staff, has told him to stop, but he just laughs at her, saying she can't take a joke. He sends one or two of these e-mails every day. She can't tell from the subject line which messages are jokes and which ones she needs to open. It is disrupting her work.

a. For each scenario above, which type of sexual harassment is described and what recourses are available? (Answers are available in *Part I: Core Knowledge*).

b. Describe how you think Emily and Jennifer might react to the sexual harassment they are experiencing. How could it impact their daily lives?

c. What support could your agency provide for the victims?

d. Do you think these types of scenarios occur often? If so, what are possible contributing factors in our culture?

e. Do you think these types of scenarios occur often to persons with disabilities? If so, what do you think could make this population targeted by harassers?

f. In Jennifer's situation where remarks are made at lunch, what could bystanders (e.g., others who may also be in the lunchroom) do to provide support to Jennifer? What could they be doing that intentionally or unintentionally provides support to Joe?

g. What are ways your agencies might raise the awareness of your client population about what sexual harassment is and what to do if they experience this form of harassment?

h. Is there any additional information that you think would be useful to know in each case, in order to assess the situation and provide support?

5. In the above scenarios, the victims felt uncomfortable about the behavior. For some victims with disabilities, the behavior may cause a variety of feelings and confusion. **Consider the following scenario and questions:** (*30 minutes*)

Lydia is a 32-year-old woman with a moderate developmental disability. She works as the receptionist at the local library. Her supervisor, Fred, repeatedly tells Lydia that she is a beautiful woman. Sometimes she purposely misses the bus so she can ask Fred for a ride home. Fred is married and knows that Lydia has a crush on him. When she asks him for a ride, he tells her that if she shows him her breasts, he'll drive her home. Lydia is flattered by the attention and feels that showing her breasts is a quick and easy way to get a ride home with Fred.

a. Is Lydia being sexually harassed?

b. Is there a difference if Lydia's employer has eight (8) employees versus 25?

c. Is there a difference if Lydia had a mild developmental disability? A severe one?

d. What if Fred asked Lydia to show him her breasts in exchange for an extra half-hour break for lunch? Would his behavior be considered sexual harassment?

e. In each of the scenarios presented, what are Lydia's alternatives?

f. Is Lydia vulnerable to increased offending behaviors by Fred? Why or why not?

Discuss how the type and severity of a developmental disability could impact a victim's ability to accurately interpret the intent of the behavior.

6. **Facilitate a group discussion.**[19] (*30 minutes*)

a. Sexual harassment is a continuum of behaviors that can range from sexual discrimination to sexual assault and sexual abuse. Sometimes assumptions about other people contribute to the harassing behavior. Discuss the following assumptions. For each assumption, consider if the gender, age and ability/disability of the persons involved could potentially impact behavior.

- All people welcome and feel flattered by attention of a sexual nature.
- Women sometimes say "no" to dates or sexual advances as a way of "playing hard to get."
- Almost everyone likes a good dirty joke once in a while.

b. Sexual harassment is a continuum of behaviors. How do you determine when a joke becomes a taunt; a look becomes a leer; a touch becomes a grope; and a tease becomes harassment?

c. When someone tries to minimize harassing behavior by comments such as "she just can't take a joke" or "I was really paying her a compliment," they are shifting the blame onto the victim. Discuss how publicizing the guidelines that follow to your client population and the community in general could impact behavior.

7. **Closing.** Ask each participant to write down how the information gained from this module discussion will:

- Change the way they interact with individual clients;
- Change the way they partner with other agencies to assist clients: and

- Promote change in their agency's policies, practices or training programs.

Then facilitate a large group discussion on this topic. (*10 minutes*)

Guidelines To Determine If Your Behavior Or Comments Are Harassing

- Would I want my actions or comments printed in the newspaper or shown on TV?
- Is there equal power between me and the person with whom I'm interacting?
- Would I behave the same way if my employer or significant others (e.g., wife, husband, partner, children, mother, etc.) were standing next to me?
- Would I behave this way if their significant others were with them?
- Would I want someone else to act this way toward a person with whom I'm in a relationship?
- Is there equal initiation and participation between me and the person with whom I'm interacting?

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]U.S. Equal Employment Opportunity Commission (EEOC), Sexual harassment, http://archive.eeoc.gov/types/sexual_harassment.html. Note that online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]West Virginia Foundation for Rape Information and Services (FRIS), *Sexual harassment*, http://www.fris.org/.

[4]FRIS, *Sexual harassment brochure*, http://www.fris.org/.

[5]FRIS, Sexual harassment.

[6]Section drawn from FRIS, *Sexual harassment,* and Sexual Harassment Support, *Effect of sexual harassment/what is sexual harassment and why is it so difficult to confront*, http://www.sexualharassmentsupport.org/.

[7]Health care and social services personnel, emergency medical service personnel, religious and school personnel, child care/foster care workers, law enforcement officials and personnel of nursing home or other residential facilities.

[8]Rape Abuse and Incest National Network (RAINN), *Mandatory reporting database* (updated December 2008), http://www.rainn.org/public-policy/legal-resources/mandatory-reporting-database. Link takes you to two WV charts: one for children and one for persons categorized as disabled/elderly.

[9]There is no state criminal law that applies specifically to sexual harassment. *The West Virginia State Code (WVC§61-2-9a.)* addresses stalking and harassment broadly, but does not specifically discuss sexual harassment.

[10]Section adapted from FRIS, Sexual harassment.

[11]Sexual Harassment Support.

[12]EEOC, *How to file a charge of employment discrimination*, http://www.eeoc.gov/types/.

[13]West Virginia Human Rights Commission, *Your guide to frequently asked questions in discrimination complaints*, 3, http://www.wvf.state.wv.us/wvhrc/.

[14]U.S. Department of Education, Office for Civil Rights, Sexual harassment: It's not academic (2008), 18, http://www.ed.gov/about/offices/list/ocr/sexharassresources.html.

[15]Information about the complaint process was drawn from Sexual Harassment Support, *Legal options for sexual harassment.*

[16]Paragraph partially drawn from U.S. Department of Justice, Employment Litigation Section, *Frequently asked questions* (updated 2008), http://www.usdoj.gov/crt/emp/.

[17]Some additional information on use of private attorneys is offered through Sexual Harassment Support, *What you can do if you are being sexually harassed.*

[18]Part of discussion question 4 was drawn from material from Northern Arizona University, *Safe working and learning environment project orientation packet*, as well as the Mayo Medical Center, Mutual Respect and Sexual Harassment Education Program (1997).

[19]Discussion question 6 was drawn from material from Northern Arizona University and Mayo Medical Center.

Mandatory Reporting

This module is designed to develop service providers' understanding of West Virginia law regarding mandatory reporting of sexual violence against adults who are considered "incapacitated."

Key Points

- In West Virginia, designated persons are mandatory reporters of suspected abuse or neglect of adults who are incapacitated, or of emergency situations where adults who are incapacitated are at imminent risk of serious harm. These persons include: medical, dental and mental health professionals; Christian Science practitioners; religious healers; social service workers; law enforcement officers; humane officers; state or regional ombudsmen; and employees of nursing homes or other residential facilities.
- Abuse, neglect or an emergency situation involving an adult who is incapacitated should be reported to the local Department of Health and Human Resources (DHHR), Adult Protective Services (APS), *or* the 24-hour hotline provided for this purpose (800-352-6513). If you suspect a crime has been committed, contact the local law enforcement agency. If you are uncertain, you can contact law enforcement and they, in turn, may direct you to DHHR/APS.
- When you call DHHR to make a report, be prepared to provide (as it is available) the name, address and phone number of the alleged victim; name, address and phone number of the alleged perpetrator; your name, phone number and address (although anonymous reports are accepted); information on the physical, cognitive and emotional functioning of the victim and the perpetrator; and the reason for your concern.[1]
- The initial verbal report to DHHR should be followed within 48 hours with a written report. DHHR's *APS Mandatory Reporting Form* can be used for this purpose or your agency can use its own form. In addition, copies of the report are to be distributed by the reporter to various parties (law enforcement/prosecution, ombudsman program, OHFLAC, long-term care facility administration, and/or medical examiner/coroner), depending on the circumstances of the allegations.

B5. Mandatory Reporting

Purpose

It may not always be clear to service providers who work with individuals with disabilities if they are mandated by law to report sexual violence, which situations require a report, to whom they are required to report and how to go about reporting. This module is designed to develop service providers' knowledge of West Virginia law regarding mandatory reporting of sexual violence against adults who are considered incapacitated. For purposes of mandatory abuse reporting, an adult is considered "incapacitated" when s/he cannot independently conduct daily life sustaining activities due to a physical, mental or other infirmity.[2]

This module also encourages discussion on how to ensure that agency staff members have a full understanding of what the law mandates, including timelines for reporting, under what circumstances to report and the reporting procedures. (For supplemental information on this topic, see *Sexual Violence 101. Confidentiality* and *Disability 101. Guardianship and Conservatorship.*)

Given that the definition of "incapacitated adult" for mandatory reporting is very broad, including physical and mental infirmities, it is important to be very clear that this definition only applies under the mandatory reporting laws. The definition of "incapacitated adult" may be different, and more narrow, in other contexts.

Objectives

Those who complete this module will be able to:

- Discuss state mandated provisions for mandatory reporting and identify who are considered mandatory reporters of abuse, neglect or an emergency situation[3] involving individuals the state refers to as "incapacitated adults;"
- Determine if they are mandatory reporters and how to make a report;
- Understand the process for submitting their agency's West Virginia APS mandatory reporting form;
- Discuss policies and practices regarding mandatory reporting of different partnering agencies; and
- Discuss ethical issues related to mandatory reporting and the consequences of non-compliance for mandatory reporters.

Part 1: CORE KNOWLEDGE

What is a mandatory reporter?

For the purpose of this module, "mandated reporters" refers to professionals who, in the course of their work, are required to report or cause a report to be made whenever mistreatment of an adult who is incapacitated has been observed or is suspected, or if an adult who is incapacitated is at imminent risk of serious harm.[4]

Mandated reporters are designated by law to help protect persons who may not be able to protect themselves. Mandated reporting is a complicated issue, since all professionals are not well trained on this issue. *First and foremost, you need to talk with your supervisor and determine if you are a mandated reporter under West Virginia law.*

What state laws relate to mandatory reporting of incidents of sexual violence involving adult victims who are incapacitated?[5]

In addition to the general provisions related to the reporting of abuse, neglect or an emergency situation involving an adult who is incapacitated, the *West Virginia Code (WVC§9-6-9)* also identifies various individuals who are mandatory reporters.[6] If any of these individuals believe, suspect or know that an adult who is incapacitated is being subjected to, or has the potential to be subjected to abuse, neglect or an emergency situation, they **must** immediately report the circumstances to the local DHHR. **The following are identified as mandatory reporters**:

- Medical, dental and mental health professionals;
- Religious healers and Christian Science practitioners;[7]
- Social service workers, including those employed by the DHHR;
- Law enforcement officers;
- Humane officers;[8]

- State or regional ombudsmen;[9] or
- Any employee of a nursing home or other residential facility.

These requirements apply without regard to where victims reside (e.g., their own home, home of another individual or an institutional/facility setting). As stated in *WVC§9-6-14*, failure to make such a report can be punishable by a fine of up to $100 or imprisonment of up to 10 days. Note also that reporters are provided with immunity from civil or criminal liability if the suspected sexual assault/abuse is unsubstantiated.[10]

FYI **Sexual violence victims, as well as their families and caregivers, may be reluctant to report.** Keep in mind that the safety of victims is your primary responsibility and the reason you are required to report. It is good practice to explain your reporting requirements to victims during your initial interactions with them so they fully understand their options for assistance as well as possible unintended repercussions that could result from reporting.[11] To the extent possible, help address any concerns they may have about reporting (e.g., fear of placement in an assisted living facility).

FYI This module focuses on adults with disabilities who are incapacitated. As detailed in the next section, the reporting process for adult victims differs from cases of suspected or observed mistreatment of a *minor*, for which mandatory reporters in West Virginia (according to *WVC §49-6A-2*) include: medical, dental or mental health professionals, religious healers and members of the clergy, Christian Science practitioners, social service workers, school teachers and other school personnel, child care or foster care workers, humane officers, emergency medical services personnel, peace officers or law enforcement officials, circuit court and family court judges, employees of the Division of Juvenile Services and magistrates.[12] The 24-hour hotline number to report child abuse and neglect is the same as the hotline for reporting adult abuse and neglect (800-352-6513).

What are the procedures for making a mandated report?

Reports of abuse or neglect involving an adult who is incapacitated should be made directly to the local DHHR/APS[13] or the 24-hour hotline that is provided for this purpose—800-352-6513 (use the hotline especially after regular business hours).

FYI **If you are a mandated reporter and suspect abuse or neglect of an adult who is incapacitated, you are required to report to your local DHHR/APS or the state DHHR hotline. If you suspect a crime has occurred, call the local law enforcement agency.** If you are not certain of which agency to involve, you can always call law enforcement first. They, in turn, may direct you to DHHR/APS.

FYI **Your obligation to report only needs to be based on a suspicion of mistreatment.** Your suspicion may be based on a disclosure by a victim or your observations of a pattern of indicators associated with mistreatment (e.g., physical signs of a sexual assault, sudden changes in behavior, emotional distress, etc.). It is not your role to verify that mistreatment is occurring or has occurred. If you question whether a report should be made, discuss the circumstances of the case with your supervisor. You can also call DHHR or law enforcement and, without giving the identifying information on the case, describe the situation and ask if it warrants a report. (*See Sexual Violence 101. Indicators of Sexual Violence.*)

When you call DHHR to make a report, you will be asked to provide the following information (to the extent that it is available):

- Name, address and phone number of the victim;
- Identifying information of the victim such as: date of birth, social security number, age and ethnicity;

- Name, address and phone number of the alleged perpetrator;
- Identifying information of the alleged perpetrator, including the nature of the relationship between the victim and the perpetrator;
- Your name, phone number and address (West Virginia permits anonymous reporting; however, it is helpful if the agency receiving the report has your contact information in case additional information is needed);
- Information, if applicable, on the physical, cognitive and emotional functioning of the victim and the perpetrator; and
- The reason for your concern (e.g., type of sexual violence and injuries incurred).

If you do not know the answer to a question, say so. Do not guess.

Do mandatory reporters have any other obligations beyond making a verbal report to DHHR?

Individuals who are mandated to report suspected or known cases of abuse, neglect or emergency situations must follow their initial verbal report to DHHR with a written report. This written report must be submitted to the local DHHR within *48 hours* following the verbal report. Each agency should have a form for reporting to DHHR. A sample *APS Mandatory Reporting Form*, created by DHHR, can be used (a copy of this form can be found at the end of this module).

In addition to the submission of this report to DHHR, the reporter is to distribute copies to various parties, depending on the circumstances of the allegations:

- If the victim is a resident of a nursing home or other residential facility, submit a report to a state/regional ombudsman,[14] the Office of Health Facility Licensure and Certification (OHFLAC)[15] and the facility administrator;
- In the case of the death of the victim, submit a report to the local medical examiner or coroner;
- If abuse or neglect is believed to have been a contributing factor to the death, also submit the report to law enforcement; and
- In the case of a violent crime, sexual assault, domestic violence, murder, etc., submit a report to law enforcement and the prosecuting attorney.

FYI Beyond sharing copies with the above parties as appropriate given the circumstances of the allegation, DHHR reports of abuse, neglect or emergency situations involving an adult who is incapacitated are confidential (including the identity of the reporter) and are not to be released unless court ordered.[16] If the referent later seeks status information about the case, DHHR can only inform the referent that it "is taking appropriate action." DHHR cannot tell the referent whether an investigation has been initiated or is underway.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. How does West Virginia law define an adult who is incapacitated? *See page B5.1.*
2. Who does West Virginia law identify as mandatory reporters? *See pages B5.2–B5.3.*
3. What agency takes reports of suspected abuse, neglect or emergency situations involving adults who are incapacitated? What is the 24-hour hotline number provided for this purpose? *See page B5.3.*

4. What information is needed to make a report? *See pages B5.3–B5.4.*

5. What obligations do reporters have once a verbal report is filed? *See page B5.4.*

Part 2: DISCUSSION

Projected Time for Discussion
1.25 hours

Purpose and Outcomes

This discussion is designed to help participants apply information presented in *Part 1: Core Knowledge* of this module to their collaborative work with sexual violence victims. The discussion could be incorporated into forums such as agency staff meetings, orientations and continuing education programs, as well as multi-agency meetings or trainings. Anticipated discussion outcomes include an increased understanding of mandatory reporting and related practices and processes in your community.

Refer to the learning objectives at the beginning of this module for specific outcomes for this module.

Planning

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator. The facilitator should be familiar with mandatory reporting laws related to the sexual assault and sexual abuse of incapacitated adults.
- Select a note taker.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion, as well as the copy of the *APS Mandatory Reporting Form* at the end of the module.
- Each participant should bring to the meeting:
  - A copy of their agency's policy/philosophy regarding mandatory reporting or information describing how the agency promotes compliance with this law, and their agency's APS mandatory reporting form (if different from the one developed by DHHR).
  - A copy of any training materials the agency uses to educate staff on mandatory reporting laws, protocols and policies.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, blank attendance sheet, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: (*10 minutes*)

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.

- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2. **Ask a representative from each partnering agency to share the policies, reporting forms and training materials** they brought to the meeting and summarize their contents. (*10 minutes*)

3. **As a large group, discuss the following questions:** (*45 minutes*)

a. Why is there a need for mandatory reporting?

b. Who are mandatory reporters in West Virginia? Do you identify yourself as a mandatory reporter? What are you mandated to report? What discomfort do you feel, if any, associated with being a mandatory reporter?

c. Do procedures for reporting suspected abuse or neglect of an adult who is incapacitated differ across agencies? If yes, how?

d. What are the timelines for reporting?

e. How can agencies insure that all staff members and volunteers are responding appropriately to reporting mandates?

f. What strengths and weaknesses exist in the current service delivery systems regarding mandatory reporting that may affect victims of sexual violence?

g. What are the some of the ethical issues surrounding mandatory reporting? What are the potential implications or unintended consequences for reporting suspected incidences of sexual violence?

h. What policy and/or practice changes can be made within each partnering agency to maximize compliance with this law? What specific steps need to be taken to facilitate those changes?

4. **Closing.** Ask each participant to write down how the information gained from this module discussion will:

- Change the way they interact with individual clients;
- Change the way they partner with other agencies to assist clients; and
- Promote change in their agency's policies, practices or training programs.

Then facilitate a large group discussion on this topic. (10 minutes)

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West Virginia Department of Health and Human Resources
Adult Protective Services Mandatory Reporting Form

*(Use this form to report abuse, neglect **or** situations that present an immediate risk of serious injury or death - **press firmly**)*

!!(Reporter information is confidential and must be handled accordingly by all recipients of this report)!!

Reporter Information:

Name: _____ (Preferred) _____ Date this report completed: _____

Address: _____ Telephone #: _____

Title/Relationship to Victim: _____

Are you a Mandatory Reporter? Yes_____ No_____

Alleged Victim Information: ***(Information about person who is being abused/neglected)***

Name: _____ Age/Date of Birth: _____

Address: _____

Current Location & Directions: _____

Facility Name: _____ Type of Facility: _____

_____ Describe physical/cognitive/emotional functioning of the alleged victim: _____

Substitute Decision. Maker (Type, Name and Address): _____

Alleged Perpetrator Information: ***(Information about person who is doing the abusing/neglecting of the adult)***

Name: _____ Title/Relationship to Victim: _____

Address: _____ Telephone #: _____

Describe action(s) taken to prevent further abuse/neglect: _____

☐ (Mark if additional pages attached)

Allegations: ***(Information about the incident of abuse, neglect, etc.)***

Date of Incident: _____ Time of Incident: _____

Where incident occurred: _____

Describe Incident/Injuries: _____

☐ (Mark if additional pages attached)

Was treatment outside facility required? Yes _____ No _____ If yes, provider of treatment: _____

Why is the adult unable to protect her/himself? _____

How long has the problem existed? _____

Is anyone else aware of the incident? If yes, list the name(s) & relationship to alleged victim: _____

Are there witnesses to the incident? If yes, list the name(s) & relationship to alleged victim: _____

Additional Comments:

A copy of this report must be filed with the following parties by the person completing the form (within 48 hours).
1. Original to: Adult Protective Services Unit - local Department of Health and Human Resources 2. Copy to:
☐ Office of Health Facilities Licensure & Certification (if alleged victim is resident of a nursing home or residential facility)
☐ State or regional Long-term Care Ombudsman (if alleged victim is resident of a nursing home or residential facility) ☐ Facility administrator (if alleged victim is resident of a nursing home or residential facility)** [see instructions on back]
☐ Local law enforcement agency (when applicable - e.g. violent crime, domestic violence, serious injury, death) ☐ Local prosecuting attorney (when applicable - e.g. violent crime, domestic violence, serious injury, death)
☐ Local coroner or medical examiner (in case of a death)

Instructions for Completing the WVDHHR APS Mandatory Reporting Form

This APS Mandatory Reporting Form was developed by the West Virginia Department of Health and Human Resources (DHHR) as a result of a change to the law during the 2000 session of the West Virginia Legislature. It is to be used by individuals identified as mandatory reporters for reporting Adult Protective Service (APS) situations to the local APS unit and certain other parties.

WHO/WHEN TO COMPLETE:
All individuals identified as *Mandatory Reporters* of abuse and neglect of incapacitated adults and residents of nursing homes or residential facilities are required to complete this form as part of the APS reporting process. Incidents of abuse/neglect must be reported immediately to the Adult Protective Service agency, DHHR. As follow-up to the immediate report, mandatory reporters are required to provide a written report to the local APS unit within 48 hours. This form will serve as the required written report. **Mandatory reporters include**: medical, dental or mental health professionals, Christian Science practitioners, religious healers, state & regional ombudsmen, social service workers, law enforcement officers, county humane officers and any employee of a nursing home or other residential facility.

Complete this report as thoroughly as possible. While anonymous reports will be accepted, the reporter is encouraged to provide information about herself/himself in the event additional information/follow-up is needed. If more space is required, additional pages may be attached. If so, mark the appropriate box to indicate that there is an attachment and on the attached page indicate the section of the form that is being continued. Finally, be sure to include a copy of the attachment with all copies distributed to various parties.

REQUIRED FILING:
The person completing this form is responsible for filing a copy of the completed form with all appropriate parties. The parties who are to receive a copy of the form are determined based on the circumstances of the allegation therefore, it is not necessary to send a copy to all parties in all cases. ****Note: West Virginia state law requires that this form be filed with the APS agency (DHHR) and other parties, including the facility administrator (when applicable), within 48 hours. *However*, state and federal reporting requirements for facilities that are certified to receive Medicare or Medicaid funds have not changed as a result of implementation of this form. Filing of this form *does not* replace other applicable reporting requirements.**

The original copy of the form is always to be forwarded to the APS unit of the local DHHR. Filing with other parties should be done according to the guidelines provided in the bottom section of the form (darkened portion). Indicate the party(s) to which a copy of the report has been forwarded by placing a mark in the appropriate box.

Reports that are to be filed with the Office of Health Facilities Licensure & Certification (OHFLAC) and the Long-term Care Ombudsman Program are to be mailed to the appropriate state entity. Reports that are to be filed with the Adult Protective Service agency (DHHR), law enforcement, prosecuting attorney, and coroner/medical examiner are to be sent to the appropriate local entity.

Effective Date:
Use of this form became effective on ***June 10, 2000.*** On and after June 10, 2000, this form is to be used for the purpose of filing the required written report with the Department of Health and Human Resources and other appropriate parties.

To request additional copies of this form:
Additional copies of this form may be obtained by submitting a written request to the appropriate local DHHR.

Note regarding this form: This form was undergoing revision by DHHR at the time this module was written. Therefore, several alterations were made to the 2000 version of the form that was included in the module to reflect the new changes, namely: the addition of "Mandatory" to the name of the form and the deletion of the mailing addresses for the agencies where written reports are to be sent (as these addresses may change in the updated version).

[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the term "victims" is primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]As per *WVC§9-6-9*. See http://www.legis.state.wv.us/WVCODE/Code.cfm for all code references. Note that this and all other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating the documents is doing a web search using titles.

[3]As per *WVC§9-5-9*, "emergency" or "emergency situation" means a situation or set of circumstances which presents a substantial and immediate risk of death or serious injury to an adult who is incapacitated.

[4]Adapted from Wikipedia, http://en.wikipedia.org/wiki/Mandatory_reporting.

[5]The following information on mandatory reporting was excerpted/drawn from the *West Virginia Department of Health and Human Resources Adult Protective Services Manual*.

[6]See WVC§9-6-9, http://www.legis.state.wv.us/WVCODE/Code.cfm.

[7]"Many states and territories include Christian Science practitioners or religious healers among professionals who are mandated to report suspected child maltreatment [and often mistreatment of vulnerable adults]. In most instances, they appear to be regarded as a type of health care provider."*Reporting laws: Clergy as mandated reporter (National Clearinghouse on Child Abuse and Neglect Information,* 2003), http://www.churchlawtoday.com/private/library/cltr/rrclergyreportinglaws.html. "Christian Science practitioners provide spiritual treatment through prayer that results in healing." "Treatment is based on the Bible, and the principles explained in Science and Health with Key to the Scriptures by Mary Baker Eddy. Central to this treatment is the idea of one, all-good God, who loves and cares for each of us." *Healing (Christian Science)*, http://christianscience.com/.

[8]*WVC§7-10-1*: In West Virginia, the sheriff of each county annually designates one of his or her deputies to act as humane officer of the county; or, if the county commission and sheriff agree, the county dog warden may be designated to act as the humane officer or as an additional humane officer. A humane officer investigates complaints of cruel or inhumane treatment of animals within his or her county and enforces the law relating to the prevention of cruelty to animals.

[9]An ombudsman is an advocate for residents of nursing homes, board and care homes, and assisted living facilities. Ombudsmen provide information about how to find a facility and what to do to get quality care. They are trained to resolve problems. The ombudsman can assist residents with complaints. However, unless the resident gives the ombudsman permission to share his/her concerns, these matters are kept confidential. Under the federal Older Americans Act, every state is required to have an ombudsman program that addresses complaints and advocates for improvements in the long-term care system. National Long-Term Care Ombudsmen Resource Center, http://www.ltcombudsman.org/.

[10]*WVC§9-6-12* (a): Any person who in good faith makes or causes to be made any report [of mistreatment of an incapacitated adult as defined by West Virginia law] permitted or required by this article shall be immune from any civil or criminal liability which might otherwise arise solely out of making such report.

[11]For example, there have been instances (1) where victims of domestic violence have lost custody of their children as an indirect result of reporting their victimization to law enforcement; and (2) where victims who are in the country illegally have been deported after a report of abuse. These practices are not typical and are even discouraged in many jurisdictions, but nonetheless, they have occurred.

[12]DHHR website on reporting child abuse and neglect, http://www.wvdhhr.org/bcf/children_adult/cps/report.asp. The list of mandatory reporters for minors is slightly different from that for adults who are incapacitated; each list reflects the helping professionals that typically might have contact with that population.

[13]Go to WV APS, http://www.wvdhhr.org/bcf/children_adult/aps/default.asp, for local DHHR contact information.

[14]Call 800-834-0598 to speak with a West Virginia ombudsman. Go to http://www.wvseniorservices.gov/ and click on "Staying Safe" for a description of the state administered long-term care ombudsman program and to access contact information for ombudsmen.

[15]Call OHFLAC at 304-558-0050. Go to http://www.wvdhhr.org/ohflac/ for more information about this DHHR-administered office.

[16]*WVC§9-6-8*: In addition to DHHR/state protective agencies, these confidentiality requirements are in place for state and regional long-term care ombudsmen, nursing home or facility administrators and OHFLAC.

Confidentiality

This module is designed to help service providers develop an understanding of confidentiality and release of information practices in their own and in partnering agencies. It also can assist them in identifying barriers that confidentiality issues can create for sexual violence victims with disabilities and ways to address those barriers.[1]

Key Points

- Maintaining confidentiality is a key to developing trust with victims of sexual violence.
- Information should not be released (except in cases requiring mandatory reporting) without a client's informed, written consent.
- Mandatory reporting situations require a breach of confidentiality in cases of abuse, neglect or emergency situations.
- Release of information forms should be time-limited and specific.
- Special conditions regarding release of information and informed consent exist for minors and some incapacitated adults with cognitive disabilities.[2]

B6. Confidentiality

Purpose

This module is designed to help service providers develop an understanding of confidentiality and release of information practices in their own and in partnering agencies. It also can assist them in identifying barriers that confidentiality issues can create for sexual violence victims with disabilities and ways to address those barriers.

Objectives

Those completing this module will be able to:

- Describe how confidentiality can impact services provided to victims of sexual violence;
- Define confidentiality versus privileged communication in working with sexual violence victims;
- Identify their agency's policies and practices regarding confidentiality, mandatory reporting and privileged communication;
- Discuss recommended policies for the release of information, including procedures when the victim is a minor or an adult who is incapacitated and not capable of consenting to the release;[3] and
- Understand confidentiality in the context of collaborative partnerships.

Part 1: CORE KNOWLEDGE What is confidentiality?

For the purposes of this module, maintaining client "confidentiality" means not sharing any identifying or personal information or any information shared with you/your agency unless there is a court mandate or the client has given informed consent to release the information. A confidential communication is one made with the expectation that it will not be widely repeated or shared or otherwise accessible to the general public.[4]

Victims of sexual violence are expected to share very personal, often traumatic information about their experiences in order to receive medical, emotional and legal support. It is critical for victims to be able to trust that the information shared will be kept in confidence as appropriate and allowable by law. To this end, not only do service providers need to consider how to best maintain client confidentiality with parties outside of their agencies, but they also should understand to what extent client information can and should be shared within their own agencies. For example, when a victim discloses a sexual assault to a service provider, what information does the provider's supervisor need in order to provide case supervision? What, if anything, do other staff members need to know about the victim (e.g., so that they can appropriately respond to her on the 24-hour hotline or accompany her to court)?[5]

Why is confidentiality important to victims of sexual assault?

Victims are often very reluctant to disclose that they have been sexually assaulted, to report the crime to law enforcement and to seek services because they fear the consequences of others finding out about the assault. They may fear, for example, that their family and friends will reject them and the community will blame them. They may be afraid that the offender and his family and friends will retaliate against them.

Given these concerns, it is imperative that service providers who interact with victims of sexual assault have policies in their agencies to protect the confidentiality of their communications with victims. It is also important that agencies publicize and are compliant with their confidentiality practices so that victims seeking their services know the extent of privacy they can expect.

FYI Obtain and review a copy of your agency's policies regarding confidentiality. Since, in most professions, it is unethical to breach client confidentiality, you must understand and follow the practices of your profession and your agency.

Are there confidentiality concerns for specific populations?

Two specific populations face additional confidentiality concerns: victims who are considered by state law to be incapacitated and victims living in rural communities.

Victims with disabilities who are incapacitated may have concerns in addition to the ones mentioned above, since the reporting of a sexual assault can have immediate repercussions that can impact all aspects of their lives. If the offender is the caregiver, for example, the intended consequence of a mandatory report would be to prevent further victimization through the removal of the offender from the home. An unintended consequence could be that the victim, unable to care for herself, is placed in an assisted living facility. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault* and *Abuse* and *Sexual Violence 101. Mandatory Reporting.*)

Victims living in rural areas face the reality that they may not be able to report the incident or seek services without interacting with friends and acquaintances who work in the advocacy, medical and criminal justice systems. These same friends and acquaintances may also know the offenders and even tolerate their behavior. Because of this familiarity, victims may feel that they will not receive fair and unbiased help. For many victims, their unfounded feelings of self-blame, fear of "everyone knowing their business," and/or concern about how their

family will be affected by the sexual assault overrides their desire to hold the offender accountable or to seek support services.

When victims who are incapacitated or who live in rural areas seek services, it is helpful to discuss with them what they perceive as potential challenges to maintaining confidentiality in their community and identify ways they can deal with these challenges.

What is privileged communication?

"Privileged communication" means client communications that are protected by law for specified professionals who are not required to release information without the written consent of the client, even with some court mandates. State and federal laws establish these legal privileges.

There is no "master list" indicating which agencies and professionals in the state have privileged communication. Some professions in general have privileged communication; some communications are privileged based upon the licenses and certifications of the individual. Because of space constraints, this very brief introduction to privileged communication is not intended to answer the question for you as to whether or not you have privileged communication in your work. It is included in this module since having—or not having—privileged communication impacts when information can be maintained confidentially. If you are unsure whether or not someone in your profession, position or license status is legally protected and has privileged communication with clients, it is imperative that you seek clarification from your supervisor.

Do mandatory reporters have privileged communication?

Mandatory reporters are required by law to report cases of abuse, neglect or emergency situations involving minors and adults who are incapacitated. No privileged communication exists for mandatory reporters in these circumstances. (Related mandatory reporting issues are discussed below. Also see *Sexual Violence 101. Mandatory Reporting.*)

When *can* client information be released versus when *must* client information be released?

Every agency should have a written policy regarding the release of confidential client information. In most cases, confidential information should be released:

- Upon obtaining a signed, written release by/on behalf of the client;
- If you are a mandatory reporter and circumstances indicate a situation that warrants a report of abuse, neglect or an emergency situation; or
- If a court mandates the release of information.

When is a written release of information needed? What should be included in the release?

In general, personal identifying client information should not be released without the informed, written consent of the client (or the guardian, if one exists, if the client lacks competency to give consent). (See *Disabilities 101. Guardianship and Conservatorship.*) Informed consent means that the person agreeing to the release understands what they are releasing, to whom and when.

Specifically, a written release should indicate:

- Who is releasing the information and with whom the information is to be shared;

- What information is to be shared and how it will be used (e.g., to obtain victim compensation benefits, investigate the case, or prove or disprove the case during court proceedings);
- How the information is to be released (e.g., by e-mail, phone, fax, mail or in person), with recognition that e-mail and fax may be more likely to be intercepted by others who may not be included on the release;
- A reasonable time limit for the release of information (e.g., 15 to 30 days), indicating the dates and times for the release and the expiration of the release;
- Potential risks related to releasing information (e.g., that the agency releasing the information and the client may not be able to control what happens to the information once it has been released, and that the agency or person receiving the information may be required by law or practice to share it with others); and
- The dated and witnessed signature of the client/guardian.

A *Sample Release of Information Form* at the end of this module includes all of the above components.

Asking clients to sign a blank release form unfairly reserves the right to seek/release information about them in the future without their knowledge or additional permission. Therefore, any policies that request clients to sign a blank release form—which would enable an agency to contact an undesignated entity at any time in the future—would not meet the criteria for informed consent.

What if the person is a minor? What if the person is an adult who is incapacitated and does not understand what she is signing?

Minors are typically unable to legally provide informed consent. Therefore, when the client is a minor, the written release of information should be signed by the minor where possible and the non-abusive parent or guardian of the child. Emancipated minors, however, can make most of their own decisions and do not need a signature of their parent or guardian.[6] With adults who are incapacitated, the issue is whether they are competent to give consent. If a client is not capable of providing consent to release information, the written release should be signed by the client where possible and the non-abusive guardian, if that person exists. In West Virginia, a person is legally considered to be competent unless a court has determined otherwise. (See *Disabilities 101. Guardianship and Conservatorship.*)

These are general guidelines; however, if your agency receives any funding under the Violence Against Women Act, these are mandatory practices for funding compliance.

Talk with your supervisor to determine if your agency receives funding under the Violence Against Women Act. Obtain a copy of your agency's client release of information form and review it for compliance purposes.

Are written releases of information necessary for multidisciplinary teams that review client cases?

Each worker on the team must follow their agency's policy for confidentiality and the release of *identifying* information. If, for example, you wanted to discuss a specific client's case at a multidisciplinary meeting in order to improve the service delivery system, that client would need to sign a release of information form for that specific meeting for each person participating in the discussion.

Non-personal identifying information can be released as long as you can ensure that, once all of the aggregate data is compiled, the victim cannot be identified. For example, if at a team meeting you discussed the importance of having a private waiting area at the hospital for victims because of feedback you have received, that feedback probably could not be traced back to a specific victim. However, if you said that a victim that you worked with

last month told you that the hospital had difficulty obtaining an interpreter for her and she had to wait in the general waiting room with her seven children, there would be the potential that others in your meeting could trace that situation back to a specific client. That would be a breach of confidentiality.

What are the mandatory reporting requirements related to releasing information?

West Virginia law determines who is required to report suspected cases of abuse, neglect or an emergency situation involving adults who are incapacitated and minors. It also defines the criteria for those categories. (See *Sexual Violence 101. Mandatory Reporting*.)

- Mandatory reporters in cases of suspected mistreatment of adults who are incapacitated include medical, dental and mental health professionals, Christian Science practitioners, religious healers, social service workers, law enforcement officers, humane officers, state or regional ombudsmen, or any employee of a nursing home or other residential facility.[7]
- In cases of the mistreatment of a minor, mandatory reporters include medical, dental or mental health professionals, religious healers and members of the clergy, Christian Science practitioners, social service workers, school teachers and other school personnel, child care or foster care workers, humane officers, emergency medical services personnel, peace officers or law enforcement officials, circuit court judges and family court judges, employees of the Division of Juvenile Services and magistrates.[8]

Even if your position does not fall into one of these mandatory reporter categories, you should always consider the safety of any victim in an emergency situation and the need to report if there is a threat of imminent harm to them or a third party.

If you are a mandatory reporter, you do not need a release of information from the victim. However, if your agency receives Violence Against Women Act funds, you are required to make a reasonable attempt to notify the victim of the report. If it would be dangerous to do so, it could be reasonable not to inform the victim. Best practice would be to support the victim in making a self-report. Not only can self-reporting begin the process to help the victim regain control in her life, but the likelihood of holding an offender accountable may increase if the victim is willing to be involved in the investigative process.

What should you do if a release of information is court-ordered?

It is important for you to talk with your supervisor and discuss your agency's procedures if a victim's records are subpoenaed. In West Virginia, certain entities and professions have privileged communication. For example, sexual assault advocates do not have privileged communication (as of the time of this writing, 8/2010), but advocates working within domestic violence shelters and dual programs do. That privilege is "qualified" and in some cases the records may be subject to *in camera* review by the court (meaning the judge will review the information in question in her/his private chambers without a jury and come to a decision about its release). Therefore, if a client's case record is subpoenaed, a determination must be made as to if or how the information should be provided. This determination should be made with your supervisor in conjunction with the local court.

FYI If you will not be completing *Part 2: Discussion* in this module with your partnering community agencies, it may be useful to review the discussion questions with your supervisor to ensure your understanding of your agency's policies and procedures regarding confidentiality.

What about the confidentiality of victims' medical records?

Most sexual assault victims with disabilities will have had prior interactions with health care professionals. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) established laws protecting the privacy of certain

health information. HIPAA, among other provisions, limits the release of medical information, gives patients the right to a copy of their own health records, allows patients to learn what information was disclosed and how their information may be used, and essentially gives patients more control over their health information. HIPAA covers the dissemination of medical information, both written and oral. If, in your work with sexual violence victims with disabilities, you will have access to or become knowledgeable of a victim's medical information, you should learn more about how HIPAA regulations protect the confidentiality of certain health information. Additional information on HIPAA and protected health information can be found at www.cdc.gov.

Where can I find more information on confidentiality issues?

The Victim Rights Law Center (VRLC) created a resource, *Beyond the Criminal Justice System: Using the Law to Help Restore the Lives of Sexual Assault Victims, A Practical Guide for Attorneys and Advocates,* to assist in meeting the legal needs of sexual assault victims. Two chapters will assist you in examining the issues of confidentiality and informed consent. Chapter 3, "Privacy: a Pre-Eminent Concern for Sexual Assault Victims," includes sections on victim credibility, unexpected consequences of an authorized release, the difference between confidentiality and privilege, victims' privacy concerns, and special vulnerabilities—mental health and mandatory reporting. Chapter 12, "Representing Sexual Assault Victims with Disabilities," provides additional information, including initial considerations when working with victims with disabilities, privacy issues, ensuring privacy and informed consent when there are multiple service providers, maintaining confidentiality, and HIPAA issues. Contact VRLC through http://www.victimrights.org/ to find out how to obtain this resource.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What does it mean for a service provider to maintain client confidentiality? *See page B6.2.*
2. What are reasons that confidentiality may be important to victims of sexual assault? *See page B6.2.*
3. What confidentiality concerns are specific to victims who are considered by state law to be incapacitated and victims living in rural communities? *See pages B6.2–B6.3.*
4. What is privileged communication? *See page B6.3.*
5. What situations warrant a release of client information? *See page B6.3.*
6. What should be included in a written release of information? *See pages B6.3–B6.4.*
7. What if the client is a minor or an adult who is considered by state law to be incapacitated and cannot give consent to release information? *See page B6.5.*
8. What should service providers do if a release of victim information is court-ordered? *See page B6.5.*
9. How does the Health Insurance Portability and Accountability Act (HIPAA) impact the confidentiality of a victim's medical records? *See pages B6.5–B6.6.*

Part 2: DISCUSSION

Projected Time for Discussion
2 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* in this module to their collaborative work with sexual violence victims with disabilities. The discussion could be incorporated into forums such as agency staff meetings, orientations and continuing education programs, as well as multi-agency meetings or trainings. Anticipated discussion outcomes include an increased understanding of confidentiality barriers and challenges experienced by victims with disabilities and victims in rural areas; identification of ways to enhance confidentiality through agency policies and procedures; and increased knowledge of confidentiality and mandatory reporting requirements that impact victim safety.

Refer to the learning objectives at the beginning of this module for specific outcomes for this module on confidentiality.

Preparation

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator for the discussion. The facilitator should be familiar with confidentiality issues as they relate to victims of sexual violence.
- Select a note taker.
- Prior to the meeting, participants and the facilitator should review and bring to the meeting a copy of the *Sample Release of Information Form* included in this module.
- Participants should review and bring to the meeting copies of the confidentiality policy and release of information form used by their respective agencies.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

NOTE: This toolkit was developed to assist communities in addressing gaps in services to sexual assault victims with disabilities. It is anticipated that in discussing the issue of confidentiality, agencies may find that their policies and forms may need to be revised. Partners are encouraged to engage in an open discussion in an effort to develop procedures that best meet the needs of victims and adhere to existing laws.

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.

- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2. **Ask a representative from each partnering agency to share their agency's confidentiality policy and practices** and whether or not agency staff are mandatory reporters and/or have privileged communication. *(10 minutes)*

3. **Discuss the following questions:** *(up to 35 minutes)*

a. Why is confidentiality a concern for:

- Victims of sexual violence?
- Victims of sexual violence with disabilities?
- Victims of sexual violence in rural areas?

Discuss these questions separately, as it is important to note that special concerns exist for each one. The depth of your discussion will impact your level of understanding of the reluctance of victims to disclose and the challenges you face as service providers in bridging those challenges.

b. What are some potential unintended consequences related to client confidentiality and providing services to victims with disabilities who do not have the capacity to consent to sexual intercourse?

c. Are there ways that services can be provided to victims with disabilities without resulting in the unintended consequences?

4. **Ask a representative from each partnering agency to share their agency's release of information form.** Ask the group to review the *Sample Release of Information Form* provided with this module. Then **discuss the following questions**: *(up to 35 minutes)*

a. Inherent in signing a release of information form should be that individuals understand what they are giving permission to and recognize the intended and potential unintended consequences of releasing information. This is "informed consent." What challenges do service providers face when obtaining informed consent with victims with different types of cognitive disabilities?

b. How is consent obtained when the victim has a guardian? What if the guardian is the suspected offender?

c. What procedures do your agencies have in place for training staff on the issues of informed consent, consent through guardians, and consent when the guardian is the offender?

d. What components of the *Sample Release of Information Form* provide specific protection for victims with disabilities?

5. **Ask participants to review the following scenarios individually and then as a large group discuss the questions posed in each scenario:** *(20 minutes)*

Scenario 1

You are assisting 24-year-old Jason in filing a Crime Victims Compensation Fund claim for injuries sustained in a sexual assault. You need the medical expenses from his doctor to complete the form. Jason does not seem to have the capacity to understand the purpose of the Crime Victims Compensation Fund. You are concerned that his lack of understanding

prevents him from giving his informed consent to release the medical information to you. He is, however, willing to sign the release of information form. What do you do?

Scenario 2

Ann is blind and lives alone in a rural community. She was sexually assaulted by her family physician during her annual physical exam yesterday and now has extreme pain when urinating. The physician is well known and loved in the community. Ann wants to report the assault, but fears her credibility and reputation will be challenged—both at the local hospital and throughout the criminal justice system. How can you, as a local service provider, help her?

Answers:

Scenario 1: According to West Virginia law, unless a court has determined that Jason is not able to make health care decisions on his own behalf, he is considered competent to sign the form. Therefore, you should accept that he can consent and proceed with the request for the release of information. You should make every effort, in multiple meetings, to explain in basic language to Jason the purpose of the form and the Fund. You should also keep him informed on the progress of the request for the release. (See *Disabilities 101. Guardianship and Conservatorship.*)

Scenario 2: While validating Ann's concerns regarding reporting the assault, you can stress that it is critical to address her immediate medical needs. To avoid people who might know her in her community, you could discuss the possibility of going to a hospital in a neighboring county for care (including addressing how she will get to/from the hospital and any available accommodations). You can also tell her that, in West Virginia, she can have a forensic medical examination conducted and a sex crime kit collected (typically within 96 hours of a sexual assault) without immediately reporting the incident to law enforcement (as long as she is not incapacitated). Evidence collected can be stored for up to 18 months, giving her more time to decide about whether to report to law enforcement and to build a support network. (After that 18 month period, she can still report, but evidence that was collected through the forensic medical exam will have been destroyed.) Additionally, you can help her explore other options, such as reporting the assault to the state medical licensing board. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault and Abuse, Sexual Violence 101. Mandatory Reporting, Sexual Violence 101. Sexual Assault Forensic Medical Examination* and *Disabilities 101. Accommodating Persons with Disabilities.*)

6. **Closing.** Ask each participant to write down how the information gained from this module discussion will:

- Change the way they interact with individual clients;
- Change the way they partner with other agencies to assist clients; and
- Promote change in their agency's policies, practices or training programs.

Then facilitate a large group discussion on this topic. *(10 minutes)*

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Sample Release of Information Form

Created by Julie Field, J.D., Consultant

[APPROPRIATE AGENCY LETTERHEAD]

READ FIRST: Before you decide whether or not to let [Program/Agency Name] share some of your confidential information with another agency or person, an advocate at [Program/Agency Name] will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want [Program/Agency Name] to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom and

I understand that [Program/Agency Name] has an obligation to keep my personal information, identifying information and my records confidential. I also understand that I can choose to allow [Program/Agency Name] to release some of my personal information to certain individuals or agencies.

I, _____, authorize [Program/Agency Name] to share the following specific information with: (name below)

Who I want to have my information:	Name: Specific Office at Agency: Phone Number:

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

What info about me will be shared:	*(List as specifically as possible, for example: name, dates of service, any documents).*
Why I want my info shared: (purpose)	*(List as specifically as possible, for example: to receive benefits).*

Please note: There is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by [Program/Agency Name].

I understand:

That I do not have to sign a release form. I do not have to allow [Program/Agency Name] to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like [Program/Agency Name] to release information about me in the future, I will need to sign another written, time-limited release.

That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from [Program/Agency Name].

That [Program/Agency Name] and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

Expiration should meet the needs of the victim, which is typically no more than 15 to 30 days, but may be shorter or longer.

This release expires on Date: _____ Time: _____

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signed: _____ **Date:**_____ **Witness:** _____

Reaffirmation and Extension

(if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid and I would like to extend the release until
(New Date) _____ (New Time) _____

Signed:_____ **Date:**_____

Witness:_____

[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]As per *WVC§9-6-11*.

[3]As per *WVC§9-6-9*, "incapacitated adult" means any person who by reason of physical, mental or other infirmity is unable to independently carry out the daily activities of life necessary to sustaining life and reasonable health. For an online reference to the state code, see http://www.legis.state.wv.us/WVCODE/Code.cfm. Note the occasional use of legal terms in this module that deviate from "person first" language (which places the focus on the person, not the disability). While these legal terms would not be our choice of language, they currently define the law and influence charging decisions nonetheless. First responders are urged to avoid use of terms such as "incapacitated adult" in their interactions with victims, as their use could increase a victim's reluctance to seek assistance with safety, healing and justice. (See *Disabilities 101. Person First Language*.)

[4]Victim Rights Law Center, *Beyond the criminal justice system: Using the law to help restore the lives of sexual assault victims* (Boston, MA and Portland, OR: 2007). This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested that you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[5]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

[6]*WVC§49-7-27*: A child over the age of sixteen may petition a court to be declared emancipated. The parents or custodians shall be made respondents and, in addition to personal service thereon, there shall be publication as a Class II legal advertisement in compliance with the provisions of article three (3), chapter 59 of this code. Upon a showing that such child can provide for his physical and financial well-being and has the ability to make decisions for himself, the court may, for good cause shown, declare the child emancipated. The child shall thereafter have full capacity to contract in his own right and the parents or custodians shall have no right to the custody and control of such child or duty to provide the child with care and financial support. A child over the age of 16 years who marries shall be emancipated by operation of law. An emancipated child shall have all of the privileges, rights and duties of an adult, including the right of contract, except that such child shall remain a child as defined for the purposes of articles five (5) and five-a (5a.) of this chapter.

[7]See *WVC§9-6-9*.

[8]From the West Virginia DHHR website on reporting child abuse and neglect, http://www.wvdhhr.org/bcf/children_adult/cps/report.asp. Also see *WVC§49-6A-2*.

West Virginia Crime Victims Compensation Fund

This module offers information on what expenses are eligible for compensation through the West Virginia Crime Victims Compensation Fund, the basic process for filing a claim for compensation, and where to refer victims for assistance in filing a claim.[1]

Key Points

- The West Virginia Crime Victims Compensation Fund provides compensation to victims of crime who have suffered personal injury and have incurred out-of-pocket losses as a result of a criminal act.
- West Virginia residents are eligible to file a claim with the Crime Victims Compensation Fund if they are: victims of a crime that caused personal injury and out-of-pocket losses; dependents of a deceased victim of a crime; victims of terrorism overseas; or victims of crime in another state that does not have a compensation program. To be eligible, the crime must be reported to law enforcement within 72 hours (with possible exceptions). The victim must document expenses from the injury inflicted by the crime and fully cooperate with law enforcement. A claim must be filed within two years.
- To file a claim, an application must be completed and submitted to the Crime Victims Compensation Fund. There is no fee to file and an attorney is not required. Victim advocates at rape crisis centers are trained to assist victims in filing claims.
- Once a claim has been filed, a claim investigator reviews the case, creates a Finding of Fact and Recommendation (FFR) and sends a copy to the victim. The victim may file a response to the FFR within 30 days. A judge then reviews the FFR, all case documents and the victim's response, if any, and makes a decision. A copy of the decision is sent to the victim. If the victim or claim investigator disagrees with the decision, they have 30 days to file an appeal. The case will then be transferred to another judge and the victim has 21 days to request a hearing. At the hearing, the victim and other parties may have the opportunity to testify and initial findings are discussed. The court then determines if there is sufficient evidence to award the victim benefits or if the claim will be denied.
- Sexual assault victims can have a forensic medical exam conducted without immediately reporting the crime to law enforcement. If they choose not to report, they are not eligible for compensation through the Crime Victims Compensation Fund. Because there is no statute of limitations on sexual assault, they can later report the crime to law enforcement. If they then file a claim and a judge finds that the victim can provide good cause as to why there was a delay in reporting past the 72 hour eligibility time period, the claim could be approved. The determination is left to the discretion of the judge under the parameters of the state statute.

B7. West Virginia Crime Victims Compensation Fund

Purpose

In addition to physical injury and trauma, sexual victimization can result in both out-of-pocket expenses and loss of income. If the crime is reported to law enforcement, victims may be eligible for compensation for those expenses through the West Virginia Crime Victims Compensation Fund. In the event that a client discloses victimization, service providers need to have a basic understanding of what expenses are eligible for compensation through the Crime Victims Compensation Fund, the basic process for filing a claim for compensation, and where to refer the victim for assistance in filing a claim.[2] This knowledge will enable service providers to better assist victims in accessing all possible resources to support them in the recovery process.

Objectives

Those who complete this module will be able to:

- Explain the purpose of the West Virginia Crime Victims Compensation Fund;
- Understand how a claim is processed; and
- Provide information to victims on the Crime Victims Compensation Fund.

Preparation

Download a copy of the Crime Victims Compensation Fund Application Form through http://www.legis.state.wv.us/Joint/victims/main.cfm.[3]

CORE KNOWLEDGE

What is the West Virginia Crime Victims Compensation Act?

The Crime Victims Compensation Act was created in 1981 and enacted on January 1, 1982 (*WVC§14-2A*). Its purpose was to establish "a fund which pays certain compensation and medical benefits to innocent victims of crime."

What is the West Virginia Crime Victims Compensation Fund?

The West Virginia Crime Victims Compensation Fund is a program administered by the state's Court of Claims. The program is funded through court fees collected from persons who have been convicted of or plead guilty to a misdemeanor or felony (with the exception of non-moving traffic violations). The program receives $50 per felony, $8 per misdemeanor, $10 for other offenses, 20 percent of assessed fines in drunk-driving cases and 60 percent of the state's annual Victims of Crime Act grant. The Crime Victims Compensation Fund provides compensation to innocent victims of crime who have *suffered personal injury and who have incurred out-of-pocket losses* as a result of a criminal act.

Who is eligible?

- A WV resident who is an innocent victim of a crime that caused personal injury and out-of-pocket losses
- A dependent of a deceased victim of a crime
- A WV resident who is a victim of terrorism overseas
- A resident of WV who was a victim of a crime in another state that does not have a compensation program

Who is not eligible?

- Persons who commit a crime
- Persons who are injured while they are incarcerated
- Persons who do not cooperate with law enforcement or claim investigators from the Crime Victims Compensation Fund

What is required?

- The crime must have been reported to law enforcement within 72 hours.
- The victim must have documented expenses from the personal injury inflicted by the crime.
- The victim must fully cooperate with law enforcement officials.
- A claim must be filed with the WV Crime Victims Compensation Fund within 2 years. Exceptions:
  - o If the victim is a child, the child has until her 20th birthday to file a claim.
  - o Extended time for filing may be granted if there is "good cause" for filing after the specified time frames.

What are the benefits?

The West Virginia Crime Victims Compensation Fund is a "payer of last resort," which means it can be accessed once all other resources have been exhausted. Other sources that victims may access include: private insurance (medical, optical and dental), employee sick and annual leave benefits, unemployment benefits, court ordered restitutions, life insurance over $25,000, auto insurance, public program benefits and civil lawsuit recoveries. The Crime Victims Compensation Fund does not cover personal property (except medically necessary items such as eyeglasses and hearing aids) and lost wages for individuals other than the victim. Each claim is handled on a case-by-case basis. If a victim's expenses are paid by the Crime Victims Compensation Fund and the victim later receives compensation from another source, the victim is responsible for notifying the Crime Victims Compensation Fund and may be obligated to repay amounts for which it was later determined she was not eligible.

Maximum awards:

- $25,000 in personal injury cases
- $50,000 in death cases, which includes $7,000 for funeral/burial
- $100,000 in permanent disability cases (in addition to the $25,000)

Compensable expenses:

- Medical expenses
- Mental health counseling
- Mental health counseling for secondary victims up to $1,000
- Lost earnings
- Funeral/burial costs up to $7,000
- Relocation up to $1,000
- Travel to a medical treatment facility, to attend criminal proceedings or to return a minor from out-of-state or out-of-country
- Crime-scene cleanup (landlords)
- Rehabilitation
- Attorney fees (public defender rates)
- Replacement services, to do what victims would normally do themselves but no longer can because of the crime. (Examples: A victim owned a store and worked 60 hours per week. Due to his injury, he cannot work and has to hire someone to complete the work he did in those 60 hours. The Crime Victims Compensation Fund could pay for his replacement. If a victim was not able to care for herself because of a crime-related injury, the Crime Victims Compensation Fund could pay the costs of an in-home nurse. Services can be paid until the maximum dollar amount set for this category is reached.)

Test Your Knowledge on Crime Victims Compensation Fund Eligibility

1. *A 23-year-old woman with no health insurance was sexually assaulted in her home. She is receiving therapy and was prescribed an antidepressant medication for PTSD (post-traumatic stress disorder). Could she be eligible for benefits to cover the costs of therapy and medication?*
2. *A 50-year-old woman who is legally blind was sexually assaulted and, as a result, her eyeglasses were broken. Her vision insurance will only cover 50 percent of the total cost to replace her eyeglasses. Could she be eligible for benefits?*
3. *If a 5-year-old was present when his mother was raped and he is now suffering from anxiety due to the traumatic incident, could he be eligible for mental health benefits?*

Answers: "Yes" to all. However, these cases are dependent upon the crime having been reported to law enforcement and eligibility status subject to individual case findings by the Crime Victims Compensation Fund.

How do you file a claim?

There is no fee to file a claim and an attorney is not required. Victim advocates at rape crisis centers are trained to assist victims in filing claims. However, if a victim seeks the services of an attorney *and the claim is approved,* reasonable attorney fees can be paid by the Crime Victims Compensation Fund.

If a victim is uncertain about the eligibility of any aspect of a claim, additional information may be obtained by calling the West Virginia Crime Victims Compensation Fund. An application can be downloaded through

http://www.legis.state.wv.us/Joint/victims/main.cfm or is available at the local prosecuting attorney's office. Below is the related contact information:

WV Crime Victims Compensation Fund
1900 Kanawha Blvd. East, Room W-334, Charleston, WV 26305-0610
Phone: 304-347-4850, 877-562-6878 (in state)
Email: ctclaims@mail.wvnet.edu

How is the claim processed?

Once a claim has been filed, the Crime Victims Compensation Fund assigns a claim investigator to review the case. Based on the information gathered during the investigation, the claim investigator files a "Finding of Fact and Recommendation," or FFR, and a copy is sent to the victim. The victim may file a response to the FFR within 30 days. One of the state's three Court of Claims' judges then will review the FFR, all file documents, and the victim's response, if any. The judge will then make a decision and a copy of the order will be sent to the victim. If the victim or claim investigator disagrees with the decision rendered by the judge from the Court of Claims, they have 30 days to file an appeal. The case will then be transferred to another judge and the victim has 21 days to request a hearing. When scheduling a hearing date, the judge will make every effort to accommodate the victim by choosing a location that is local and convenient. At the hearing, the victim and other parties may have the opportunity to testify and the initial findings will be discussed. The court will determine if there is sufficient evidence to award the victim benefits or if the claim will be denied.

Are there special eligibility concerns for sexual assault victims?

Sexual assault victims can face unique circumstances regarding eligibility for the Crime Victims Compensation Fund. They can have a forensic medical exam conducted without reporting the crime to law enforcement. *Having a forensic medical exam conducted does not establish that a crime occurred.* Therefore a victim may not be eligible for compensation through the Crime Victims Compensation Fund unless the crime is reported to law enforcement. However, since there is no statute of limitations regarding sexual assault, a victim could later report the crime to law enforcement. *If the Court of Claims' judge finds that the victim can provide good cause as to why there was a delay in reporting the crime past the 72 hour eligibility time period, the claim could be approved.* The determination is left to the discretion of the judge under the parameters of the state statute. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault and Abuse* and *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What agency administers the West Virginia Crime Victims Compensation Fund? How is it funded? *See page B7.2.*
2. What are the eligibility criteria to file a claim with the Fund? *See page B7.2.*
3. How many years after the crime occurred can a claim be filed? *See page B7.3.*
4. What expenses are eligible for reimbursement? What are the maximum awards? *See pages B7.3–B7.4.*
5. Is there a fee to file a claim? *See page B7.4.*
6. Who can assist victims in filing claims? Is an attorney needed to file? *See page B7.4.*

7. Once a claim is filed, what is the process for making a decision? What happens if the victim or claim investigator disagrees with the decision? *See page B7.5.*

8. Are there exceptions for sexual assault victims to the standard time period in which crimes must be reported to be eligible for compensation? *See page B7. 5.*

Funding was provided by Grant No. 2006-FW-AX-K001 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this module are those of the authors and do not necessarily reflect the views of the U.S. Department of Justice, Office on Violence Against Women.

[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the terms "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" generally are used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims may be referred to as female and examples provided often have female victims.

[3]Note that online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

Understanding and Addressing Emotional Trauma

This module offers basic information on emotional trauma and on supporting victims of sexual violence in healing from trauma. It recognizes that victims with disabilities may face additional environmental and/or attitudinal barriers that impede their healing and encourages service providers to work with victims to eliminate such barriers.[1]

Key Points

- A traumatic event is one in which an individual experiences, witnesses or is confronted with actual or threatened death, serious injury or a threat to their physical wellbeing.[2] Emotional trauma—caused by events such as sexual and physical violence, emotional abuse or neglect, natural disasters, serious accidents and acts of war and terrorism—can shatter an individual's sense of security. However, any situation that leaves a person overwhelmed, frightened and feeling alone can be traumatic.[3] It is not the objective facts that determine whether an event is traumatic, but a person's subjective emotional experience of the event.[4]
- The following are examples of factors that may influence whether a person's reactions to a stressful event are traumatic:[5] severity and frequency of the event; personal history; individual coping skills, values and beliefs; and the level of support from family, friends and/or professionals.
- Traumatic reactions may include physical, emotional and cognitive symptoms. Additional symptoms—intrusive re-experiencing of the trauma, emotional numbing and avoidance, and arousal (e.g., hyper-vigilance and overreactions)—are key indicators of post-traumatic stress disorder (PTSD). PTSD symptoms specific to survivors of sexual violence are also known as rape trauma syndrome. The long-term impact of emotional trauma can affect both victims (emotionally, physically and psychologically) and their relationships with others.[6]
- Service providers can help victims understand how sexual violence can cause traumatic reactions and how trauma can affect them. To provide this help, providers can do the following: ask victims for guidance in identifying their reactions and what assistance they want; discuss with victims what accommodations and resources they may need; affirm that it is possible to heal; explain the services offered through their local rape crisis center; explain that mental health treatment for trauma is often critical to recovery, what it involves and how to obtain it; and offer crisis intervention to victims who are in crisis (or immediately refer them to professionals who can).

B8. Understanding and Addressing Emotional Trauma

Purpose

Sexual violence victims' needs are often impacted by their traumatic reactions to the violence perpetrated against them. This module contains basic information to build service providers' general understanding of emotional trauma. It also includes ways to support victims in healing from the trauma of sexual violence.

SEXUAL VIOLENCE 101

As discussed in the *Disabilities 101* modules, victims with disabilities may have to contend with environmental and/or attitudinal barriers when seeking support to heal from the trauma of sexual violence. For example, persons with disabilities that impact their mobility may have trouble accessing services unless accommodations are available. Persons with disabilities that affect speech may have difficulty finding someone who has the skills and patience to help them convey what they are experiencing and help them cope with the trauma. (See *Disabilities 101. Tips for Communicating with Persons with Disabilities.*) Persons with mental illnesses and developmental disabilities who disclose sexual violence may find their account of what happened discredited or questioned by others. (See *Disabilities 101. Working with Victims with Mental Illnesses.*) It is critical that service providers identify barriers that can impede healing from emotional trauma and then work with victims to eliminate those barriers.

Objectives

Those completing this module will be able to:

- Understand emotional trauma and its causes;
- Discuss symptoms of emotional trauma, including those associated with post-traumatic stress reactions;
- Define rape trauma syndrome; and
- Discuss how service providers can assist sexual violence victims in healing from emotional trauma.

CORE KNOWLEDGE

What is emotional trauma and what causes it?

A traumatic event is one in which an individual experiences, witnesses or is confronted with actual or threatened death, serious injury or a threat to the physical wellbeing of oneself or others.[7] Events long-recognized as potentially traumatic include sexual and physical violence, emotional abuse or neglect, natural disasters, serious accidents and acts of war and terrorism.[8] Emotional trauma caused by such events can shatter an individual's sense of security. However, any situation that leaves a person intensely overwhelmed, frightened and feeling alone can be traumatic.[9] It is not the objective facts that determine whether an event is traumatic, but a person's subjective emotional experience of the event.[10]

This module focuses on emotional trauma caused by sexual violence. It recognizes that the trauma victims of sexual violence face may be impacted by other life circumstances (e.g., if a victim with a disability had recently lost a parent and was moved to a residential facility) or by the lack of support to heal from the trauma.

FYI People can feel emotionally stressed for any number of reasons—work pressures, relationship problems, financial worries, etc. A person's nervous system is deregulated for relatively short periods of time due to stress, but then it reverts to a normal state of equilibrium.[11] For people who are traumatized, reverting to "normalcy" can take much longer and the outcomes can have far greater impact on their ability to function on a daily basis.[12,13]

Why can sexual violence cause trauma for one victim and not another?

The following factors may influence whether victims' reactions to sexual violence are traumatic and the extent of the trauma they experience:[14]

- Severity and frequency of the victimization;
- Personal history (e.g., prior victimizations, their age at the time of the violence, their relationship with the offender, etc.);

- Added meaning the victimization may represent for individuals (e.g., a survivor of childhood sexual abuse may interpret a rape as an adult as proof that she will never escape sexual violence); [15]
- Individual coping skills, values and beliefs; and
- Reactions and support from family, friends and/or professionals.

What are symptoms of emotional trauma?

(See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors* and *Sexual Violence 101. Indicators of Sexual Violence* for common indicators of victims' reactions to sexual violence. See *Disabilities 101. Working with Victims with Mental Illnesses* for further descriptions of symptoms of psychological conditions.)

A traumatized person may experience one or more of the following symptoms:[16]

- **Physical:** Eating and sleep disturbances, sexual dysfunction, low energy and chronic, unexplained pain.
- **Emotional:** Depression; spontaneous crying; feelings of despair and hopelessness; anxiety and panic attacks; fearfulness; compulsive and obsessive behaviors; feelings of being out of control, irritable, angry and resentful; emotional numbness; and withdrawal from normal routines and relationships.
- **Cognitive:** Memory lapses, especially about the traumatic event; difficulty in making decisions; decreased ability to concentrate; hyperactivity; and impulsivity.

FYI First responders and service providers need to know that trauma can affect memory. Therefore, a change in a victim's account of what happened should not immediately be perceived that she is lying. Instead, it should be understood in the context of the impact of trauma.

The additional symptoms listed below are linked with severe traumatic events, including sexual violence:[17]

- **Re-experiencing the trauma:** Intrusive thoughts, flashbacks or nightmares and a sudden flood of emotions or images related to the traumatic event. Intrusive symptoms sometimes cause people to lose touch with the "here and now" and react in ways that they did when the trauma originally occurred.[18] For example, many years later a victim of child sexual abuse may hide in a closet when feeling threatened, even if the perceived threat is not abuse-related.[19] Trauma can be triggered by unique circumstances, such as walking through a department store and smelling cologne that the offender wore during the assault or hearing a song in an elevator that happened to be on the radio during the rape. Such circumstances, which the victim cannot control, can make healing difficult.
- **Emotional numbing and avoidance:** Amnesia; avoidance of situations that resemble the initial event; detachment to avoid painful emotions and feeling overwhelmed; and an altered sense of time. Frequently, people use drugs or alcohol to avoid trauma-related feelings and memories.[20]
- **Arousal:** Hyper-vigilance; jumpiness and an extreme sense of being "on guard;" overreactions, including sudden, unprovoked anger; general anxiety; insomnia; and obsession with death.

Intrusive re-experiencing, avoidance and arousal are key indicators of post-traumatic stress disorder (PTSD). PTSD is associated with high rates of medical and mental health service use and is possibly the highest per-capita cost of any psychological condition.[21]

FYI Nearly one-third of rape victims develop PTSD during their lifetimes.[22]

FYI Because symptoms of PTSD can appear immediately or long after the traumatic event, people don't always connect the way they are feeling now with that event. Also, those with PTSD may avoid diagnosis and treatment or be misdiagnosed (e.g., with common co-occurring psychological conditions, such as depression, substance abuse and bipolar illness, or with physical ailments such as headaches, chest pains and digestive or gynecological problems).[23]

Rape Trauma Syndrome

Information drawn from http://www.rainn.org/

PTSD symptoms specific to survivors of sexual violence are also known as rape trauma syndrome. These symptoms have been categorized into three phases, based on the work of Ann Wolbert Burgess and Lynda Lytle Holmstrom (Rape Trauma Syndrome, *American Journal of Psychiatry,* 131(1974), 981-86.):

- ***Acute phase:*** Occurs immediately after the assault and usually lasts a few days to several weeks. Common reactions include being openly emotional, being controlled/without emotion and experiencing shocked disbelief/disorientation.
- ***Outward adjustment phase:*** Individual resumes what appears to be her "normal" life, but inside is suffering from considerable turmoil. Primary coping techniques utilized include: minimization (pretends that "everything is fine" or that "it could have been worse"); dramatization (cannot stop talking about the assault—it dominates her life and identity); suppression (refuses to discuss or acts as if it did not happen); explanation (analyzes what happened); and flight (tries to escape the pain by moving, changing jobs, changing appearance, changing relationships, etc.).
- ***Resolution phase:*** The assault is no longer the central focus of the individual's life. The survivor may recognize that while she will never forget the assault, the pain and negative impact usually lessen over time.

Note that survivors don't necessarily progress through the phases of rape trauma syndrome in a sequential manner.

What are the possible effects of emotional trauma?

If not addressed, emotional trauma can create lasting difficulties in a person's life.[24] Some specific effects could include: substance abuse; compulsive behavioral patterns; self-destructive and impulsive behavior; uncontrollable reactive thoughts; inability to make healthy professional or lifestyle choices; dissociative symptoms; feeling permanently damaged; a loss of previously sustained beliefs; and feelings of ineffectiveness, shame, despair and hopelessness.[25] Unresolved emotional trauma can also impact interpersonal interactions, contributing to sexual problems, the inability to maintain close relationships or choose appropriate friends and partners, social withdrawal, and feelings of being constantly threatened and hostile towards others.[26]

Emotional Trauma and Persons with Mental Illnesses

Some trauma symptoms (compulsive or self-destructive behavior, uncontrollable thoughts, depression, etc.) are also symptoms of mental illnesses. Service providers must be knowledgeable about trauma to be able to differentiate between symptoms of trauma versus mental illnesses and to respond appropriately.

Trauma can exacerbate symptoms for persons who have mental illnesses. For example, a victim with paranoia may understandably be more afraid to stay by herself after an assault. Someone who was depressed prior to a rape may have increased difficulties in healing from the trauma. Mental illnesses and trauma both need to be central considerations in safety planning and providing support services. (See *Disabilities 101. Working with Victims with Mental Illnesses.*)

How can service providers assist survivors of sexual violence in overcoming traumatic reactions?

Unfortunately, people who have survived sexual violence cannot erase it from their lives. Yet it is important for them to know that they can cope with and overcome its traumatic effects. In The Courage to Heal, Ellen Bass and Laura Davis offer this hopeful message to childhood sexual abuse survivors, which is applicable for all sexual violence victims:[27]

> "It is possible to heal. It is even possible to thrive. Thriving means more than just an alleviation of symptoms, more than band-aids, more than functioning adequately. Thriving means enjoying a feeling of wholeness, satisfaction in your life and work, genuine love and trust in your relationships, pleasure in your body."

No matter how committed a victim is to healing and thriving, however, these tasks are difficult to accomplish in isolation.[28] Several considerations are offered below for service providers who assist victims in taking their first steps towards recovery.

- Help victims understand how sexual violence can cause traumatic reactions and how trauma can affect them. For example, many victims have feelings of "going crazy" after an assault; those feelings need to be examined in the context of their response to trauma.
- Ask victims for guidance in identifying their reactions to the sexual violence and what assistance they would like. Explain that not every victim of sexual violence experiences trauma. Each victim who is traumatized has a unique combination of reactions, and their reactions may be impacted by other life circumstances.
- Affirm with victims who are experiencing trauma that while it may not feel like they will ever overcome the emotional devastation caused by the violence, it is possible to heal.
- Encourage victims to seek support from their families and friends and to tap into resources in their communities for support and for treatment of trauma. Ideally, victims will utilize a combination of resources to help them work through their pain and to achieve healing.[29]
- Explain to victims that mental health treatment for trauma may be available and involves managing symptoms and working through the trauma. Be clear that treatment strategies can vary, depending on factors such as the source and nature of the trauma, the age of the victim at the time of the traumatic event, and other circumstances related to the event.[30] Let them know that counseling is often an important part of recovery for trauma survivors and medications may be used to help reduce some of the related symptoms.[31]
- Explain to victims the services offered through their local rape crisis center. These centers typically offer a 24-hour crisis phone line, various support groups, one-on-one support and advocacy. Advocates can aid victims in determining steps they would like to take to move towards healing, based on their needs and wishes. Advocates can also provide information and referrals to a wide range of resources, including counselors at their rape crisis centers and mental health treatment providers who may have experience working with victims of sexual assault.

- In addition to encouraging victims to obtain referrals through the rape crisis center, they can also go to Mental Health America's factsheet on finding treatment through http://www.mentalhealthamerica.net/ and check with their community-based mental health agency for the services it offers or referrals to private providers. Another resource for finding private mental health providers is Psychology Today's Online Therapy Directory through http://www.psychologytoday.com/ (search by city/zip code). This publication is produced by the National Mental Health Association. (Also see resources listed in *Disabilities 101. Working with Victims with Mental Illnesses.*)
- Provide crisis intervention to victims who are in crisis (or immediately refer them to professionals who can). In addition to the local rape crisis center's 24-hour hotline, the National Suicide Prevention Lifeline is available 24 hours a day at 800-273-TALK (8255). Calls are routed to the nearest crisis center in its network. For information, go to http://www.suicidepreventionlifeline.org/. There may be additional resources for crisis intervention in your community. (See *Sexual Violence 101. Crisis Intervention.*)
- Explain that if a service provider cannot accommodate the needs of victims with disabilities or does not have information on accommodations offered by other providers, local disability service agencies may be able to offer assistance and/or appropriate referrals (e.g., providing victims who are deaf/hard of hearing with a listing of certified interpreters and tips for exercising their rights to request this service from a provider).

FYI The National Mental Health Information Center at http://mentalhealth.samhsa.gov/topics/ offers a wealth of information on trauma topics. Sidran Institute's Risking Connections program at http://www.riskingconnection.com also offers a list of related resources.

Vicarious Trauma

Persons who are exposed to the trauma of others can share some of the same symptoms. This "vicarious trauma" or "compassion fatigue" can result in many physical and emotional symptoms, including guilt, exhaustion and insomnia. Service providers need to learn to care for their own emotional needs as they work to assist victims. Creating a balance between work and relaxation, talking to a supervisor about disturbing cases, and making self-care a priority can help reduce vicarious trauma.

Applying the Knowledge

Consider the following case scenario in the context of what you have learned through this module. What are the issues for service providers to address and how might they initially support the victim in dealing with her traumatic reactions to her recent sexual assault?

Anna is a 55-year-old woman with cerebral palsy who resides in an assisted living facility. She calls your agency and explains that a male stranger entered her room that afternoon, shut the door, sexually assaulted her and then fled. She disclosed the attack to a nurse at the facility, who in turn contacted law enforcement as well as facility administrators and security. Law enforcement is enroute to the facility. Anna tells you that she doesn't think she will be comfortable or feel safe living in the facility in the future. She feels totally vulnerable to "creeps like the guy who assaulted her" who see her as easy prey—she uses a wheelchair and has a limited range of motion in her upper and lower body. She tells you that the assault has brought up memories of sexual abuse she experienced as a child that was perpetrated by a family acquaintance. At that time, she told her father about the abuse and was immediately protected. This time, however, she is afraid because she doesn't know who will protect her. (Her father passed away 10 years ago.) She feels that she can't trust anyone. Anna rarely sees her mother, due to her mother's poor health and limited physical mobility.

Immediate issues for service providers to consider:

- Clearly, Anna has been traumatized by the recent sexual assault. She is panicked about her safety. She is extremely on guard and distrusting. Unpleasant memories of an earlier assault have resurfaced, but she remembers being protected from further abuse by her father. She wishes that she had her father's support to deal with the current situation and to keep her safe.
- Service providers can initially assist Anna in dealing with her growing anxiety and fear by offering crisis intervention and help in planning for her immediate safety and well-being. Safety planning must take into account her limited mobility. It should also consider security measures available at the facility (security guards and cameras as well as staff monitoring of patient rooms) and the potential need for placement in another facility. Whether her mother has a role in her decision making will also impact planning. (See *Sexual Violence 101. Crisis Intervention, Sexual Violence 101. Safety Planning* and *Disabilities 101. Guardianship and Conservatorship.*)
- Anna can be reassured that her heightened feelings of anxiety are normal after experiencing the trauma of sexual assault. Service providers can encourage her to address the emotional trauma, just as she would be encouraged to seek treatment for physical injuries after the assault.
- Service providers can discuss with Anna what assistance they can provide for her, other community resources for victims of sexual violence and accommodations for people with disabilities (e.g., transportation to and from services when needed). They can aid her in identifying her immediate service and accommodations needs and in requesting these services and available accommodations. (See *Collaboration 101. Creating a Community Resource List* and *Disabilities 101. Accommodating Persons with Disabilities.*) In particular, they can mention that the rape crisis center offers accompaniment for victims when they report to law enforcement, seek forensic medical care, go to court, etc. They can ask her if she is interested in these services. (If she is interested, they can offer to connect her with the services). Service providers can also offer referrals to mental health providers who treat trauma related to sexual violence, as well as help her explore other sources of support, including her family, friends and other community professionals.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What causes emotional trauma? What experiences are commonly recognized as being potentially traumatic? *See page B8.2.*
2. What are examples of barriers that could impede healing from trauma for sexual assault victims with disabilities? *See page B8.2.*
3. What factors might influence whether a person's reaction to a stressful event is traumatic? *See pages B8.2–B8.3.*
4. What are symptoms of emotional trauma? *See page B8.3.*
5. What additional symptoms are key indicators of post-traumatic stress disorder (PTSD)? *See page B8.4.*
6. What are the three phases of rape trauma syndrome? *See page B8.4.*
7. What are some of the potential long-term effects of emotional trauma? *See page B8.4.*
8. How can service providers help sexual violence victims take their first steps towards recovery from trauma? *See pages B8.5–B8.6.*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the terms "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" generally are used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]American Psychiatric Association, *Diagnostic and statistical manual of mental disorders,* 4th ed. (Washington, DC: 2000). As cited in Witness Justice, Trauma—*The common denominator* (Frederick, MD), through http://mentalhealth.samhsa.gov/nctic/trauma.asp. This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]M. Smith & J. Segal, *Healing emotional and psychological trauma: Symptoms, treatment and recovery,* HELPGUIDE.org (last modified 2008), through http://helpguide.org.

[4]Smith & Segal.

[5]Santa Barbara Graduate Institute Center for Clinical Studies and Research and LA County Early Intervention and Identification Group, *Emotional and psychological trauma: Causes and effects, symptoms and treatment* (Healing Resources.info, reprinted from Helpguide.org, 2005), through http://www.healingresources.info.

[6]Paragraph from Santa Barbara Graduate Institute et al.

[7]American Psychiatric Association.

[8]Santa Barbara Graduate Institute et al.; and Center for Addiction and Mental Health, *Understanding psychological trauma* (Ontario, Canada, 2010), through http://www.camh.net.

[9]Smith & Segal.

[10]Smith & Segal.

[11]Drawn from Santa Barbara Graduate Institute et al.

[12]Drawn from Santa Barbara Graduate Institute et al.

[13]Also see Witness Justice for a description of "the science of trauma."

[14]This sentence and following bullets drawn from Santa Barbara Graduate Institute et al.

[15]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see endnote in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims/clients are often referred to as female.

[16]Bullets from Santa Barbara Graduate Institute et al.

[17]Symptoms listed, except where noted, from Santa Barbara Graduate Institute et al.

[18]Sidran Institute, *What is post-traumatic stress disorder?* (2000), through http://www.sidran.org. Through the same website, also see E. Giller, *What is psychological trauma?* (Workshop presentation at the Annual Conference of the Maryland Mental Hygiene Administration, 1999).

[19]Sidran Institute.

[20]Sidran Institute.

[21]Sidran Institute.

[22]*Rape in America: A Report to the Nation* (Arlington, VA: National Center for Victims of Crime and Crime Victims Research and Treatment Center, 1992).

[23]Paragraph from Sidran Institute.

[24]Center for Addiction and Mental Health.
[25]Santa Barbara Graduate Institute et al.
[26]Santa Barbara Graduate Institute et al.
[27]E. Bass & L. Davis, *The Courage to Heal,* 20 (New York: Harper & Row Publishers, Inc., 1988).
[28]Bass & Davis.
[29]Bass & Davis.
[30]For an explanation of a range of treatment strategies and resources, see Smith & Segal; and Santa Barbara Graduate Institute et al.
[31]Paragraph from Sidran Institute.

Crisis Intervention

This module is designed to assist service providers in developing a basic understanding of crisis intervention; identifying common reactions and coping mechanisms of sexual violence victims; and learning responses to effectively assist victims in crisis.[1]

Key Points

- Through crisis intervention, service providers can provide a safe environment where individuals can express their feelings and develop healthy coping strategies to deal with their traumatic reactions to sexual violence. When providing crisis intervention, service providers can: support victims and help them meet their needs; stabilize their reactions to the trauma; help them prioritize and plan to resolve their concerns; and provide informational and referral services.
- Basic crisis intervention responses are the same regardless of whether or not a victim has a disability. Each victim's specific needs should be taken into account as they may influence communication methods, accommodations, mandatory reporting, confidentiality, informational and referral resources, and options identified to help them cope with the crisis.
- There is no wrong or right way for a victim to react to the trauma of sexual violence. Examples of common victim responses include anxiety or fear; depression; shock; disorientation; intrusive memories and flashbacks; hyperarousal;[2] anger; self-blame and shame; avoidance of memories; suicidal thoughts; withdrawal; emotional numbness; negative beliefs about self, family, friends and the future; problems with relationships; sleep disturbances and nightmares; physical health symptoms and problematic coping behaviors.
- Specific recommendations for service providers when responding to a victim in crisis include the following: Remain calm and help calm the victim. Make sure the victim is safe. Determine if the victim needs any accommodations. Address the victim's medical concerns, urging her to seek any needed care following the sexual assault. Discuss reporting options. Address specific concerns of the victim, helping to prioritize the concerns in terms of urgency. Tell the victim what your agency can and cannot do for her. Disclose any mandatory reporting requirements. Provide the victim with contact information for the local rape crisis center, explain services offered and, with her permission, connect her with a victim advocate.[3] Strive to display acceptance, empathy and support for the victim.

B9. Crisis Intervention

Purpose

What do service providers do if a client they are working with, who has disclosed sexual victimization, is in crisis? The initial support and reaction that victims receive after a disclosure of sexual assault can profoundly impact their own reactions to their victimization and their recovery. While rape crisis center advocates are specifically trained to provide crisis intervention to victims of sexual violence, other service providers are not. For example, service providers in agencies serving persons with disabilities may interact with clients who, for the first time,

disclose sexual victimization. They must then provide basic crisis intervention if it is needed. Therefore, it is critical that service providers are informed and competent in their initial responses, as well as able to quickly connect victims to rape crisis centers for additional crisis intervention and ongoing support.

This module is designed to assist service providers in developing a basic understanding of crisis intervention; identifying common reactions and coping mechanisms of sexual violence victims; and learning specific supportive responses to effectively assist victims in crisis. (For a more in-depth examination of indicators of sexual violence and trauma that victims may experience, see *Sexual Violence 101. Indicators of Sexual Violence* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

Objectives

Those completing this module will be able to:

- Define crisis intervention;
- Identify possible responses to the trauma of sexual violence; and
- Understand appropriate intervention responses to victims in crisis to facilitate post-trauma healing.

Part 1: CORE KNOWLEDGE

What is a "crisis" for sexual assault victims?

Merriam-Webster's dictionary defines crisis as… *an unstable or crucial time or state of affairs in which a decisive change is impending; especially one with the distinct possibility of a highly undesirable outcome.*[4] In the case of a sexual assault, crisis sometimes is narrowly defined as 72 hours after the traumatic event.[5] However, since the impact of sexual assault often lasts for years, and since most victims never report the violence or seek help, many factors can re-introduce the trauma of the assault for a victim. For example, hearing a song in an elevator can trigger memories of an assault if that same song was on the radio at the time of the rape. Knowing that an offender is going to be released from prison after 25 years can cause a resurgence of fear and other emotions. Unresolved trauma in unreported cases can result in similar emotional responses. For example, having to attend class on a daily basis with the offender or having weekly Sunday meals with an offending relative can prevent the victim from overcoming the feelings of stress, fear and helplessness often associated with a crisis. Therefore, this module recognizes that many incidences over time can trigger crisis responses, rather than viewing a crisis as occurring only within a predetermined time frame after a sexual assault. It also acknowledges that crisis responses can impact the physical, mental, emotional/psychological and spiritual health of the victim.

What is crisis intervention?

Intervention simply means to *mediate, get involved or intercede.*[6] Crisis intervention attempts to stabilize the reactions to an immediate problem. Sometimes referred to as "emotional first aid" designed to "stop the emotional bleeding;" management, not resolution, is the goal.

What is the role of service providers in providing crisis intervention?

Through crisis intervention, service providers can provide a safe environment where a victim can express her feelings and develop healthy coping strategies to deal with her traumatic reactions to sexual violence. In general, when providing crisis intervention to a sexual assault victim, service providers can support the victim and help her meet her identified needs; stabilize her reactions to the trauma; help her prioritize and plan to resolve her concerns; and provide informational and referral services (including connecting her with the local rape crisis center).

To offer crisis intervention, service providers must be knowledgeable about sexual victimization, the laws and potential resources. (See the *Sexual Violence 101 modules*.)

How do victims of sexual violence react in a crisis?

Just as each person reacts differently to stress, each person also reacts differently to trauma. (See *Sexual Violence 101. Understanding and Addressing Trauma.*) It is critical that a service provider not judge a victim based on her response to the sexual violence (e.g., assume she is unaffected by the rape if she is calm and seems in control of her emotions). A victim's response can begin with avoidance or denial (e.g., "If I don't think about it I won't have to deal with it" or "It wasn't rape"). A common reaction is shock. Some victims become hysterical. Others may be unable to cry. These are all natural responses after a crisis. Feelings slowly surface as a victim finds the strength to deal with the reality of the assault.

Many victims are angry if their offender is someone they know. They may feel betrayed. They may feel anger at their family or friends for not protecting them. They may be angry with themselves for being vulnerable. Victims may blame themselves. They may think: "If I hadn't worn that dress…" or "If I hadn't hired that caregiver…" or "If I hadn't been drinking…" or "If I hadn't gone to that particular party…" These feelings of self-blame are often the reasons that victims do not report, so it is important for service providers to challenge these beliefs. (*See page B9-7.*) The offender is always responsible for the sexual violence, not the victim.

Other victims may be afraid. Fear is a common reaction if the offender is a stranger or if the offender is someone known to the victim and has threatened further harm if she reports the assault.

For many reasons, a victim may have difficulty labeling an attack as sexual assault. For example, she may have had previous consensual contact with the offender (e.g., kissing or dancing). She may have voluntarily consumed alcohol or drugs prior to the assault. She may not remember the attack or only have vague memories of it (e.g., because she was drugged by the offender). She may not have physically fought back or tried to get away. She may not have been physically injured. If she is in a relationship with the offender, she may justify sexual violence as "just rough sex." She may not be able to understand or want to believe that an authority figure (e.g., a teacher or clergy) sexually abused her (e.g., possibly because they "are in love" and she "enjoyed it"). Again, it is important for service providers to challenge these reasons, educate victims about what constitutes sexual violence and stress that the victim's behavior did not cause the violence.

There are many possible victim responses to sexual violence. They include:

- Depression
- Shock, disorientation and difficulty concentrating
- Unwanted and/or intrusive memories and flashbacks
- Hyperarousal (constantly alert, on the lookout, etc.)
- Anger
- Self-blame/guilt and shame
- Avoidance of memories/reminders
- Suicidal thoughts
- Withdrawal, shutting down/emotional numbness
- Negative beliefs about self, family, friends and the future
- Problems with other relationships
- Sleep disturbances/nightmares
- Physical health symptoms (stomach aches, migraines, etc.)
- Problematic coping behaviors (avoidance, denial, etc.)

(Also see *Sexual Violence 101. Indicators of Sexual Violence* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

Is crisis intervention for sexual violence victims who have disabilities different from crisis intervention for those without disabilities?

No, basic crisis intervention strategies should be used regardless of whether or not a victim has a disability. Additionally, each victim's needs should be taken into account as they may influence communication methods, accommodations, mandatory reporting, confidentiality, informational and referral resources, and options identified to help cope with the crisis. Consider:

- A crisis may exacerbate pre-existing conditions related to a person's disability. For example, if the person has a disability that affects her speech, a crisis may cause this disability to be more evident and make communication difficult.
- Disabilities that affect thought processes may be directly influenced by a crisis. For example, a person with a cognitive disability who has difficulty finding words to communicate effectively may find that a crisis renders her at a complete loss for words.
- A disability may be a factor in escaping the crisis. For example, a victim may feel unsafe in her home, but be unable to flee due to a physical disability.

To learn about a victim's circumstances, service providers need to:

1. **Listen** to what she says about herself (e.g., I had a stroke a few years ago that left me with memory loss).
2. **Ask questions** (e.g., What, if any, accommodations do you need to access services?).
3. **Observe verbal/nonverbal cues** (comments such as "It's not worth living like this" [said in a flat tone of voice] or "He's not here but I feel him burning me" [said in a trembling voice followed by hysterical crying]); slurred or stuttering speech; dazed appearance; and visible accommodations (e.g., presence of a service animal or use of a wheelchair).

Respect a victim's decisions about disclosing details of her situation—she may feel that some information is not pertinent for service providers to know (her disabilities, age, if there is a guardian, marital status, sexual preference, employment history, substance use, criminal record, etc.). She may not be cognizant of what information is relevant—gentle probing by service providers may help obtain a better picture of her circumstances. For example, a client tells a service provider that last week five boys from her church decided to "fall in love with her." She is now very upset that they are saying mean things about her and don't "love her" anymore. The service provider may ask open ended questions to learn/confirm she has Down syndrome and that the boys gang raped her.

FYI **In working with any victim, it is good practice to ask "Is there anything I should know that will enable me to better assist you?"** This one question can help identify the services that a victim needs and wants.

(Also see the *Disabilities 101* modules, particularly *Tips for Communicating with Persons with Disabilities* and *Accommodating Persons with Disabilities*.)

How should service providers respond to a victim who is in crisis?

To immediately respond to a victim who is in crisis, service providers should:

- **Remain calm and help calm the victim.** Although it is difficult to do so if the victim is hysterical, try to calm her so she can make rational, informed decisions. (*See Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

- **Make sure the victim is safe.** If she is not, encourage her to take the necessary steps to enhance her safety. If there is imminent danger, seek emergency assistance according to the policies of your agency. (See *Sexual Violence 101. Safety Planning.*)
- **Determine if the victim needs any accommodations**, such as an American Sign Language (ASL) or language interpreter, materials in an alternate format and/or assistive technology such as a communication device. If requested by the victim, help secure/coordinate needed accommodations. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- **Address the victim's medical concerns.** If the assault just occurred and the victim has been physically injured, urge her to seek medical assistance. Sometimes injuries are not visible, so encourage her to seek treatment if she is unsure. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
- **Discuss options for reporting.** Explain that, in West Virginia, she can decide whether or not to report a sexual assault to law enforcement, unless the situation meets the criteria for mandatory reporting requirements.[7] A West Virginia resident over the age of 18 is presumed to be competent unless a court determines otherwise. If someone is declared legally incompetent, they are considered a protected person and a court will appoint a guardian and/or conservator. (See *Sexual Violence 101. Mandatory Reporting* and *Disabilities 101. Guardianship and Conservatorship.*)
- **Address the specific concerns of the victim.** To provide effective crisis intervention, a service provider may be asked to answer specific questions and address specific concerns of the victim. Below are examples of possible issues, along with the titles of other modules where further information can be found.
  - Is what happened to me illegal? (See *Sexual Violence 101. Sexual Assault and Abuse Laws* and *Sexual Violence 101. Sexual Harassment.*)
  - I can't afford to go to the hospital or pay for medical treatment. Can someone pay for it? (See *Sexual Violence 101. West Virginia Crime Victims Compensation Fund.*)
  - I'm afraid I'll get pregnant or HIV because of the rape. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
  - What do I do to preserve evidence of the assault? (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
  - What's going to happen if I go to the hospital? (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
  - Why did the law enforcement officer I spoke with tell me not to eat, drink, go to the bathroom or change my clothes until after I am examined at the hospital? (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
  - I'm afraid he'll come back. (See *Sexual Violence 101. Safety Planning.*)
  - I don't feel safe in my home anymore. I'm also afraid for my children's safety. (See *Sexual Violence 101. Safety Planning.*)
  - I'm worried about telling my parents or partner about the assault (See *Sexual Violence 101. Safety Planning* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

Service providers can help calm a victim by reassuring her that they will assist her in addressing all of her needs (in collaboration with others, particularly the local rape crisis center) and ***then help her prioritize her concerns in terms of urgency.***

- **Provide the victim with the contact information for the local rape crisis center** for additional crisis intervention services, hospital accompaniment and follow-up support. If the victim agrees and agency policies permit, the service provider can immediately connect her with a local advocate (e.g., by calling the local rape crisis center directly or through the national 24-hour sexual assault hotline at 1-800-656-HOPE).

FYI Service providers should be knowledgeable about the services of the local rape crisis center to be able to effectively assist victims. (The *West Virginia Protocol for Responding to Victims of Sexual Assault*, available through www.fris.org, provides an overview and checklist on the role of the advocate and the services provided by a rape crisis center.) For example:

  - What are the scope and limitations of services offered? (e.g., Does the agency provide transportation for victims? Do advocates provide victim accompaniment during the forensic medical examination? Are counseling services and support groups available through the center? Are legal services offered?)
  - Are there age limits for the victims served? Are services provided to family members and significant others of victims?
  - How are services accessed? Are they free?
  - What specific resources exist within the rape crisis center for serving victims with disabilities? (E.g., Is there a list of interpreters? What other accommodations are offered? Does the center collaborate with other agencies to secure needed accommodations?) (See *Disabilities 101. Accommodating Persons with Disabilities.*)
  - What informational materials are available for victims? Is the information available in alternate formats (e.g., large print, Braille, etc.)?

- **As soon as possible in their interactions with the victim, service providers should tell her what they can and cannot do for her.** They should inform her about reporting requirements—for example, if they are a mandated reporter to Child Protective Services (CPS) and/or Adult Protective Services (APS). They should let the victim know they are there to help and to support her decisions. They should also know their own limitations. If service providers are uncomfortable or overwhelmed, they should ask their supervisors for assistance and/or consult with the local rape crisis center.

Throughout their interactions, service providers should display acceptance, empathy and support for the victim.

- ***Acceptance*** can be conveyed verbally (e.g., comments such as "I believe you" or "It's not your fault") or demonstrated non-verbally (e.g., listening, maintaining eye contact, etc.).
- ***Empathy*** can also be demonstrated verbally (e.g., "I'm so sorry this happened to you" or "You must have been terrified") or non-verbally (e.g., helping find clothing for her to wear home from the hospital if her clothes are kept for evidence or by providing tissues if she is crying).
- ***Support*** can be shown in many ways. For example, service providers can:
  - *Reassure the victim she took the right action by asking for help* and that you are glad she told you.

- *Remind the victim that any response to the trauma of sexual victimization is normal and valid.* Service providers can reassure her that many victims experience similar reactions—and these feelings will not last forever. Providing this information soon after the assault may reduce or prevent depression, post-traumatic stress disorder (PTSD) and anxiety by preventing the development of potentially damaging negative thoughts.[8] (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

- *Challenge self-blaming comments.* For example, if a victim is blaming herself because she went to a fraternity party, service providers can try to refocus her attention on her survival and coping skills. Service providers can reassure her by saying "Had you known you would be raped, you wouldn't have gone to the party." Self-blame tends to increase if drugs or alcohol were involved. Service providers can reassure her that her willingness to go to the party or to drink did not mean she consented to sex.

- *Let the victim know about the recovery process.* Service providers can help her understand that emotional healing is as important as physical healing. They can assess her social support systems, discuss any need for additional assistance—medical, legal, emotional and spiritual—and then make referrals as appropriate to her situation and choices. It is helpful to be knowledgeable of available community services. (See *Collaboration 101. Creating a Community Resource List.* Also see the resources available through the state sexual assault coalition website at www.fris.org.)

- Anticipate that the *victim will have additional questions and concerns after a period of time.* Knowledge is power and information may help her regain control. Service providers can encourage the victim to seek further assistance from the local rape crisis center and other community resources.

Whatever the situation, the overriding way to be supportive of victims is to listen and believe them. The healing power of just those two components—listening and believing—is extraordinary.

Service providers who work with sexual violence victims, regardless of their field of work or agency affiliation, can experience vicarious trauma after providing crisis intervention. They should make sure that they practice self-care, as they can best help others when they take good care of themselves.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What are examples of situations that might trigger a crisis for a sexual assault victim? *See page B9.2.*
2. What is the purpose of crisis intervention in general? As specifically related to sexual assault victims? *See page B9.2.*
3. What reactions to sexual violence are "normal" for victims? *See page B9.3.*
4. Does the crisis response vary if the victim has a disability? *See page B9.4.*
5. What specific actions can service providers take when responding to a victim who is in crisis? *See pages B9.4–B9.6.*
6. What are ways that service providers can convey acceptance, empathy and support for a victim? *See pages B9.6–B9.7.*

Part 2: DISCUSSION

Projected Time for Discussion
2 hours

Purpose and Outcomes

This section is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their actual work with sexual violence victims. These role-play activities could be incorporated into forums such as agency staff meetings as well as volunteer meetings or trainings. Anticipated discussion outcomes include an increased understanding of service providers' roles in crisis intervention when serving sexual assault victims and the opportunity to practice crisis intervention skills using case scenarios.

Refer to the learning objectives at the beginning of this module for specific outcomes for this module on crisis intervention.

Key Points for the Group to Consider

All skills take practice to perfect and it is preferable not to practice crisis intervention skills with a victim in crisis! One of the best ways to practice intervention skills is to role play different scenarios that a service provider might experience. Although role playing can seem awkward for some, consider that it is an opportunity to "do no harm" during the learning process. It enables service providers to identify areas in which they need additional information and practice without impacting a victim's healing process. If all group members agree to approach the activities as a learning process with the goal to help each other, then the commitment to investing some thought and creativity into the roles will add more reality to the experience.

Planning

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator. The facilitator should be familiar with crisis intervention, victims' responses, and role-playing.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, blank attendance sheet, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: *(5 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the scenarios. In general, there are no right or wrong responses, only different approaches.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among the participants and ultimately may shut down dialogue. The purpose of the role play scenarios is to provide the opportunity to practice new skills and obtain constructive feedback.

2. **Explain/demonstrate role-play activities.** Spend a few minutes discussing the concept of role-plays and their purpose in developing intervention skills. Some group members may have never had the experience of role-playing. Talk about the value in using individual creativity in building upon the roles outlined in the scenarios. If requested, have the facilitator demonstrate by role-playing the first scenario with a more experienced member of the group serving in the role of the victim (as directed in Activity 3). Following the demonstration, discuss the pertinent questions listed in Activity 4.

3. **Facilitate role-playing.** (*See Role-Play Scenarios* below. Keep in mind that in scenarios 1–5, the victims could have a disability even if one is not noted.)

Separate participants into pairs or small groups (the facilitator needs to determine how the group will be divided). Ideally, participants should be divided into groups of two, with each member of the pair rotating between playing the role of the service provider and the role of the victim. (Adapt the gender of the victim in each role-play to match the gender of the persons participating.) After two to three role-plays, new pairs should be formed. Continue the process with the next set of role-plays. Follow each role-play with a discussion as directed in Activity 4. *(Allow 5 minutes for each role-play, for a total of 30 minutes.)*

For individuals who are reading these scenarios without the benefit of a role-playing partner, write down an outline of how you would respond as the service provider in each scenario. After writing down your responses, look at the end of this module for some suggested responses to consider for each scenario.

Scenario 1

A woman calls who was sexually assaulted earlier in the evening. She wants help and wants to report the crime. What do you do? Would your response change if she discloses she is blind?

Scenario 2

You receive an email from a 14-year-old girl who was raped two days ago at a party. She is extremely scared that she is pregnant and wants emergency contraception. She hasn't told anyone and, although she is close to her mother, she is afraid that her mother will not believe her and will be angry because she was drinking. She does not want to make a report to law enforcement. How do you explain mandatory reporting laws (if applicable)? How do you help make it safe for her to get services? Would your response change if she discloses she is deaf?

Scenario 3

A caller who was sexually assaulted the night before is concerned about AIDS. She would like to have a medical exam but is unsure about reporting the assault to law enforcement. She's heard that there's a drug to prevent AIDS. Is there? If so, she has no money. Can you help her? If you do not have all the information she is requesting, what do you do? Would your response change if she discloses she has a mental illness and "tends to obsess about things?"

Scenario 4

A 19-year-old college freshman had too much to drink 10 days ago at a campus party, was gang raped and never reported the incident because she was afraid of being charged with underage drinking. She kept her clothes and did not wash them. The guys are now bragging on campus. She is angry and wants the offenders to be held accountable. What are her options? Would your response change if she discloses she has a cognitive disability which makes communication difficult? (She does not have a guardian.)

Scenario 5

A caller was raped a number of weeks ago by his male date. He has an extensive history of being abused and wants to talk about the painful details of the assault. What do you do? Would your response change if he discloses that he has had depression periodically for 10 years?

Scenario 6

A 24-year-old woman who appears to have Down syndrome stops by your table at the mall health fair. In the course of her general conversation, she tells you about the bus driver at her group home. Females in the home call him "Uncle Bob," and he brings them candy. He often touches her "private area." She is afraid he will stop giving her candy if she says she doesn't want him to touch her there anymore. She says it's really good candy. What do you do?

4. **As a large group, facilitate a review and discussion on each scenario.** Use the questions below, as well as the suggested action steps, to help guide the discussions. *(10 minutes per scenario, for a total of 60 minutes)*

a. After each role-play, have one or two pairs present their intervention responses and actions to the large group. Discuss whether their actions were appropriate. The facilitator should summarize the ideas on how to respond to the situation and re-instruct on specific best practices as necessary.

b. What key facts in the scenario impacted your response? Did your response change when you knew the victim had a disability? (Note that basic crisis intervention strategies and goals are consistent across victim populations, but that responses may be influenced by factors such as age, cultural beliefs and values, type of sexual violence, disabilities, etc.)

c. What laws or specific resources did you need knowledge of to be able to help the victim?

d. What aspects of this scenario made it uncomfortable for you to assist the victim?

Suggested action steps for each scenario:

Scenario 1—suggested actions and issues to consider

This scenario requires basic crisis intervention. Determine her age and if she has the capacity to make her own decisions. Assess her injuries and safety. Find out her needs. Briefly explain any available services and her options regarding the forensic medical exam and reporting. If she chooses to have a forensic medical exam, discuss transportation to an appropriate facility. Advise her to not wash, change clothes, urinate, defecate, smoke, drink, eat, brush her hair or teeth or rinse her mouth and to bring the clothes she was wearing when assaulted (or a change of clothes if she is still wearing the clothes she wore during the assault). Identify if there is someone she trusts who can support her. Provide unconditional support. Activate advocacy, medical, law enforcement and other relevant first responders as she directs. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

If the victim discloses that she is blind, discuss accommodations she may need to access services (material in an alternate format, help in filling out forms, use of a service animal, etc.). (See *Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 2—suggested actions and issues to consider

Service providers are often unclear about mandatory reporting laws. (See *Sexual Violence 101. Mandatory Reporting.*) Review them thoroughly and discuss with your supervisor. Most service providers have mandatory reporting requirements. How can you serve this victim once you know her age? How would that change if you know her

age, but do not know her name or phone number? *Can* you provide services without obtaining identifying information from the victim? How would the age of the offender impact your response? What is the time period for taking emergency contraception? Where can it be purchased, and what are the related age limitations? In such calls it is critical to create safety for the caller, identify her concerns and explore what options are available to her. Always recognize your limitations and refer for services when necessary.

Any victim communicating through an unsecured technological device (including email, cell phone or texting) should be advised that confidentiality issues are present and should utilize more secure methods of communicating.

If the victim discloses that she is deaf, she may have access to a text telephone (TTY) or Telecommunications Relay Services (TRS). The service provider would need to be familiar with communicating via these devices. Discuss accommodations she may need to access services (e.g., ASL interpreter). (Also see *Disabilities 101. Accommodating Persons with Disabilities*.)

Scenario 3—suggested actions and issues to consider

Under West Virginia law, victims can have a forensic medical exam conducted within 96 hours of a sexual assault. Exams can be conducted without reporting the assault to law enforcement (with the exception of cases requiring mandatory reports). The collected sex crimes kit will be sent and stored at Marshall University Forensic Science Center for up to 18 months. During that time, the victim can choose to report. Unless service providers are medical professionals, they are unqualified to give medical advice. In general, prophylactic/preventive treatment is available in most communities if started within 72 hours of exposure. The treatment's side effects can be difficult to tolerate. The known risk of contracting HIV from one unprotected sexual encounter is slight. Encourage the victim to go to or contact the hospital to receive detailed information on HIV prophylactic treatment from medical professionals as well as other services (if she chooses), such as a forensic medical exam, advocacy and an opportunity to report the crime. HIV treatment could possibly be paid out of the West Virginia Crime Victims Compensation Fund; however to access those funds, the rape would have to be reported to law enforcement. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination* and *Sexual Violence 101. West Virginia Crime Victims Compensation Fund.*)

If the victim discloses that she has a mental illness and "tends to obsess," it may be useful to again stress that it is unlikely she has been exposed to HIV, but that it is important to quickly address her concerns with a health professional and decide whether she is a candidate for prophylactic treatment. Discuss accommodations she may need to access services (e.g., transportation if she doesn't drive, accompaniment, etc.). (See *Disabilities 101. Working with Victims with Mental Illnesses* and *Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 4—suggested actions and issues to consider

This is a good example of a case that has several additional variables. First, the victim could conceivably be charged with underage drinking; it is helpful to know your local prosecutor's position on that issue. In most cases, forensic medical exams are conducted up to 96 hours following a rape. However, each case needs to be considered separately. If she was gang raped, there may have been significant tearing and bruising, which still could be visible and documented. The fact that she did not wash her clothes could provide the necessary DNA evidence. DNA, if not destroyed, can remain indefinitely. You would want to review the options with the victim. Those options would also include any appropriate reporting and disciplinary actions available through the local college. Utilize the services of the local rape crisis center for additional support and information. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

If the victim discloses having a cognitive disability that makes it difficult to communicate, discuss accommodations she may need (e.g., the method in which you communicate with her, assistance in filling out forms, etc.). (See

Disabilities 101. Tips for Communicating with Persons with Disabilities and *Disabilities 101. Accommodating Persons with Disabilities*.)

Scenario 5—suggested actions and issues to consider

Crisis intervention is a normalizing process that strives to return victims to pre-crisis levels of functioning. Having callers remain in an extreme emotional state or repeatedly revisit a traumatic event can be counterproductive. For some victims, the process of telling and re-telling the story can be therapeutic. Focus on what the caller needs right now. If he has never talked about the assault, then support him in disclosing and listen. If he has focused only on the assault since the rape and seems fixated on the attack, continue to listen but recognize that he may need additional interventions. Review his safety plan. Help him return to the present moment, find out how he helped himself feel better in the past, identify his support systems and make a self-care plan for the next few days. Possibly refer him for ongoing counseling. (See *Sexual Violence 101. Safety Planning*.)

If the victim discloses that he has a history of depression, talk with him about accommodations he may need (assistance in reaching out to other service providers, financial aid for counseling, etc.). Also, discuss how the most recent victimization may exacerbate his depression, as well as trigger unwanted thoughts about any past victimization. If he is open to it, talk with him about what he usually does to cope with depression, if there is anyone supporting him in dealing with it, and if so, encourage him to connect with them for additional support. (See *Disabilities 101. Working with Victims with Mental Illnesses* and *Disabilities 101. Accommodating Persons with Disabilities*.)

Scenario 6—suggested actions and issues to consider

This scenario presents several complicating factors: Is this a case of sexual abuse by an authority figure? Is the victim's capacity to consent to these sexual acts an issue? Are you a mandated reporter? While the victim may not be in crisis, since she views the sexual act as a means to an end (candy) rather than abusive, you need to take the suspected abuse seriously. Find a private place to talk with her. Validate her decision to tell you about the situation and explain that help is available. You should disclose that you are a mandated reporter (if you are). Explain in language she can understand that if she tells you that someone is harming her, you must tell someone on her behalf. Remember that your role is not to investigate the abuse, but to provide support and report any suspected abuse of those who cannot speak for themselves. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault and Abuse* and *Sexual Violence 101. Mandatory Reporting*.)

Ask her for the information you need to make a report to APS, such as her contact information and any specifics about what occurred (when, where, etc.). Ask if there is someone that helps her make decisions (the term "guardian" may have no relevance to her). If so, ask for contact information for that person and for the group home. (See *Sexual Violence 101. Confidentiality* and *Disabilities 101. Guardianship and Conservatorship*.)

FYI To close this activity, stress to participants that **when providing crisis intervention services, it is important to remain in the role of providing support for the victim.** Once people disclose victimization, in addition to dealing with the trauma of the assault, they usually begin wrestling with whether they took the right action by telling you about it. **Your reaction is critical to their healing process. Focus on their immediate needs by providing the support and information they need.**

5. **Closing.** Ask participants to write down any questions they have or additional information they need based on the role-play activities. Discuss their plans for getting the information they need to better provide crisis intervention services. *(10 minutes)*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the terms "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]Symptoms that stem from high levels of anxiety, such as: "Having a difficult time falling or staying asleep; feeling more irritable or having outbursts of anger; having difficulty concentrating; feeling constantly on guard or like danger is lurking around every corner; and being jumpy or easily startled." (M. Tull, *About.com* Health's disease and conditions: PTSD (*hyperarousal*) (2009), http://ptsd.about.com/od/glossary/g/hyperarousaldef.htm.) Note this and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

[4]Merriam-Webster Dictionary (accessed October 23, 2009), www.merriam-webster.com.

[5]L. Ledray & S. Moscinski, *Advocate/counselor training, Training manual* (Washington, DC: Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice), 104.

[6]www.merriam-webster.com (accessed October 23, 2009).

[7]*Legislative Bill HB08-1217* (Division of Criminal Justice, 2008)(accessed October 23, 2009), http://dcj.state.co.us/OVP/Documents/Forensic%20Exams/Information_for_Medical_Facilitiesweb.pdf.

[8]Ledray & Moscinski.

Safety Planning

This module offers basic information for service providers on safety planning with clients who disclose sexual victimization. It includes considerations when clients have disabilities.[1]

Key Points

- Safety planning is a thoughtful, deliberate process in which a helper and a victim together create a plan to enhance safety for the victim. Each victim's circumstances, safety needs and concerns are unique.[2]
- **The following are steps for safety planning with a victim in crisis:**
  - Ask the victim the reason she is calling/requesting help.
  - Ask if she has immediate or pending safety concerns for herself or her family.
  - Ask her if you can help in developing a plan of action to address her immediate safety needs. The plan should identify: specific steps the victim can take to address her immediate safety concerns; supportive persons in her life who can help with safety and their roles in the process; specific safety strategies that may prove difficult to achieve and accommodations needed to reduce or eliminate these barriers; any essential items the victim needs if she has to flee her current location; and referrals to community resources to meet her urgent needs.
  - Encourage the victim to follow up to let you know how she is doing and/or to develop a longer-term plan for safety and other assistance (unless the victim is referred to another agency for long-term planning).
- **The following are steps for safety planning when the victim has time to prepare:**
  - Build rapport with and listen to the victim.
  - Help the victim identify fears, obstacles, threats and barriers to her safety, health and well-being.
  - Ask the victim what she needs to do to be safe. Subsequently, help her develop a plan for safety in multiple situations, as appropriate to her circumstances and safety goals. Consider strategies to prevent future incidents of harm by others; strategies to facilitate protection and seeking help during a potentially unsafe interaction; strategies to obtain emotional support; plans for acquiring any necessary accommodations; and referral services that offer additional assistance the victim may need to promote her safety, health and well-being. Offer her safety planning materials in an alternate format as necessary.
  - If needed, practice and repeatedly discuss the safety plan until the victim feels comfortable with it. Encourage the victim to periodically review/update the plan as her situation changes.

B10. Safety Planning

Purpose

This module provides a reference for service providers in safety planning with sexual violence victims. It has four main components: introduction, safety planning for victims in crisis, general safety planning for victims who are not in crisis and safety issues for persons with specific disabilities. These topics are in one module so you can compare strategies across different types of situations and types of disabilities. Due to the length of the module, consider reviewing the module in two or three sessions.

Objectives

Those who complete this module will be able to:

- Understand the basic components of safety planning and its importance for sexual violence victims; and
- Gain knowledge about safety concerns of victims of sexual violence with disabilities and how to help them plan for their safety.

Preparation

- Review agency forms, policies and procedures on safety planning with clients.

Part 1: CORE KNOWLEDGE

Why is it critical to address the safety needs of sexual violence victims?

Sexual violence can shatter many victims' feelings of safety.[3] Victims may not feel physically safe for months or years after an assault.[4] If victims have or worry about ongoing contact with their perpetrators, their post-assault fears and hyper-vigilance may be especially acute.[5] Victims may develop an elevated general fear after an assault (of men, crowds, being alone, being out at night, etc.). They may face threats to their health, such as contracting a sexually transmitted infection or HIV/AIDs. The emotional distress they experience can also increase their risk of self-inflicted harm. (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

Victims may be unable or unwilling to seek assistance to enhance their safety for many reasons. They may be afraid that their perpetrators will retaliate or they may be immobilized by the emotional reactions or fears caused by the assault.[6] Victims with disabilities may face additional barriers to safety, due to challenges presented by their individual circumstances. For example, a victim may be physically dependent on an abusive caregiver and unable to seek help because the perpetrator isolates her from others and she lacks the social supports, financial means or transportation needed to escape. A victim with clinical depression may sink into a deeper depression and think about ending her life.[7] (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors* and *Sexual Violence 101. Indicators of Sexual Violence.*)

Victims' feelings of security and control in their lives can be enhanced when service providers provide an opportunity to discuss their safety concerns and ways to reduce their risk of further harm. They can help victims with disabilities examine if and how their disabilities impact safety and identify accommodations that may be useful in overcoming barriers to safety. Recognizing that victims' situations and safety concerns may change over time (e.g., if their level of functioning/mobility changes or if they start having flashbacks years after the assault), safety planning should be an ongoing process rather than a one-time event. It is critical that service providers also realize that victims with disabilities may worry that a disclosure of sexual assault may lead to a loss of independence. Therefore, they should support victims in making their own choices about their safety, to the

extent possible, instead of deciding what is best for them.[8] (See *Disabilities 101. Self-Advocacy with Victims with Disabilities.*)

What does safety mean to sexual violence victims?

Safety can have different meanings to individuals in the aftermath of being sexually victimized. For example, it can include safety from:

- *Continued physical harm, intimidation and retaliation by their perpetrators* (e.g., immediately following the violence; if they live with their perpetrator; if the perpetrator is someone the victim is likely to see in the community; if the perpetrator is arrested and then released on bail; during an investigation and prosecution; after the perpetrator is released from prison; etc.). Victims may be concerned for themselves as well as for the safety of their family, friends, pets and service animals. Victims may also fear retaliation from the family or friends of their perpetrator.
- *Other persons, places or things they fear as a result of the sexual violence or existing fears that are exacerbated by the violence* (e.g., if the assault occurred in a parking garage, a victim may have a fear of using a parking garage).
- *Potentially life-altering and fatal health issues resulting from the sexual violence,* such as sexually transmitted infections (STIs), HIV/AIDs, depression and pregnancy.
- *Self-inflicted harm and other self-destructive behaviors in reaction to the emotional distress triggered by the sexual assault* (e.g., suicide attempts, self-mutilation, excessive drinking, drug use, unsafe sexual activity, compulsive overeating or binge eating).

(See *Sexual Violence 101. Understanding and Addressing Emotional Trauma* and *Sexual Violence 101. Crisis Intervention.*)

What is safety planning?

Safety planning is a thoughtful, deliberate process in which a helper and a victim together create a plan to enhance safety to the extent possible for the victim.[9] Given the dangers that victims potentially face, the process of safety planning is critical in helping them identify and address their unique safety needs. However, victims *must also understand that while a safety plan may help them reduce their risk of future harm, it does not guarantee prevention of further victimization.* It is important to emphasize that sexual victimization is never the victim's fault. Providing a consistent message across service delivery systems that sexual victimization is never their fault can help victims reframe their experience and aid in their recovery from the trauma they experienced.

There are two main forms of safety planning for victims discussed in this module: planning when victims are in a crisis; and planning when they have time to prepare. When victims are in crisis and/or experiencing imminent danger, their immediate focus typically is on finding a safe location (e.g., away from the perpetrator, the place where the assault occurred or the situation that is causing them fear) and on seeking support to help them become safer (e.g., law enforcement officers to protect them from the perpetrator, emergency medical services technicians to treat serious injury and/or a crisis counselor to help them deal with their distress). In non-crisis situations, victims have more time to focus on their comprehensive safety needs.

Safety plans should be based on victims' self-identified needs and goals rather than professionals' opinions or family members' concerns. To the extent possible, victims should make their own choices about planning for safety. It is understandable that family, friends and others who support victims want them to be safe from harm after a sexual assault. For example, a family member may want an older victim with disabilities placed in a residential facility rather than living in the community on her own. A service provider may feel that a victim with a mental illness who has suicidal thoughts is the "safest" in an

in-patient psychiatric hospital. Yet these safety "solutions" may represent a loss of independence for victims and may not be their personal choices. *Victim-centered safety plans, on the other hand, can help restore power and control to victims as they make decisions about their safety.* For example, the older victim may ultimately choose to remain living in the community, but with a caregiver and enhanced security measures. The victim with a mental illness may decide to address her suicidal feelings through out-patient counseling, contact with supportive friends and use of a 24-hour crisis line.[10] (See *Disabilities 101. Self-Advocacy and Victims with Disabilities, Disabilities 101. Guardianship and Conservatorship* and *Sexual Violence 101. Working with Victims with Mental Illnesses.*)

Which agencies should assist victims with safety planning?

All agencies that interact with sexual violence victims should have the capacity to do basic safety planning with them, both in crisis and non-crisis situations. They should have policies and procedures to facilitate this planning with victims and provide training for staff to implement these policies and procedures. However, all agencies do not need to be experts in safety planning or in implementing safety plans. Rather, each agency should develop relationships with other providers in the community and share resource lists. (See *Collaboration 101. Creating a Community Resource List.*) Staff can then connect victims with more comprehensive assistance to access services, information and accommodations. For example, disability service providers can refer victims to the rape crisis center for detailed information about what to do following a sexual assault.

How can service providers assist victims who are in crisis in planning for their safety?[11]

If a victim who is in crisis contacts any service agency, the provider should quickly gather information and offer help in planning for her safety. Keep in mind that a victim in crisis often requires immediate assistance to be safe and that the provider's interaction with her may just be for a matter of minutes, depending upon her circumstances. The provider can encourage the victim, when there is more time, to develop a longer-term safety plan and offer aid in developing that plan (as discussed later in this module). NOTE: There will be some overlap in crisis and longer-term safety planning. (See *Sexual Violence 101. Crisis Intervention.*)

CHECKLIST FOR SAFETY PLANNING WITH A VICTIM IN CRISIS

- ❍ **Ask the victim the reason she is calling/requesting help.**
  - Convey that you are glad she called/requested help, you believe her, the violence was not her fault, you are sorry the violence occurred, and you can assist her in getting help.
  - Respect and accommodate the pace of communication and the needs, abilities and experiences of the victim.
- ❍ **Ask the victim if she has immediate or pending safety concerns for herself, her family, any pets and/or service animals. Ask her to be specific.**
  - Validate her concerns about safety.
  - In the case of imminent danger, call 911 as per your agency's policy.
  - If the assault was recent, explain the importance of getting immediate attention for any injuries as well as for the prevention of sexually transmitted infections and pregnancy (if relevant). Help facilitate medical care for the victim as per your agency's policy. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
  - If relevant, explain to the victim the mandatory reporting requirements, as defined by state law. (See *Sexual Violence 101. Mandatory Reporting.*) Recognize that victims with disabilities may be reluctant to involve law

enforcement or other authorities for a variety of reasons. (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors.*) If a mandatory report is required, encourage the victim to initiate the report and offer assistance in reporting.

- ❍ **If she discloses having a disability, ask her to explain any concerns she has related to how the disability may affect her safety.**
  - It may be difficult for her to identify if and how a disability impacts the situation (e.g., because she has not considered this issue before or has trouble comprehending the extent of the danger posed). Provide support as necessary in talking through this issue.
- ❍ **Ask the victim if you can help her in developing a plan to address her immediate safety needs** (for her and her dependents, pets and service animals as applicable to the situation). The plan should identify specific tasks, persons and resources that can help meet her needs. These could include:
  - Specific steps the victim can take to address her immediate safety concerns. Offer assistance in brainstorming creative solutions to safety that are within her abilities and resources.[12]
  - Supportive persons whom the victim can turn to for help with safety needs and their potential roles in the process.
  - Specific safety strategies that may prove difficult to achieve and accommodations available to reduce or eliminate any barriers. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
  - Essential items needed, if time and safety allow, when the victim has to flee from her current location (e.g., medications, assistive devices, information about services and financial benefits, key insurance and legal documents, money, caseworker's name and phone number, information about a legal guardian, etc.) and any assistance needed to obtain these items. (See the next section for a more extensive list of items.)
  - Referrals to community resources to meet the victim's urgent needs. As appropriate, ask if you can immediately connect her with agencies to help her deal with the situation (e.g., to the local rape crisis center).
- ❍ **Encourage the victim to follow up to let you know how she is doing and to develop a longer-term plan for safety and other assistance** (if the victim is not referred to another agency for long-term planning).

What is involved in longer-term safety planning with victims with disabilities?

If victims are not in crisis, service providers can help them develop a more long-term safety plan. In general, longer-term safety planning involves the steps described below.[13]

CHECKLIST FOR GENERAL SAFETY PLANNING WHEN THERE IS TIME TO PREPARE

- ❍ **Build rapport with and listen to the victim.** Respect and accommodate the pace of communication and the needs, abilities and experiences of each victim. Do not underestimate the power of compassionate listening—victims can benefit simply from being heard, believed and supported in their decisions regarding safety.[14] (See *Sexual Violence 101. Crisis Intervention.*)
- ❍ **Help the victim identify fears, obstacles, threats and barriers to safety, health and well-being that may be in her life.** Also consider these issues as they apply to her dependents, pets and service animals. (See the next section on issues specific to victims with disabilities.)

- **Ask the victim if and how any needs for accommodations might impact her safety and safety planning.** Consider what accommodations might help meet her safety needs. (See *Disabilities 101. Accommodating Persons with Disabilities.* Also see the next section on issues specific to victims with disabilities.)
  - Consider support persons who can assist with safety needs and discuss their roles.
  - Consider community resources available for safety and possible barriers she may encounter in accessing them. For example, a courthouse that is not physically accessible may permit a protection order court hearing to occur by telephone to accommodate petitioners who use wheelchairs.[15]
  - If the victim knows her perpetrator, discuss if and how the perpetrator could potentially prevent her from using services and resources. For example, if the victim is deaf, an abusive spouse or caregiver could tell her that 911 will not respond to her TTY calls, or may try to act as an interpreter for her during a hospital visit to control the content of her statements to healthcare providers. Provide the victim with clarifying information and brainstorm options for these situations.[16]
- **Ask the victim what she needs to do to be safe.** The victim is an expert on what safety techniques will work best for her, given her strengths, circumstances and accommodation needs. Most victims will be able to state their preferred methods for accomplishing a task. Rely on the victim's creativity and knowledge, while providing her with information on sexual violence and, if necessary, suggestions for additional methods of reaching the same goals.[17]
  - Recognize, however, that a victim may have difficulty identifying the possible safety solutions and accommodations she needs (due to a disability, misinformation about available resources, isolation from society, etc.). While service providers cannot know every detail about every type of disability, they must understand the basic functions needed to develop and implement a safety plan, be aware of available safety planning strategies, and explore how a disability might affect those safety planning functions and accommodations.[18]
  - Help the victim create a safety plan for multiple situations as appropriate to her circumstances and safety concerns and goals. Below are some ideas.[19]
    - ***Strategies to prevent future incidents of harm by others:***
      - Report the violence to law enforcement or other authorities (with the expectation that the perpetrator will be arrested/incarcerated or otherwise remove/restrict access to the victim).
      - Minimize financial dependency on one person; include more than one person in financial arrangements (e.g., assisted living staff and a family member or a guardian and a service provider).
      - Obtain and understand basic information on sexual violence, personal boundaries, personal safety and community resources.
      - Inform caregivers and service providers that any sexual violence will be reported to law enforcement and follow through with reports.
      - Reduce isolation through multiple social connections (family, friends, church, neighbors, social networks, etc.).
      - Maintain regular conversations with someone other than the caregiver (with a doctor, advocate, family member, Adult Protective Services (APS) worker, clergy, etc.) who can verify personal safety.
      - Obtain a restraining/protective order, if eligible.

- — Screen personal care attendants before hiring and guardians before appointment.[20] (See *Disabilities 101. Guardianship and Conservatorship.*) If the perpetrator is the caregiver, arrange for alternative personal assistance.
- — Identify a supportive family member/friend to live with, either temporarily or permanently. Also identify family members, friends and others who can regularly check in to monitor safety.
- — If there are children, grandchildren or other dependents, devise a plan of safety for them when with/not with them. Inform schools, day care programs, etc. about who has permission to pick them up and who does not.
- — Reduce chances of contact with the perpetrator by moving to another safe, accessible residence or room in a residential facility, transferring to another class/program, changing routines, etc.
- — Identify safe communication methods for corresponding and interacting with service providers (ask providers to use plain envelopes, mail information only to locations deemed safe by the victim, make contact only through phone numbers and e-mail addresses deemed safe by the victim, address victim safety getting to and from appointments, etc.).
- — Change and add locks and install alarm systems and other home security measures (keep windows shut and locked at all times, increase outside lighting, etc.).
- — Change telephone numbers and e-mail addresses. New numbers should be unlisted and unpublished. Screen telephone calls.
- — Hide/disarm/remove weapons.
- — If vehicles and any adaptations are used, they should be in good working order. Keep the gas tank at least half full so there is always enough gas to leave a situation quickly if necessary.
- — Obtain an escort to the car, bus, taxi or other transportation being utilized. Also, a friend and/or family member can be asked to call to check on the victim's safe arrival at a destination at a specified time.
- — If the perpetrator is convicted, make victim impact statements during sentencing and parole hearings. These may result in a longer prison sentence and/or special conditions during incarceration and/or probation and parole.

o ***Strategies to facilitate protection/seeking help during a potentially unsafe interaction:***

- — Ensure access to communication (phone, cell phone, TTY machine, computer/Internet service, etc.) if help is needed.
- — Maintain access to assistive mobility devices.
- — Identify who can help and have emergency numbers and a phone/other communication devices readily available (e.g., program 911 into a cell phone or activate an alarm button).
- — Identify a signal, such as placing a towel in the window or using a code word (e.g., the word "red" could mean "I'm in danger"), which will alert neighbors, family or friends to send help.
- — Teach children and other dependents how to contact law enforcement and emergency services.
- — Plan routes/destinations to escape a variety of dangerous situations (at home, at work, at school, while

in transit, in public buildings and places, etc.) and identify/secure accommodations and what assistance is needed. If a service animal is used or there are dependents, the plan should also include how to get them to safety. If leaving during a dangerous situation, plan to drive directly to the police station.

— Gather together:

- ☐ Important contact information (law enforcement, APS, rape crisis center, domestic violence agency, home health agencies, caseworkers, disability service providers, friends or past caregivers who might be willing to help with personal care tasks during transitional periods, etc.);
- ☐ Important documents, both for the victim and any dependents (protection orders, driver's license and other I.D. cards, birth certificates, social security cards, benefit award letters, proof of disability, work permits, green cards, passports, divorce and custody papers, leases, rental agreement/house deed, car registration/insurance papers, fixed route bus passes, mobility ID cards, special transit ID cards, etc.);
- ☐ Spare keys;
- ☐ Money, bank books, checkbooks, credit/debit cards, ATM cards, mortgage payment book and public assistance cards;
- ☐ Medications and medical documents (insurance papers, Medicaid and Medical Assistance document/cards, medical records, prescriptions, service animal's medical/shot records, etc.);
- ☐ Assistive devices and supplies;
- ☐ Food and supplies for a service animal; and
- ☐ Personal items (address books, pictures, jewelry, clothing, a few toys for small children, items of sentimental value, etc.).

Store these items in an easily accessed/safe location (e.g., at a friend's house) if a quick escape is needed. Remember, however, that no item is as important as the victim's safety.

— If a protection order is in place, carry it at all times and give copies to trustworthy people at places of employment, school and other frequented sites or where protection from the perpetrator is needed.

— During an incident, try to move away from rooms that have any possible weapons, like the kitchen. Seek shelter in a room where a door can be locked and that has a working phone/communication device. Or, if possible, look for an exit, yell for help or try to flee.

o ***Strategies for obtaining emotional support:***

— Identify a 24-hour/consistent source of support, crisis intervention and contact as needed.

— Decide who can provide the needed support (e.g., caseworkers, service providers, family and/or friends) to talk about the sexual violence. Spend time with these individuals (in person or through phone/online contact).

— Participate in support groups and counseling.

- If there is a need to be in communication with the perpetrator, maximize safety in doing so—whether by telephone, writing a letter, e-mail or in the company of a third person. Debrief with a support person after any communication/interaction with the perpetrator.
- Seek assistance with daily functions as needed (e.g., explore childcare options, request time off from work/school or ask for a reduced workload).
- Attend to physical needs and concerns (e.g., if nightmares and difficulty sleeping are issues, talk with a doctor about possible remedies).
- Participate in activities that soothe, calm and lift spirits such as playing with and caring for pets, listening to music, exercising, meditating or praying, reading or listening to inspirational materials, finding a hobby, or attending community activities.
- If there is a concern about self-harm:
  - ☐ Remove items that could be used for self-harm;
  - ☐ Ask a supportive person to lock up and/or limit the amount of medications easily accessible;
  - ☐ In advance, consider what to do to stay safe if suicidal thoughts or thoughts about self-harm occur (e.g., go to a public place or a hospital, visit a friend, journal, call the crisis hotline, etc.).

- ***Identification of referral services*** that offer additional assistance in promoting safety, health and well-being.

- **If needed, practice and repeatedly discuss the safety plan** with the victim until she feels comfortable with it.
- **Encourage the victim to periodically review and update the safety plan as her situation changes.** Different circumstances may require different safety strategies (e.g., changes in the victim's place of residence, capacity to function or need for assistance). Encourage the victim to inform supportive friends, family and others of changes to the plan.
- **Offer the victim safety planning materials in alternate formats as needed.**

What are specific issues that victims with disabilities face in safety planning, as well as potential solutions?

The charts below offer examples of different safety issues and potential solutions. [21] These examples are not meant to be an all-inclusive listing of points to consider for safety, as each victim's needs are unique.

Victims with Cognitive Disabilities
Safety issues • Cognitive disabilities generally fall into the following categories: learning disabilities such as dyslexia, attention deficit hyperactivity disorder (ADHD), brain injuries and genetic diseases such as Down syndrome, autism and dementia.[22] People with cognitive disabilities may or may not have issues with language, learning, mobility and capacity for independent living. However, the range of capabilities of people with cognitive disabilities is probably greater than with any other type of disability.[23]

- Some people with cognitive disabilities are overprotected and discouraged from being independent or interacting with others. Often, they are limited to segregated services and programs (e.g., in residential, healthcare, educational and work settings).
- Some individuals with cognitive disabilities are taught to comply with authority at all times and this can impact their ability to identify options for safety. (See *Disabilities 101. Self-Advocacy and Victims with Disabilities.*)

Possible safety solutions

- When safety planning with victims with cognitive disabilities, keep in mind that the plan must match what they can process and retain. For example, a one-step plan to call a friend, family member or case manager may work best for some individuals. Others will be able to process and retain more detailed safety planning information. (See *Disabilities 101. Tips for Communicating with Persons with Disabilities.*)
- Depending upon a victim's needs, frequently review the safety plan. Consider role-playing potential scenarios so the victim can practice the planned response.
- Consider including photographs and phone numbers of trusted persons in the plan.
- If a victim is not able to maintain confidentiality, help arrange for services that do not have to be kept confidential (e.g., shelter or program locations).
- Ask for a guardian to be assigned to victims when appropriate. (See *Disabilities 101. Guardianship and Conservatorship.*)
- In group living situations, develop strategies with nonoffending staff, guardians and family members to allow for monitoring and dual oversight of the victim's safety at all times. Oversight strategies planned to ensure the safety of residents should strive to maintain the independence and autonomy of the victim. (See *Disabilities 101. Self-Advocacy and Victims with Disabilities.*)

Victims with Sensory Disabilities

Hearing

Safety issues

- Not all individuals who are deaf or hard of hearing use sign language or even the same form of sign language. Some may have difficulty reading and understanding complex documents. Ask the person what method of communication is preferred. (See *Disabilities 101. Tips for Communicating with Persons with Disabilities.*)
- It may be difficult for a person who is deaf or hard of hearing to keep the assault hidden from others in the Deaf community. This community is often very cohesive and it is not uncommon for one person's crisis to be common knowledge within days.

Possible safety solutions

- Check with the victim before engaging any specific services for them (e.g., an emergency interpreter service may work with or for the perpetrator).
- You cannot tell the identity of a person talking on the TTY. Perpetrators may pretend to be victims using the TTY to gain information. If this situation is a possibility, set up a code word with the victim (e.g., the name of her cat) to verify with whom you are speaking.

- Save an outgoing message to 911 typed into the TTY memory so that a victim can quickly request an emergency police response. The message should include her address and any existing protection order information.
- Erase the memory on the TTY machine after a confidential conversation. The TTY has a computer chip that retains previous phone calls in its memory. If a victim is leaving the TTY behind, the perpetrator might be able to find out where she went by reading the phone conversation from the TTY memory.
- Perpetrators may damage TTY machines to prevent victims from communicating with others. Note that the West Virginia Division of Rehabilitation Services (www.wvdrs.org or 800-642-8207) provides low interest loans to qualified individuals with disabilities to purchase assistive technology. In addition, the Centers for Independent Living within the state operate a Community Living Services program that also provides funding to individuals with disabilities to purchase assistive devices or pay for home modifications to improve accessibility. See www.mtstcil.org.
- Flashing lights and vibrating pagers can be connected to a motion detector, alarm system, doorbell or other devices to increase a victim's safety.

Vision

Safety issues

- There are several types of vision disabilities, each requiring differing accommodations. People who are legally blind may be able to read large print or move about without mobility aids. They may be able to perceive light and darkness, some color or see nothing at all. Some persons who are blind may read Braille, but the majority of people who are blind do not. Some use service animals, some do not. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- People with service animals WILL NOT leave their animals; service animals need to be included in any plan to flee a situation.
- Perpetrators may try to use the animals to control victims because of their dependency on the animals.

Possible safety solutions

- Vibrating pagers or fans can be hooked up to a motion detector or alarm system to quietly signal the victim that the alarm has been set off.
- Service dogs can signal to the victim the presence of someone they know well. In a dangerous situation, they can serve as an excuse to get out of the house for a walk.
- Service dogs can be easily trained by a professional to "smile on command." Smiling dogs look like they are baring their teeth (e.g., getting ready to attack) and could be used as a deterrent.
- If at all possible, victims should not leave service animals behind if they flee. Safety planning should include identifying alternate care for the service animal if needed, bringing food and supplies for the animal, inclusion of the animal's medical/shot records with other necessary papers, etc.
- If you offer to escort a victim somewhere and your offer is accepted, allow the person to hold your arm and direct them rather than pulling them. Let the person control her movements to the extent possible. Verbally describe the area as you travel through it.

Speech/Communication

Safety issue

- Victims with communication disabilities may have difficulty conveying their needs for assistance in an emergency situation. (See *Disabilities 101. Tips for Communicating with Persons with Disabilities.*)

Possible safety solutions

- With the victim's permission, identify a person who has information about the victim's personal history and sexual violence chronology and is willing to assist in explaining her situation in a crisis.
- Pre-record a message with pertinent information onto a tape recorder and place it near the phone so it that can be played during a 911 call.
- Activate emergency assistance using alarm buttons and bracelets.

Victims with Mobility Disabilities

Safety issues

- There is a wide range of physical abilities among those who use wheelchairs and other assistive devices. Some people do not use wheelchairs exclusively and may also use canes, leg braces or nothing at all for brief periods of time.
- When giving directions to a person, consider the distance, weather conditions and physical obstacles such as stairs, curbs, steep hills and other possible transportation barriers. (See *Disabilities 101. Tips for Communicating with Persons with Disabilities.*)
- Some folding wheelchairs have arm pieces or leg braces that can be removed and potentially used as a weapon.

Possible safety solutions

- When the victim needs immediate help and must use a phone that is monitored or controlled by the perpetrator, it may be helpful to develop a prearranged code word (e.g., the name of her cat) or pre-designated illness (e.g., she can't talk because of a migraine) that communicates to the provider that the victim is in a crisis situation.
- It is important that people with limited mobility stay as close to a pathway to safety as possible. For example, a victim might sleep on the ground floor of a multi-story residence to make escape easier. A cell phone or alarm system could enable her to immediately call for assistance. Safety items should be within the victim's reach. For example, the front door spy hole (also known as a "peep hole") should be at the eye level of the person who will be using it. Phones could be installed both near the victim's bed and where she is during waking hours.
- Many 911 call centers store information in their database that is instantly available on a computer screen to 911 dispatchers. When a person with a disability calls in an emergency, it is possible to retrieve past information that would assist the law enforcement response. As a safety planning strategy, review with the victim the specific disability-related information that would be helpful to provide to the 911 dispatchers in an emergency situation.

- As a safety planning strategy, people who routinely use personal care attendants can learn techniques for screening them during the hiring process and have emergency replacement caregivers available.
- When strategizing with a victim who has an abusive caregiver, discuss alternatives for the personal care tasks (e.g., cooking, house cleaning, shopping, accompaniments, clerical assistance, lifting and transferring, feeding, bathing, bowel and bladder care, and dressing) for which the caregiver is responsible.

Victims with Hidden Disabilities

Safety issues

- Hidden disabilities in this module refer to those disabilities that may not be easily detected by or apparent to others. This category could include disabilities already mentioned, as well as chronic health conditions that can cause disabilities such as HIV/AIDS, seizure disorders, asthma, diabetes, heart disease and substance abuse.
- Some people with disabilities may have difficulty with breathing. Many different substances may be responsible for the constriction of air passages that is symptomatic of asthma. Stress may also be a factor in causing difficulty with breathing.
- People with diabetes who take insulin may be subject to insulin shock brought on by exercise, stress, an overdose of insulin or too little food. Too much sugar in the blood and not enough insulin may result in a diabetic coma.
- An individual's seizure threshold may be influenced by many factors such as emotional upset, bodily discomfort, stress, hunger, fatigue or changes in medication.

Possible safety solutions

- Discuss with the victim her pattern of stress-related illness and any signals that her symptoms may be increasing. Ask her to identify methods she uses to limit the increase of symptoms in stressful situations. Brainstorm additional options.
- Determine where to get information about specific disabilities.

Victims with Mental Illnesses

(See Sexual Violence 101. Working with Victims with Mental Illnesses, Sexual Violence 101. Understanding and Addressing Emotional Trauma and *Disabilities 101. Tips for Communicating with Persons with Disabilities.)*

Safety issues

- Mental illnesses typically are recurring, ongoing conditions. Societal discrimination is a barrier to accessing services for victims with mental illnesses.
- People with certain mental health diagnoses may develop patterns of relating to others that make relationships

difficult to initiate and maintain. Community resources available for these individuals may be significantly less accessible for this reason.

- Dissociated or fragmented thoughts and an inability to process information may affect a victim's ability to recognize and avoid danger, as well as possibly impact her credibility from the perspective of the criminal justice system.
- A high percentage of adults diagnosed with serious mental illnesses have histories of childhood abuse. It can be helpful to provide these individuals with basic information regarding flashbacks and memory triggers to traumatic experiences.
- Abusive caregivers/partners may tamper with victims' medications as a control tactic.

Possible safety solutions

- Regardless of whether a mental illness was present before the onset of the sexual violence, sexual victimization can have many emotional and behavioral effects, leading to a trauma-induced diagnosis or the exacerbation of an existing mental illness. Service providers can stress this fact with victims.
- For victims who are distrustful of service programs, providers can help them build their trust by responding empathically to disclosures of sexual violence and initiating discussions about safety. In turn, victims may be willing to share more information that allows providers to learn about their history of victimization, their individual circumstances, their needs and the accommodations required to access services.
- Part of building trust is letting victims know early in your interactions with them the limitations of your services (e.g., your agency provides crisis intervention and support, but not counseling) and the scope of confidentiality your program can maintain (e.g., that you are a mandatory reporter as per state law and 911 will be called in the case of imminent danger). (See *Sexual Violence 101. Mandatory Reporting* and *Sexual Violence 101. Confidentiality.*)
- Collaborate with other local community providers (e.g., a mental health practitioner who understands both sexual violence and disability issues) to brainstorm how to best assist victims in specific cases as needed. Also, offer to connect victims with these providers to expand the resources available to them.
- Many individuals are able to identify their memory triggers and are able and willing to both plan to avoid these situations, as well as to learn how to deal with the flashbacks.
- Support victims by developing creative ways for them to provide personal information and history in a crisis. It is sometimes helpful to identify a person or a system that has information about a victim's personal history and sexual violence chronology and is willing to assist in explaining her situation in a crisis.

Test Your Knowledge
Refer to the pages in this module as indicated to find the answer to each question.

1. How can safety planning help victims increase their safety and well-being? *See pages B10.2–B10.3.*
2. What steps can service providers take to aid sexual violence victims in crisis in planning for their safety and well-being? *See pages B10.4–B10.5.*
3. What steps can service providers take to assist victims in planning for their safety when there is time to prepare? *See pages B10.5–B10.9.*
4. What are examples of specific issues that victims with disabilities face in safety planning, as well as potential safety solutions? Please describe for victims with cognitive disabilities, sensory disabilities (hearing, vision and speech), mobility disabilities, hidden disabilities, and mental illnesses. *See pages B10.9–B10.14.*

Part 2: DISCUSSION

Projected Time for Discussion
2 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their collaborative work with sexual violence victims. The discussion could be incorporated into forums such as agency staff meetings as well as multi-agency meetings or trainings. Anticipated discussion outcomes include an increased understanding of the safety issues faced by sexual violence victims and victims with disabilities, as well as ways to plan to address those issues.

Refer to the learning objectives at the beginning of this module for specific outcomes for this module.

Planning

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator. The facilitator should be familiar with safety planning with victims of sexual violence and with victims with disabilities.
- Select a note taker.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion. Each participant should bring to the meeting a copy of their agency's policies, procedures and forms related to safety planning.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, blank attendance sheet, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable to express their opinions and feelings on the various topics. There are no right or wrong answers, only different perspectives.

- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and the expectations for confidentiality in the context of this partnership.

2. **Ask a representative from each partnering agency to share their agency's approach to safety planning with clients and any tools they use** to facilitate this process.

   Then, ask participants to discuss the following questions in a large group: *(25 minutes)*

a. Are the approaches to safety planning that their agencies use narrower, as broad as or broader than the approaches discussed in the *Part I: Core Knowledge*? Explain.

b. Do the approaches to safety planning that their agencies use allow for individualized planning and flexibility?[24] Explain.

c. What different issues have agencies addressed when safety planning with clients? For example, abuse by caregivers and victims' concerns about long- term care placement.

3. **Ask participants to read over the following two scenarios and then discuss the questions for each in a large group.** *(60 minutes)*

Scenario 1

Jessica, a 19-year-old college student, was recently sexually assaulted by another student who is in several of her classes. She calls your agency in crisis and explains that she fears intimidation by the perpetrator and his friends, getting a sexually transmitted infection and becoming pregnant. She is afraid that she will not be able to quickly flee the perpetrator or his friends if he comes after her, due to a vision disability and difficulty walking. She reveals that she has been contemplating *suicide due to the intense shame and self-blame she is feeling. She also fears that her parents, who are overprotective to begin with, will want her to quit school and come home so "they can take care of her." She feels that by going home, she will lose her independence after struggling for so long to gain it.*

Scenario 1 questions to consider:

a. What steps can your agency take to respond to the crisis that Jessica is facing and help facilitate her immediate safety?

b. Jessica follows up the next day, as requested, to let your agency know she is safe. What steps can your agency take at this point to help Jessica develop a longer-term plan for safety?

c. What other agencies may be able to provide information or assistance to Jessica to help enhance her safety, health and well-being and/or provide accommodations? What steps can your agency suggest to Jessica to connect her with these resources?

Scenario 2

Hank is a 35 year-old man with moderate autism who lives in a residential facility (a group home). Tom, a new staff person at the group home, takes Hank to a physician's office for his annual physical exam. When helping Hank change into a patient dressing gown, Tom fondles Hank's genitals and buttocks and then tells Hank to lay down on the exam table to wait for the doctor. Hank does what Tom says and is too afraid to say anything about the sexual contact. Back at the group home, Hank avoids Tom as much as possible. Hank's brother, who is Hank's guardian, visits a few days later. He notices that Hank is acting more nervous and withdrawn than usual, especially when Tom is around (Tom is the staff person on

duty during his visit). The brother asks Hank what is going on. Hank just keeps repeating "Tom is a pervert" and says that he doesn't want to be around him. The brother isn't sure what to do; he calls your agency for guidance.

Scenario 2 questions to consider:

a. What steps can your agency take to respond to the brother and help facilitate Hank's immediate safety?

b. Subsequently, what steps can your agency take to help Hank develop a longer-term plan for safety? How can the brother fit into the plan?

c. What other agencies may be able to provide information or assistance to Hank to help enhance his safety and well-being and/or provide accommodations?

d. What steps can the service provider from your agency suggest to Hank and his brother to connect them with these resources?

4. **As a large group, ask participants to discuss the following questions:**[25] *(15 minutes)*

a. How do you support clients in making their own choices about safety, even if risk is involved, and balance that with your concerns for their safety? (See *Disabilities 101. Self-Advocacy and Victims with Disabilities.*)

b. What are ways service providers exclude victims from their own safety planning? How can agencies strengthen victims' voices in this process?

5. **Closing.** Ask each participant to write down how the information gained from this discussion will promote change in their agency's policies, practices or training programs and their next steps in the process of initiating that change. Then facilitate a large group discussion on this topic. *(15 minutes)*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the term "victims" is primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" generally are used to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

[3]Victim Rights Law Center, *Beyond the criminal justice system: Using the law to help restore the lives of sexual assault victims. A practical online training module for attorneys and advocates and other professionals* (Boston, MA and Portland, OR, 2009).

[4]Victim Rights Law Center.

[5]Victim Rights Law Center.

[6]Victim Rights Law Center.

[7]A useful resource in considering safety planning for persons with disabilities is Community Living British Columbia, *Addressing personal vulnerability through planning: A guide to identifying and incorporating intentional safeguards when planning with adults with developmental disabilities and their families* (Canada, 2009).

[8]Drawn from Day One: The Sexual Assault and Trauma Resource Center, Rhode Island Coalition Against Domestic Violence and PAL: An Advocacy Organization for Families and People with Disabilities, *Is your agency prepared to ACT? Conversation modules to explore the intersection of violence and disability* (Advocacy Collaboration Training Initiative, 2004), 37-43.

[9]National Clearinghouse on Abuse in Later Life, Anticipate: *Identifying victim strengths and planning for safety concerns,* Trainers Module (Madison, WI: Wisconsin Coalition Against Domestic Violence, 2003), 7-9, through http://www.ncall.us/docs/. This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested that you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[10]Concept for this paragraph drawn from Day One et al., 39.

[11]Section adapted from C. Hoog, *Model protocol on safety planning for domestic violence victims with disabilities* (Olympia, WA: Washington State Coalition Against Domestic Violence, 2004).

[12]C. Hoog, *Enough and yet not enough: An educational resource manual on domestic violence advocacy for persons with disabilities in Washington state,* 83-90 (Olympia, WA: Washington State Coalition Against Domestic Violence, 2003), http://www.mincava.umn.edu/documents/wscdv/wscdv.pdf.

[13]Adapted from Hoog, Model protocol; B. Brandl, C. Dyer, C. Heisler, J. Otto, L. Stiegel and R. Thomas, *Elder abuse detection and intervention,* 205-8 (New York: Springer Publishing Company, 2007); and National Clearinghouse on Abuse in Later Life, *Interactive training exercises on domestic abuse in later life, Safety planning: A guide for individuals with physical disabilities, and Safety planning:* How you can help (cognitive disabilities) (Madison, WI: Wisconsin Coalition Against Domestic Violence), all through http://www.ncall.us/docs/.

[14]Hoog, *Enough and yet not enough.*

[15]Paragraph from Hoog, *Model protocol.*

[16]Paragraph from Hoog, *Model protocol.*

[17]Paragraph from Hoog, *Model protocol.*

[18]Paragraph from Hoog, *Model protocol.*

[19]Adapted from National Clearinghouse on Abuse in Later Life, *Anticipate; Safety planning: A guide for individuals with physical disabilities and Safety planning: How you can help (cognitive disabilities);* and Hoog, Enough and yet not enough.

[20]See C. Hughes, *Stop the violence, break the silence training guide: Building bridges between domestic violence and sexual assault agencies, disability service agencies, people with disabilities, family and caregivers,* 72-4 (Austin, TX: Disability Services ASAP of SafePlace, 2005).

[21]With exceptions as noted, this section excerpted and adapted from Day One et al., 37-43. Originally excerpted and adapted from Hoog, *Model protocol.*

[22]Disability definitions, http://studentdisability.wayne.edu/handbook/010._disability_definitions_list_6.05.pdf.

[23]While persons with profound cognitive disabilities may need considerable assistance with their daily functioning, individuals with less severe cognitive disabilities have greater levels of functioning, perhaps even to the extent that the disability is not discovered or diagnosed. Adapted from WebAIM—Web Accessibility in Mind, *Cognitive disabilities,* http://www.webaim.org/articles/cognitive/.

[24]Question adapted from Day One et al., 40.

[25]Questions adapted from Day One et al., 39-41.

Sexual Assault Forensic Medical Examination

This module provides basic information on the sexual assault forensic medical examination and related considerations for victims with disabilities.[1]

Key Points

Service providers to whom victims first disclose sexual victimization can help facilitate the forensic medical exam process by following the steps below (after addressing victims' immediate needs for medical treatment, crisis intervention and safety planning).

- Explain to victims (and their caregivers/guardians when appropriate) the need for a forensic medical examination to assess medical needs and collect forensic evidence related to a recent sexual assault.
  - Explain what happens during the exam process, keeping in mind the amount of information that victims want/can handle at this time. Inform them that a victim advocate may be available to be with them during the examination and beyond. Inform them of the medical facility options and their options for transportation to a medical facility. If they have a disability, encourage them to let responders know how to best accommodate their needs.
  - Explain how to help preserve bodily evidence until it can be collected (e.g., do not wash, change clothes, urinate, defecate, smoke, drink, eat, brush hair or teeth, or rinse mouth). Explain that in suspected cases of drug/alcohol facilitated sexual assault, their first available urine should be collected and brought to the medical facility if they cannot wait to urinate until arrival at the facility. Explain that since their clothing may be taken as evidence, they may wish to arrange to have a change of clothes at the medical facility. (NOTE: In some facilities replacement clothing may be available.)
  - Explain who pays for the exam. In WV, the state covers the forensic costs if the exam is conducted within 96 hours of the crime. Victims are responsible for any non-forensic treatment costs.
  - Inform victims of their reporting options. They can have the forensic medical exam conducted within 96 hours of the crime even if they have not decided about reporting the sexual assault to law enforcement. There is no statute of limitations on reporting sexual assault. Collected evidence in a non-report will only be stored for up to 18 months.
- Explain that if the sexual assault was not recent, victims can still access medical care, advocacy and other services. They can report the crime to law enforcement and discuss with responders whether evidence might be available to corroborate their account of the sexual assault.
- Give victims the opportunity to discuss their concerns and ask questions about their health, the exam, reporting, advocacy, etc. Help them identify their options for addressing these concerns.
- Respect victims' decisions related to advocacy services, reporting (except if there is a threat of self-harm, harm to others or a mandatory reporting situation), and the forensic medical exam (the exam should never be done against their will). If victims would like to receive support from advocates, report and/or seek protective services from law enforcement or have the exam done, service providers can connect them with the appropriate responders.

B11. Sexual Assault Forensic Medical Examination

Purpose

This module offers basic information on the sexual assault forensic medical examination and related considerations when victims have disabilities. When victims initially disclose sexual violence to service providers, it is important that providers are able to generally explain the forensic medical exam process. This explanation can help victims make informed decisions related to the exam. Providers can also link victims with first responders to sexual assault, guide them in preserving evidence and obtaining support to minimize retraumatization and begin the healing process.

This module does not go into depth regarding the clinical or forensic aspects of the examination. For further guidance on the discipline-specific and coordinating roles of first responders in West Virginia before, during and after a sexual assault forensic medical exam, see the *West Virginia Protocol for Responding to Sexual Assault,* available through http://www.fris.org. Also see *A National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescent,* available through http://samfe.dna.gov.[2]

Objectives

Those completing this module will be able to:

- Describe the purpose of the sexual assault forensic medical examination, what it entails and who conducts it;
- Discuss who may be involved in the immediate response to sexual assault, their respective roles and the importance of a coordinated response to victims;
- Discuss considerations during the examination for victims with disabilities; and
- Answer related questions that often arise, such as whether the exam can be performed if victims are undecided about reporting the crime, which entities cover the cost of the exam and what happens when disclosures are delayed.

CORE KNOWLEDGE

What is the purpose of a sexual assault forensic medical examination?

Following a sexual assault, victims may require medical attention for their injuries and need to address their health concerns. There may be evidence on their bodies that could be collected and information that needs to be gathered about the assault, if the victim is considering reporting the assault to law enforcement. Since the body is the crime scene, evidence is time-sensitive and may only be present until the victim bathes, washes and/or urinates.

The purpose of the sexual assault forensic medical exam is to assess a victim's health care needs and to collect evidence for potential use during case investigation and prosecution.[3] An examination by a health care provider is still recommended even if (1) there are no visible injuries as a result of the assault, (2) the victim does not wish to have evidence collected, or (3) the assault was not recent. In these cases, the victim may have injuries that are not apparent or acute or have related health concerns.[4]

What does the forensic medical examination include?

Specifically, the forensic medical exam includes:

- Support and crisis intervention;

- Information gathering from the victim for the forensic medical history;
- An examination/medical assessment;
- Coordination of treatment of injuries;
- Documentation of biological and physical findings;
- Collection of evidence from the victim's body;
- Information, treatment and/or referrals for sexually transmitted infections, pregnancy and other non-acute medical concerns; and
- Follow-up care as needed to facilitate additional healing, treatment or collection of evidence.[5]

How is the forensic medical exam different from a medical exam?

The biggest difference is that a medical exam is solely for health purposes, while a forensic medical exam is geared to address victims' health concerns related to a sexual assault and to collect and preserve forensic evidence. And while most local health providers are able to provide general medical care, not just anyone can conduct a sexual assault forensic medical exam (as explained below). Sexual assault forensic medical examinations in West Virginia are typically performed at hospital emergency departments rather than other health care sites such as a physician's office, a clinic or campus health center.

Who conducts the forensic medical examination?

The examination is conducted by a health care provider, ideally one who has specialized education and clinical experience in the treatment of sexual assault patients and the collection of forensic evidence.[6,7] As a part of post-exam duties when the criminal justice system is involved, this health care provider (henceforth referred to as an "examiner") may also be called on to interpret, analyze and present exam findings and provide factual and/or expert opinion related to the examination.[8]

Many health facilities use sexual assault nurse examiners (SANEs) to perform these examinations. SANEs are registered nurses with advanced education and clinical preparation in sexual assault forensic medical examinations. Many SANE programs utilize on-call nurses to provide around-the-clock coverage for one or more health facilities. When a victim of sexual assault seeks help at one of these facilities, the on-call SANE is contacted to perform the examination. The SANE typically begins the examination after the victim has been assessed and treated for serious injuries. Experienced SANEs provide compassionate care, expertise in identifying physical trauma and psychological needs, skill in coordinating care and referrals, and knowledge regarding how to document injuries and other forensic evidence. Thorough evidence

Since the mid-1990s, there has been momentum to improve the quality of the sexual assault forensic medical examination and address problems historically associated with it, such as:

- Long waits in hospital emergency departments for victims to receive care;
- Limited services for victims and a lack of coordination among responders;
- Health care personnel who were not proficient in forensic evidence collection and who were reluctant because of the possibility of being subpoenaed to testify; and
- Lack of information for victims on policies regarding payment for the examination, as well as incorrect hospital billings.

Many resources are now available to help communities ensure that the examination is more effective in facilitating victim healing and case investigation. These include guides to creating standardized protocols, evidence collection kits, training programs for examiners, guides to developing sexual assault response teams (SARTs) and materials for victims describing what to expect during the examination.

Contact the West Virginia Foundation for Rape Information and Services (FRIS) at http://www.fris.org to learn about related efforts in West Virginia.

collection and testimony by SANEs have helped prosecutors obtain increased numbers of guilty pleas from offenders and have increased the number of convictions.[9]

What other responders are involved during the forensic medical exam process? What are their roles?

The term "exam process" is used to describe the coordinated intervention among first responders that occurs before, during and after the forensic medical examination.

In addition to the health care providers who conduct the exam, other local professionals can be involved in response to victims during the exam process. (Their roles are briefly summarized in the chart below). Together, they ensure that victims have access to immediate comprehensive care, work to minimize trauma, encourage the use of community resources, and facilitate case investigation (if a report is made)—all of which may lead to charges against suspects and subsequent prosecution.[10] Ensuring that victims are supported, their needs are met, their questions answered and their concerns addressed can facilitate their healing and may increase their level of comfort and involvement with the criminal justice system.

First Responders Commonly Involved in Sexual Assault Cases
Health care providers initially assess patients for acute medical needs and provide stabilization, treatment and/or consultation. Ideally, SANEs perform the forensic medical exam and post-exam activities as discussed above. Depending on victims' circumstances and needs, other health care personnel may be involved.
Sexual assault victim advocates may be involved in the initial victim contact (via 24-hour hotline or a face-to-face meeting) to offer victim advocacy, support, crisis intervention (in conjunction with the examiner), and information and referrals before, during and after the exam process. They may facilitate transportation for victims to and from the exam site and provide replacement clothing if needed. They often provide comprehensive, longer-term services designed to aid victims in addressing needs related to the assault, including but not limited to emotional support and legal and medical systems' advocacy. Advocates can assist victims with disabilities in securing any needed accommodations throughout the service delivery system.
Law enforcement (e.g., 911 dispatchers, patrol officers, officers who process crime scene evidence and investigators) respond to initial complaints, work to enhance victims' safety and arrange for victims' transportation to and from the exam site as needed. They interview victims. They ensure that forensic evidence is properly stored and transferred to the crime lab. They investigate cases—interview suspects and witnesses, request lab analyses, review medical/lab reports, prepare and execute search warrants, write reports and present cases to prosecutors.
Prosecutors determine if there is sufficient evidence for prosecution and, if so, prosecute the case. They should be available to consult with first responders as needed. Prosecutors make the final determination whether to proceed with a criminal case. Victims still have the option of seeking criminal charges if additional evidence is later uncovered or in pursuing civil legal remedies.
Forensic scientist/crime lab personnel analyze forensic evidence and provide results of the analyses to investigators/prosecutors. They may also testify in court regarding their analyses results.
Additional professionals or agencies may be involved in immediate interventions and service provision, depending on the case, jurisdictional policies and the victims' needs. For example, if victims with disabilities lack the capacity to consent, Adult Protective Services (APS) may be involved. If victims reside in a nursing home facility, and the assault occurred there, facility staff and a long-

term care ombudsman may be involved. If victims require accommodations beyond what the health facility can provide, disability service agencies may be able to assist in securing accommodations. Mental health providers may be involved in the initial response if a psychological evaluation is needed.

Victims who attend institutions of higher education may have the recourse of seeking disciplinary charges. When that happens, members of the campus judiciary board review the case to decide if the institutional code of conduct has been violated and, if so, to determine sanctions. American Indian tribes may have their own codes related to sexual assault and/or processes through which victims can seek remedies, beyond what is available through state or federal prosecution.

Victims may secure civil attorneys to protect their interests, address concerns that affect their everyday lives and long-term well-being, represent them in civil legal matters and ensure their rights are upheld during the criminal justice process. Civil attorneys sometimes are consulted during the examination process.

Responders in the same service area usually have established methods to facilitate coordination among their agencies to immediately respond in sexual assault cases (e.g., for requesting examiners at health facilities, the use of on-site services of advocates, intervention by law enforcement, consultation with prosecution, etc.). If communities have sexual assault response teams (SARTs), the teams facilitate this coordination. (For more on facilitating coordination among agencies, see the modules in *Collaboration 101*.)

FYI Service providers should know how to quickly connect victims with the appropriate responders in their communities, depending on the identified needs. The local rape crisis center is a good place to start to obtain this information. Of course, if there is a risk of imminent danger to victims or others, first call 911 for emergency assistance. The National Sexual Violence Hotline (1-800-656-HOPE) immediately connects callers with an available local rape crisis hotline. Other useful information for first responders to know:

- Is there a local SART? How is its response activated?
- What area health facilities perform sexual assault forensic medical exams? Is there a SANE program that serves the area and these facilities? What happens if victims present at facilities not equipped to do forensic medical exams?
- Can medical facilities accommodate victims with disabilities (specify the type of disability and accommodation needs)? If not, are there other options to accommodate these victims?
- Are advocates available to provide support and accompaniment before, during and after the examination?
- Do local law enforcement agencies have specially trained investigators that handle sexual assault cases? When do they get involved in cases?

Regardless of their roles, the key principles below should underlie intervention by all responders to sexual assault victims (adapted from *A National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescent*):

- Victim safety and well-being are the paramount goals of response. (See *Sexual Violence 101. Safety Planning*.)
- Victims know far more about themselves and their needs than responders.
- Victims have the right to make their own choices and those choices must be respected. To make these choices, they need information about the resources available, their options, and the expected consequences of choosing one option over another. (See *Disabilities 101. Self-Advocacy and Victims with Disabilities*.)

- All victims deserve a high-quality forensic medical exam and to be treated with respect and compassion.
- The right to confidentiality must be respected unless victims are a danger to themselves or others or in mandatory reporting situations. (See *Sexual Violence 101. Confidentiality* and *Sexual Violence 101. Mandatory Reporting*.)
- Sexual assaults committed by persons known to victims are as serious a crime as those committed by strangers.

What happens during the forensic medical exam process?

The following is a very brief overview of what happens during the exam process (see the resources listed on B11.2 of this module for more detailed information). When explaining this process to victims, provide them with opportunities to ask questions or raise related concerns. Help them identify their options for getting their questions answered and their concerns addressed.

FYI Responders should follow jurisdictional and agency policies regarding maintaining their own safety and the safety of others during the forensic medical exam process.

Exam Process Components	
Initial contact	A victim's point of entry into the service delivery system often is through initial contact with law enforcement, an advocacy agency or other service organization. A victim may also present at a health facility. First responders play a critical role in: • Assessing and addressing emergency medical assistance, safety and support needs of the victim; • Explaining to the victim the importance of medical care and evidence collection; • Coordinating transportation for the victim to the medical facility; • Explaining to the victim how to preserve bodily evidence until it can be collected at the exam facility (e.g., do not wash, change clothes, urinate, defecate, smoke, drink, eat, brush hair or teeth, or rinse mouth); • Explaining in the case of a suspected drug/alcohol facilitated sexual assault, that if the victim cannot wait to urinate until arrival at the medical facility, she should collect/bring a sample to the facility (the sooner a urine specimen is obtained after the assault, the greater the chances of detecting substances that are quickly eliminated from the body[11]); and • Explaining to the victim that clothing may be taken as evidence—she may wish to arrange to have a change of clothes at the medical facility. (In some facilities replacement clothing may be available.)

Triage and intake	Health care providers do the following, based on facility and jurisdictional policies: • Give sexual assault cases priority medical care; • Respond to acute injury, trauma care and safety needs before evidence is collected; • **With victim consent,** alert other responders of the need for their services— o An examiner to conduct the forensic medical exam; o An advocate to provide support, crisis intervention and advocacy; o A law enforcement officer to take a report, offer protection and begin the investigation; and • In a mandatory reporting situation, the assault should be reported to APS or Child Protective Services (CPS) and/or law enforcement. However, the examination cannot be done against the patient's will. It is also the victim's choice whether she wants advocacy services.
Forensic medical history As outlined in the WV Sex Crime Collection Kit. Medical facilities that conduct these exams must use this kit or one that contains all of the items in this kit. The forensic medical history is different from the investigative interview conducted by law enforcement if there is a report. The investigative interview often occurs at the medical facility at the conclusion of the examination.	The examiner seeks the following information, based on jurisdictional policies: • Date and time of the assault/examination; • Offender information (if known); • Assault-related history, including possible involvement of drugs/alcohol; • Post-assault activities of the victim; • Pertinent medical history, including, for women, contraceptive/menstruation information and gynecological history; and • Recent consensual sexual activity.
The examination See the WV Sex Crime Collection Kit.	The examiner does the following, based on jurisdictional policies: • Conducts the general physical exam; • Conducts the anogenital exam; and • Document findings using written notes, anatomical drawings and/or photography as appropriate.

Evidence collection See the WV Sex Crime Collection Kit. Many variables affect the relevance of certain types of evidence in a particular case, including whether an assault was committed by a stranger, a known offender who claims no sexual contact with the victim, or a known offender who claims the victim consented to the contact. All evidence available is important, not just DNA evidence.	The examiner collects the following, as relevant to each case and based on jurisdictional policies: • Clothing evidence; • Debris (e.g., dirt, leaves, fibers, hair, fingernail swabs); • Foreign materials and swabs (e.g., bite marks) from the surface of the body; • Hair combings; • Hair reference samples as needed; • Oral and anogenital swabs and smears; • Known blood or saliva sample or buccal swab for DNA analysis and comparison; • Toxicology samples as needed; and • Documentation of evidence as needed.
Related medical concerns While risk of pregnancy, sexually transmitted infection and HIV/AIDs from a sexual assault is low, these are major concerns for victims.	The examiner does the following, based on facility and jurisdictional policies and as relevant to the victim's age and gender: • Informs the victim of the risk of pregnancy and sexually transmitted infections, testing for HIV/AIDs, and prophylactic steps to avoid pregnancy and infection; • Provides testing/prophylactic care as needed; and • Provides referrals for related follow-up health services.
Discharge and follow-up instructions	The examiner does the following, based on facility and jurisdictional policies: • Provides the victim with the opportunity/supplies to wash, change clothes (providing replacement clothing if necessary) and get food/beverages; • Informs the victim about post-exam care (information may include referrals to address health needs related to the assault, discharge instructions, follow-up appointments with the examiner or other health providers, and contact procedures for medical follow-up and documentation of developing/healing injuries and resolution of healing); and • Coordinates with advocates, law enforcement and other involved professionals to discuss other issues with the victim, including safety planning, comfort needs, informational needs, the investigative process, advocacy and counseling options and follow-up contact procedures.

FYI The forensic medical examination is an invasive and personal procedure. The health care professional conducting the exam should ask the victim if she would like to have an advocate with her, whose only role is to provide support and comfort to the victim.[12] Extreme care should be taken to ensure that someone who may be the perpetrator (family member, caregiver, guardian, etc.) is not in the room. Under no circumstances should law enforcement or other first responders be in the examining room and under no circumstances should anyone other than health care personnel take photographs of victims' genital areas.

What can responders do to make the exam process more comfortable for persons with disabilities?[13]

(See *Disabilities 101. Tips for Communicating with Persons with Disabilities; Disabilities 101. Accommodating Persons with Disabilities; Disabilities 101. Guardianship and Conservatorship; Disabilities 101. Working with Victims with Mental Illnesses* and *Disabilities 101. Self-Advocacy and Victims with Disabilities.* Also see *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors; Sexual Violence 101. Mandatory Reporting* and *Sexual Violence 101. Safety Planning.*)

- *Understand that victims may have physical, sensory, cognitive, developmental or mental health disabilities or multiple disabilities.* Make every effort to recognize issues that could potentially arise during the exam process for victims with disabilities (both in general and in relation to their specific disability) and provide reasonable accommodations upon request.
- *Be aware that the risk of criminal victimization, including sexual assault, for people with disabilities is much higher than for people without disabilities.* People with disabilities are often victimized repeatedly by the same offender.[14] Caretakers, family members or acquaintances may be responsible for the sexual assault. In such a case, the offender may be the person transporting the victim to the medical facility. Jurisdictional and medical facilities' policies should be in place to provide guidance on how staff should screen for and handle situations that are potentially threatening to patients or facility personnel.
- *Speak directly to victims,* even when interpreters, intermediaries or guardians are present.
- *Respect victims' wishes to have or not have caregivers, family members or friends present during the exam.* Although these individuals may be accustomed to speaking on behalf of persons with disabilities, it is critical that they do not influence victims' statements during the exam process. If aid is required (e.g., from interpreters), do so only with the victims' consent.
- *Follow medical facility and jurisdictional policy for assessing the ability of adults considered by West Virginia law to be "incapacitated" to consent to the examination, evidence collection and involving protective services.* Keep in mind that the inability to consent could be temporary (e.g., due to substance use, a psychotic episode or onset of an illness such as high fever or a stroke) and victims may at some point be able to make their own decisions. Again, note that guardians could be offenders—if sexual violence by a guardian is suspected, protective services needs to be contacted.
- *Assess victims' needs for assistance during the exam process.* Explain the exam procedures to victims and ask what accommodations they require, if any (e.g., people with certain physical disabilities may need help to get on and off the exam table, may need to be positioned differently for the exam, or may need an alternative to the exam table entirely). Do not assume, however, that they will need special assistance. Also, ask for permission before proceeding to help them (or touch them or their service animals or handle their mobility or communication devices).
- *Ask victims to specify their preferred method of communication. Do not make assumptions.* Preferences and capacity can vary widely. For example, not all individuals who are deaf or hard-of-hearing understand sign language or

can read lips. Not all blind persons can read Braille. Communication equipment that may be beneficial to victims with sensory and communication disabilities include TTY machines, word boards, speech synthesizers, anatomically correct dolls, materials in alternate formats and access to interpreter services. Responders should familiarize themselves with the basics of communicating with individuals using such devices. Some victims with communication disabilities may prefer communicating through an intermediary who is familiar with their speech patterns.

- *Recognize that individuals may have some type of cognitive disability (for example, an intellectual disability, traumatic brain injury, neurodegenerative condition such as Alzheimer's disease, or stroke).* Speak to these individuals in a clear and calm voice and ask very specific and concrete questions. Be exact when explaining what will happen during the exam process and why. Be aware that some victims with cognitive disabilities may be easily distracted and have difficulty focusing. To reduce distractions, conduct the exam in an area that has no bright lights or loud noises. It may also be helpful if examiners and others present in the exam room refrain from wearing jewelry or uniforms with ornamental designs.

- *Recognize that in cases where victims cannot verbalize what happened to them during the assault, evidence collected during the forensic medical exam may be especially crucial to the investigation.*

- *Keep in mind that victims with disabilities may be reluctant to report the crime or consent to the examination for a variety of reasons, including fear of not being believed, fear of getting in trouble and fear of losing their independence.* For example, they may need extended treatment for their injuries. The perpetrator may be their caregiver and the only person they rely on for daily living assistance; reporting the assault may force them into a long-term care facility.

- *Recognize that it may be the first time victims have an anogenital exam.* The procedure should be explained in detail in language they can understand.[15] They may have limited knowledge of reproductive health issues and not be able to describe what happened to them during the sexual assault. They may not know how they feel about the incident or even identify that a crime was committed against them.

- *Some victims with disabilities may want to talk about their perceptions of the role their disability might have played in making them vulnerable to an assault.* Listen to their concerns and what the experience was like for them.[16] Assure them that the assault was not their fault. If needed, encourage discussion in a counseling setting on this issue, as well as on what might help them feel safer in the future.

- *Recognize that the examination may take longer to perform with victims with certain types of disabilities.* Examiners should avoid rushing through the examination—such action not only may distress victims, it can lead to missed evidence and information.

How long after an assault can the forensic medical exam be conducted and evidence collected?

FYI In general, the West Virginia State Police Forensic Lab indicates that 96 hours post-assault is the outside limit for conducting a forensic medical examination using the state Sex Crime Collection Kit.

Prompt examination following a sexual assault helps to quickly identify victims' medical needs and concerns. Evidence can be lost from the body and clothing through washing hands, bathing, brushing teeth, urinating, etc. Therefore the less time between the assault and the forensic medical exam, the more likely that evidence may be collected. With that said, however, *recognize that evidence may be found on victims' bodies even in cases where the disclosure of a recent sexual assault is delayed.* For example, signs of bruising or vaginal/anal tearing might be present past the 96-hour suggested evidence collection time period. Even when delayed disclosures are made, first responders may encourage victims to seek forensic medical care in some situations. Examiners can obtain

the forensic medical history, examine victims and document findings if victims are willing and evidence is potentially present. The history and documentation of exam findings can aid examiners in addressing any related medical issues and determining if and where there may be evidence to collect. Law enforcement can also interview victims to get an account of the assault, identify potential suspects and witnesses and find out if other evidence might be available (at the crime scene, suspect's home, victim's home, in a vehicle, etc.).

What if a victim is undecided about whether she wants to report the sexual assault? Should she still have forensic evidence collected?

Adult victims of a recent sexual assault can have the forensic medical exam conducted within 96 hours of the assault, whether or not they choose to report to law enforcement. If victims are children or are adults considered by West Virginia law to be "incapacitated," these crimes will be reported to the West Virginia Department of Health and Human Resources and law enforcement by health care providers. (See *Sexual Violence 101. Mandatory Reporting.*) Kits collected as part of investigations will be sent to the West Virginia State Police Forensic Lab for processing. Kits collected as non-reports are sent to Marshall University Forensic Science Center, where the collected evidence can be stored for up to 18 months, allowing the victim time to make a decision regarding reporting the sexual violence. Should the decision be made to initiate an investigation in a non-reported case, the kit can be retrieved at any time within the 18 months by contacting law enforcement and providing the kit tracking number. There is no statute of limitations on reporting a sexual assault in West Virginia, but there is an 18 month limit on the storage of the Sex Crime Collection Kits.

Who pays for the forensic medical examination?

Victims are often concerned about how the costs of the examination will be covered. The West Virginia Forensic Medical Examination Fund was established by the state legislature (*WVC§61-8B-16*) to pay for "all reasonable and customary costs of a forensic medical examination." For the medical facility and examiner to be paid for through this fund, the exam must be done within 96 hours of the assault. No payment from the fund is provided for non-forensic procedures or treatment—therefore, victims will most likely be responsible for any medical treatment, either through private pay or private insurance. Victims who report the assault to law enforcement within 72 hours (unless just cause exists) can apply to the West Virginia Crime Victims Compensation Fund for reimbursement of out-of-pocket medical costs. Rape crisis center advocates can assist victims in applying for these funds. (See *Sexual Violence 101. West Virginia Crime Victims Compensation Fund.*)

What are victims' options if the sexual assault was not recent?

Service providers should always validate victims' decisions to seek help to heal regardless of when they disclose sexual violence—whether it is hours, days, months, years or even decades later. If the sexual assault was not recent, victims can still access medical care, advocacy and other services to help them recover. They can report the crime to law enforcement. They can discuss with service providers the possibility of other existing evidence that could corroborate their account of the sexual assault.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What is a forensic medical exam? *See page B11.2.*
2. How does a forensic medical exam differ from a medical exam? *See page B11.3.*
3. Where does a forensic medical exam typically take place? *See page B11.3.*

4. Who conducts a forensic medical exam? *See page B11.3.*
5. What is a SANE? *See page B11.3.*
6. What other responders are involved in the forensic medical exam process? What are their roles? *See pages B11.4–B11.5.*
7. How would you briefly describe components of the forensic medical exam to a victim? *See pages B11.6–B11.8.*
8. What can responders do to make the forensic medical exam more comfortable for victims with disabilities? *See pages B11.9–B11.10.*
9. How long after a sexual assault can a forensic medical exam be done? *See pages B11.10–B11.11.*
10. If victims wish to have the forensic medical exam done but are undecided about reporting to law enforcement, what is the process for storing the kits? *See page B11.11.*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." Health care providers refer to the persons they serve as "patients." For convenience, the term "victims" is primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2] This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]U.S. Department of Justice, *A national protocol for sexual assault medical forensic examination, adult/adolescent* (Washington, D.C., 2004), 30-2, through http://samfe.dna.gov.

[4]The list of problems cited in the text box on this page is from K. Littel, *Implementing SANE programs in rural communities: The West Virginia regional mobile SANE project, OVC E-Bulletin* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, 2008), http://www.ovc.gov/publications/infores/WVA_Mobile_SANE_guide/welcome.html. Originally drawn from R. Campbell, *The effectiveness of SANE programs,* VAWnet Applied Research Forum (National Online Resource Center on Violence Against Women, 2004), 1; and K. Littel, *SANE programs: Improving the community response to sexual assault victims, OVC Bulletin* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, 2001), 1–2.

[5]Drawn from U.S. Department of Justice, *A national protocol,* 13.

[6]Drawn from U.S. Department of Justice, *A national protocol,* 24.

[7]Examples of terms used to describe medical professionals who are specially trained and clinically prepared to perform forensic medical examinations include sexual assault nurse examiner (SANE), forensic nurse examiner (FNE), sexual assault forensic examiner (SAFE) and sexual assault examiner (SAE). Drawn from U.S. Department of Justice, *A national protocol,* 53.

[8]Drawn from U.S. Department of Justice, *A national protocol,* 24.

[9]Paragraph from Littel, *Implementing SANE programs in rural communities: The West Virginia regional mobile SANE project.* Originally drawn in part from N. Hoffman & D. Lopez-Bonasso, West Virginia goes SANE (unpublished article).

[10]Adapted from U.S. Department of Justice, *A national protocol,* 23.

[11]Drawn from U.S. Department of Justice, *A national protocol,* 103. As cited in M. LeBeau, Toxicological investigations of drug-facilitated sexual assaults, *Forensic Science Communication* (1999), 3.

[12]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

[13]Bullets drawn from U.S. Department of Justice, *A national protocol,* 30-2.

[14]The first two sentences in this paragraph were drawn from the Office for Victims of Crime, F*irst response to victims of crime who have a disability* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, 2002), 1.

[15]Drawn from A. Conrad, *SANE/SAFE organizing manual* (Albany, NY: New York State Coalition Against Sexual Assault, 1998), 7.

[16]Drawn from L. Ledray, *SANE development and operation guide* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, 1998), 82–5.

WV S.A.F.E. TRAINING & COLLABORATION toolkit

SERVING SEXUAL VIOLENCE VICTIMS WITH DISABILITIES

A project of the

West Virginia Sexual Assault Free Environment (WV S.A.F.E.) Partnership

WV S.A.F.E. Partners:

West Virginia Foundation for Rape Information and Services (WVFRIS)

West Virginia Department of Health and Human Resources (WVDHHR)

Northern West Virginia Center for Independent Living (NWVCIL)

Fall 2010

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WV S.A.F.E. Training and Collaboration Toolkit— Serving Sexual Violence Victims with Disabilities

C. Disabilities 101

Funding was provided by Grant No. 2006-FW-AX-K001 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this toolkit are those of the authors and do not necessarily reflect the views of the U.S. Department of Justice, Office on Violence Against Women.

Forward

Service providers are finally recognizing the intersection of two issues: the prevalence of persons with disabilities who are sexually victimized and the prevalence of sexual violence victims who have disabilities. Although one in the same, the response to sexual violence victims who have disabilities may differ depending on their point of entry into the service delivery system. Sexual violence service providers have not been adequately trained in serving victims with disabilities. Disability service providers have not been trained in responding to sexual violence. There has been a lack of recognition that a coordinated community response is needed to ensure that the social service system (collectively comprised of the local, regional and state agencies that serve victims on the local level) effectively and equally meets the needs of these individuals. In West Virginia, through this project, we are bringing together service providers who aid sexual violence victims with those who serve persons with disabilities. Our goal is to increase the access victims with disabilities have to services. It is important to acknowledge that "getting to this place" did not happen overnight; rather, it required consciousness-raising and community organizing by dedicated activists. In essence, "getting to this place" is the story of two social movements—the anti-sexual violence movement and the disability rights movement—maturing into a "second wave" of activism and joining together to address needs of previously underserved populations.

The beginnings for both movements grew from the 1950s to the 1970s when minority groups—most notably African Americans, gays and lesbians, women and people with disabilities—began ardently fighting to secure their civil rights. Early in the women's rights movement, women began to speak out about their personal experiences of sexual violence. In the decades to follow, tremendous progress was made toward supporting sexual violence victims. Rape crisis programs were established in counties throughout the United States to offer crisis intervention, support and advocacy for victims, as well as community awareness and prevention. A significant body of literature and research emerged that increased public concern about sexual violence. Legislative changes—including the enactment of state laws to ensure victim rights and federal laws such as the Rape Control Act in 1975 and the Violence Against Women Act of 1994—were enacted that have increased the efficacy of the criminal justice and medical community responses to sexual violence.[1]

Encouraged particularly by the civil rights and women's rights movements, large-scale cross-disability rights activism began in the late 1960s with the goal of ending social oppression. That oppression kept children with disabilities out of the public schools and sanctioned discrimination against adults with disabilities in employment, housing and public accommodations. As part of this movement, the independent living movement emerged to support the choice of living in the community for people with even the most severe disabilities. The first independent living center opened in 1972; by the beginning of 2000, there were hundreds of such centers across the country and the world. In the meantime, a series of landmark court decisions and legislative changes—including the enactment of the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act of 1975 and the Americans with Disabilities Act of 1990—secured for individuals with disabilities unprecedented access to their civil rights.[2]

These victories for the two movements, as critical as they were, have not ended sexual violence or discrimination against persons with disabilities.[3] There is still a great need for continued activism. By coming together in localities across the country, as we are beginning to do in West Virginia, these movements are able to take the important next steps of educating one another and combining their resources to create positive systems change for sexual assault victims with disabilities. We hope you find the *West Virginia S.A.F.E. Training and Collaboration Toolkit: Serving Sexual Violence Victims with Disabilities* to be a useful resource to facilitate this cross-training and improve the response and partnerships across agencies and movements in your community.

Acknowledgements

The work of creating a toolkit involves the expertise and assistance of numerous individuals. The WV S.A.F.E. partnership is grateful to the individuals listed below for their contributions in the creation of this toolkit.

Project Partners and Primary Authors

Each of the three project partners coordinated the writing of the modules (in conjunction with the Project Consultant) within the sections pertinent to their disciplines. Each partner reviewed all of the modules during the development and pilot phases of the project. After each module was piloted and then reviewed and approved by the Office on Violence Against Women, the modules were then edited by the Toolkit Project Coordinator and Project Consultant.

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Participating Pilot Site Agencies in Marion, Ohio and Preston Counties:

- Russell Nesbitt Services
- Sexual Assault Help Center
- Task Force on Domestic Violence, "HOPE", Inc.
- Rape and Domestic Violence Information Center
- Northern West Virginia Center for Independent Living
- West Virginia Department of Health and Human Resources (Marion, Ohio and Preston counties)

Special thanks go to *Amy Loder* (Office on Violence Against Women); *Michelle Wakeley, Nikki Godfrey, Betty Irvin, Whitney Boutelle,* and *Emma Wright* (contributing authors); *Susie Layne, Wade Samples, Marion Vessels, Mark Derry, Teresa Tarr* and *Suzanne Messenger* (technical assistance with legal and policy components), West Virginia Foundation for Rape Information and Services staff and *Kathy Littel* (proofreading); *Carol Grimes* of Grimes Grafix (graphic designer) and to all of the survivors of sexual violence and women with disabilities who helped guide this work—both through this project and in creating the professional history of the individuals cited on this page. This toolkit is dedicated to ensuring that your shared experiences will help make for a better service delivery system for others.

WV S.A.F.E. Training and Collaboration Toolkit—Serving Sexual Violence Victims with Disabilities[4]

This toolkit offers guidance for service providers on working collaboratively to integrate accessible services for sexual violence victims with disabilities into the existing social service delivery system. *The purpose is to provide the information and resources needed to begin the process of collaborating and cross-training among relevant agencies. Using the tools in the toolkit, agencies can build their capacity to offer responsive, accessible services to sexual violence victims with disabilities.* The toolkit's focus is on adult and adolescent victims with disabilities.

The concept for and contents of this toolkit evolved over a four-year period from the work of a project coordinated by several West Virginia statewide/regional agencies and piloted by local agencies from three counties. Although the toolkit is written for a West Virginia audience, other states and communities are welcome to adapt the materials to meet their needs.

This *User's Guide* explains the toolkit's features and organization as well as the pilot project.

Toolkit Features

The toolkit's main feature is a collection of educational modules intended to:

- **Facilitate dialogue and collaboration among partnering agencies** to improve the accessibility and appropriateness of services across systems for sexual violence victims with disabilities (see the *Collaboration 101* modules);
- **Build individual providers' knowledge** related to fundamental issues in providing accessible and responsive services to sexual violence victims with disabilities (see *Disabilities 101* and *Sexual Violence 101* modules); and
- **Provide tools to facilitate assessment and planning by individual agencies** to improve the accessibility and appropriateness of their services for sexual violence victims with disabilities (see the *Tools to Increase Access* modules).

The toolkit was developed with the recognition that both individual and partnering agencies will adapt the toolkit materials to assist them in providing accessible and appropriate services to sexual violence victims with disabilities. NOTE:

- Individuals and agencies can use all of the modules and materials or select only the modules and materials that address their specific needs.
- Individuals and agencies can decide the sequencing of the modules that meets their needs, depending on factors such as the types of services each agency provides, who will be trained (designated or all staff, volunteers, students, board members), etc.
- Collaborative groups can decide the selection and sequencing of the modules to utilize based on the partnering service providers, strengths and gaps in the current response, level of existing collaboration among service agencies, issues that need to be addressed, etc.
- Individual agencies and partnerships may wish to add information and discussions on other pertinent issues not addressed through the modules.

Because the toolkit is available online, those using it can benefit from new material that may periodically be added. The toolkit can be accessed at http://www.fris.org/ to check for updates.

Background: Toolkit Development

In 2006, the West Virginia Foundation for Rape Information and Services (FRIS) received a grant from the U.S. Department of Justice, Office on Violence Against Women (OVW) to examine and implement changes to local and state systems that respond to women with disabilities and deaf women who are victims of sexual assault. Entitled *West Virginia Sexual Assault Free Environment* (WV S.A.F.E.), the resulting collaboration consists of three core team partner agencies: FRIS, the West Virginia Department of Health and Human Resources (DHHR) and the Northern West Virginia Center for Independent Living (NWVCIL).[5]

This collaborative's broad mission is to identify and address state and local gaps and barriers in services and policies that impede the provision of effective, accessible and seamless services to survivors of sexual assault among women with disabilities and deaf women. The shared vision is:

> *".. [C]reating permanent systems change at all levels of the sexual assault and disability systems and state policy in which effective services for women with disabilities and deaf women are fully integrated into the existing structure of victim services and advocacy."*

The statewide partnership, and subsequent participation of their counterparts in three counties (Marion, Ohio and Preston counties), conducted needs assessments and developed a strategic plan. The plan included the following short-term goals and objectives:

1. Foster collaboration among local service providers who interact with survivors with disabilities (to overcome fragmentation of services). Objectives: Coordinate and implement on-going partnership meetings and formalize collaborative processes among pilot site partners.

2. Build a sustainable common knowledge base among local service providers and among statewide partnering agencies. Objectives: Develop and implement a capacity building plan to strengthen the knowledge base and sustainable practices.

3. Ensure services and supports are accessible and responsive to the needs of women with disabilities and deaf women. Objectives: Assess accessibility with pilot site and state partners and implement prioritized components of accessibility transition plans.

The toolkit is the result of the sustainable cross-training component of this four-year project. Note that the materials are applicable to serving all adult/adolescent victims of sexual violence (recognizing the vast majority are women) and that the term "persons with disabilities" became inclusive of deaf persons, unless otherwise indicated.

Note also that while a limited number of agencies officially partnered in this pilot project, the benefit to victims can increase when the partnership is welcoming of any agency that might provide services to victims with disabilities. To that end, longer-term goals include: expanding local pilot site partnerships to include all points of entry into the service delivery system for victims with disabilities; improving the accessibility of those points of entry; providing ongoing capacity building opportunities; and replicating this systems-change model in additional counties in West Virginia.

Toolkit Organization

Toolkit Components. The toolkit offers a set of four separate components: *A. Collaboration 101, B. Sexual Violence 101, C. Disabilities 101* and *D. Tools to Increase Access.* Each component is comprised of a series of informational modules.

Structure of the modules within each component. The individual modules within these components are primarily organized into two main sections: *Core Knowledge* and *Discussion*. Some modules include both sections while others include only the *Core Knowledge* or the *Discussion* section. Several of the *Tools to Increase Access* use a checklist, rather than a narrative format. All of the remaining modules include a cover page featuring a brief overview and the key points. Each also includes an introduction describing the purpose, objectives and any preparation needed.

- ***Core Knowledge:*** Depending on the content, the *Core Knowledge* section provides basic information on the topic. It may also include *Test Your Knowledge* questions to evaluate what was learned. These can be useful both for the reader and for supervisors who may choose to use the questions to gauge the knowledge of staff and volunteers.

  The *Core Knowledge* section is intended for individual use—e.g., for self-paced learning, one-on-one training of employees such as agency orientation or continuing education, volunteer trainings, review prior to an agency or multi-agency discussion, etc.

- ***Discussion:*** The *Discussion* section is designed for use in a group setting, either within an agency or with outside partnerships. Each *Discussion* section indicates the estimated time frame for the dialogue and the preparation needed, if any; describes suggested activities and questions (targeted to create a common knowledge base, improve agency response and build collaboration); and ends with a closing assessment of what was learned during the discussion and changes providers/agencies plan to make as a result of the discussion.

- ***Resources:*** Some modules also include related forms and/or other sample materials.

The modules were developed to maximize agencies' finite resources for in-house and multi-agency training. To that end, an effort was made to offer *Core Knowledge* sections that simplified complex topics as much as possible. It is a delicate balance to find a format in which the information provided can be easily understood but that provides enough detail to assist the reader in offering responsive assistance to victims with disabilities. As appropriate in each *Core Knowledge* and *Discussion* section, guided probes and case scenarios are included to assist service providers in applying the information to impact service delivery changes both within their own agencies and their communities.

Cross-referencing of modules. The modules were generally developed so they can be used independently of one another; however, a few make reference to other modules as prerequisites. Reference to other modules is also made throughout the modules so the reader can easily gain further knowledge on a particular topic.

Terminology used. Across all modules, the following should be noted:

- Agencies that interact with sexual violence victims and persons with disabilities typically refer to the individuals they serve as "clients," "consumers" and/or "victims." For convenience, "victims" and "clients" are primarily used.

- The terms "sexual violence" and "sexual assault" generally will be used to encompass sexual assault, sexual abuse and other forms of sexual violence.

- In recognition that the vast majority of victims of sexual violence are female and the vast majority of offenders are male,[6] individual victims are often referred to using female pronouns and individual offenders are often referred to using male pronouns. This use of pronouns in no way implies that males are not victims of sexual violence or that females are not offenders; it is written in this format solely for the ease of reading the material.

Reproduction of materials. The non-commercial use and adaptation of these modules to increase knowledge about serving sexual violence victims with disabilities is permitted. Please credit any material used from this toolkit to the West Virginia Sexual Assault Free Environment (WV S.A.F.E.) project, a partnership of the West Virginia Foundation for Rape Information and Services, the Northern West Virginia Center for Independent Living and the West Virginia Department of Health and Human Resources (2010).

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[1]This paragraph was drawn primarily from California Coalition Against Sexual Assault, *A vision to end sexual assault—The CALCASA strategic forum report* (2001), as well as J. Meyers, *History of sexual assault prevention efforts* (Colorado Coalition Against Sexual Assault, 2000) and P. Poskins, *History of the anti-rape movement in Illinois*. All can be accessed through http://new.vawnet.org/category/index_pages.php ?category_id=576.

[2]This paragraph was drawn from University of California Berkley, *Introduction: The disability rights and independent living movement* (last updated 2010), through http://bancroft.berkeley.edu/collections/drilm/index.html.

[3]Adapted from University of California Berkley.

[4]Note that the format used in this *User's Guide* was in part modeled after the Office for Victims of Crime's *Sexual assault advocate/counselor training, trainer's manual* (Office of Justice Programs, U.S. Department of Justice), https://www.ovcttac.gov/saact/index.cfm.

[5]An additional partner, the West Virginia University Center for Excellence in Disabilities, participated in the first two years of the project.

[6]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (C. Rennison, Rape and sexual assault: Reporting to police and medical attention, 1992–2000 (Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2002), 1, http://bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=92; and P. Tjaden & N. Thoennes, *Prevalence, incidence and consequences of violence against women: Findings from the National Violence Against Women Survey* (Washington, DC: National Institute of Justice, Office of Justice Programs, U.S. Department of Justice, 1998), 2–4, http://www.ojp.usdoj.gov/nij/publications/welcome.htm. Regarding sex offenders, males make up the vast majority, but females also commit sexual crimes. In 1994, less than 1 percent of all incarcerated rape and sexual assault offenders were female (L. Greenfeld, *Sex offenses and offenders: An analysis of data on rape and sexual assault, U.S. Department of Justice, Bureau of Justice Statistics* (Washington, DC: 1997). As cited in R. Freeman-Longo, *Myths and facts about sex offenders* (Center for Sex Offender Management, 2000), http://www.csom.org/pubs.

Disability Laws

This module provides a broad overview of seven major laws designed to ensure that people with disabilities have equal access to the goods, services and opportunities offered to the general public. Having a basic understanding of civil rights laws relevant to people with disabilities can help service providers improve their ability to refer to appropriate resources should clients reveal that they have been victims of discrimination due to a disability.[1] An increased awareness of these laws can lead agencies to voluntarily comply with disability laws and, subsequently, improve access to their own services for persons with disabilities.

Key Points

- The **Americans with Disabilities Act (ADA)** prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation and telecommunication.[2] *Title I* addresses employment discrimination. *Title II* requires that state and local governments give people with disabilities an equal opportunity to benefit from their programs, services and activities. *Title III* mandates public entities to comply with basic nondiscrimination requirements prohibiting exclusion, segregation and unequal treatment of people with disabilities, as well as with requirements related to architectural standards for new and modified buildings. *Title IV* requires telephone companies to establish telecommunications relay services and requires closed captioning of federally funded public service announcements. *Title V* addresses miscellaneous items.
- The **Fair Housing Act (FHA)** prohibits housing discrimination on the basis of race, color, religion, sex, disability, familial status and national origin. West Virginia also has a Fair Housing Act that has nine protected classes, adding blindness and ancestry to the seven protected classes in the federal legislation. The West Virginia Human Rights Commission lists 10 protected classes, adding age.
- The **Air Carrier Access Act (ACAA)** seeks to minimize problems that travelers with disabilities face as they try to access public domestic or foreign air carriers.
- The **Civil Rights of Institutionalized Persons Act (CRIPA)** authorizes the U.S. Attorney General to investigate conditions of confinement at state and local government institutions. Its purpose is to uncover and correct problems that can negatively impact the health and safety of people living in these institutions.
- The **Rehabilitation Act** prohibits discrimination on the basis of disability in programs conducted by federal agencies and those receiving federal financial assistance, as well as in federal employment and in employment practices of federal contractors.
- The **Architectural Barriers Act (ABA)** states that buildings and facilities that are designed, constructed or altered with federal funds, or leased by a federal agency, must comply with the federal standards for physical accessibility.
- The **Individuals with Disabilities Education Act (IDEA)** requires public schools to make available to all eligible children with disabilities a free and appropriate public education in the least restrictive environment and specific to their individual needs.[3]

C1. Disability Laws

Purpose

This module provides a broad overview of major laws designed to ensure that people with disabilities have equal access to the goods, services and opportunities offered to the general public. The information in this module is intended to provide guidance, not advice, on basic rights and obligations under federal disability laws and provide you with resources where you can learn more. It does not cover every law that may have protections for individuals with disabilities.

Consider the following scenarios and questions:

1. *A nursing home patient seeks your assistance, saying she and several other residents were repeatedly sexually abused by staff, but no facility administrators will respond. What civil rights disability law can help remedy this problem and what federal entity can be contacted?*
2. *You have a client who is blind and has a service animal. She is seeking safe housing in a new apartment complex that does not allow pets. What law addresses her related legal rights? What resources are available to help her with this problem?*
3. *A client who uses a wheelchair is seeking services from your agency, but your offices are located on an inaccessible second floor. What law details your agency's legal obligation to this client?*
4. *If a woman who uses a wheelchair applies for a job with your agency and your offices are located on an inaccessible second floor, what is your agency's legal obligation?*
5. *A client with HIV/AIDS tells you that she has a job interview scheduled. Although she appears healthy, she is concerned that if the employing agency learns of her medical condition, it will not hire her. Can the agency ask prospective staff if they have a disability?*
6. *A client who is receiving support services through your agency shares her worry about securing developmentally appropriate K-12 education for her child who has Down syndrome. She fears the mainstream public school program will not meet her child's special needs, but she does not have the money for a private school. What law might ensure her child specialized services through public schools?*

These scenarios and questions illustrate why it is important for service providers to have a basic understanding of civil rights laws relevant to people with disabilities. Not only can this awareness help service providers make appropriate referrals to outside resources should clients reveal that they have been victims of discrimination due to a disability, it can lead agencies to voluntarily comply with those laws and, subsequently, improve access to services for persons with disabilities. (As you read this module, find the answers to the above questions. Compare your answers with those provided on pages *C1.9–C1.10* of this module.)

Objective

Those who complete this module will be able to:

- Discuss major laws that promote equal access to goods, services and opportunities for people with disabilities.

CORE KNOWLEDGE What civil rights disability laws does this module discuss?

The seven key laws discussed in this module include: The Americans with Disabilities Act, the Fair Housing Act, the Air Carrier Access Act, the Civil Rights of Institutionalized Persons Act, the Rehabilitation Act, the Architectural Barriers Act, and the Individuals with Disabilities Education Act.

FYI This module presents a considerable amount of information. It is intended to be a point of reference for service providers to quickly locate information on disability laws. Given the complexity of these laws, an effort has been made to provide simple summaries of their main features and related resources.

FYI Much of the information in this module is drawn from A Guide to Disability Rights Law (U.S. Department of Justice, Civil Rights Division, Disability Rights Section, 2005), http://www.ada.gov/cguide.htm. Also see J. Brennan, *The Disability Law Handbook* (DBTAC Southwest ADA Center, 2009), through http://dlrp.org/html/publications/ and *Federal Laws Prohibiting Job Discrimination: Questions and Answers* (U.S. Equal Employment Opportunity Commission, 1998), http://www.eeoc.gov/facts/qanda.html. These resources may be useful if questions arise about disability laws that are beyond the scope of this module.

What is the Americans with Disabilities Act?

The Americans with Disabilities Act (ADA) of 1990 is a comprehensive civil rights law that prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation and telecommunication.[4] An individual with a disability is defined by the ADA as "a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment,[5] or a person who is perceived by others as having such an impairment. The ADA does not specifically name all of the impairments that are covered."[6] A major life activity is one the average person can perform with little or no difficulty such as breathing, walking, talking, hearing, seeing, working and self care.[7] The ADA is divided into five sections or "titles" with each covering a different area. Titles I through IV are particularly applicable to local service providers/agencies. (Some ADA requirements are discussed in *Tools to Increase Access. Physical Accessibility Checklist for Existing Facilities*.)

Title I: Employment

- Requires employers with 15 or more employees to provide qualified individuals with disabilities an equal opportunity to benefit from the full range of employment-related opportunities available to others. To be qualified, a person with a disability must have the skills, experience and education the job requires of all applicants.
- Prohibits discrimination in recruitment, hiring, promotions, training, pay, social activities and other privileges of employment; restricts interview questions related to a person's disability before a job offer is made; and requires employers to provide accommodations for employees who have disabilities unless doing so would cause an undue hardship for the employer.[8] (See *Disabilities 101. Accommodating People with Disabilities*.)

Related resources:[9]

- Charges of employment discrimination on the basis of disability may be filed at any U.S. Equal Employment Opportunity Commission (EEOC) field office. To find the EEOC field office in your geographic area, contact: 800-669-4000 (voice), 800-669-6820 (TTY) or go to the EEOC website at http://www.eeoc.gov/. In West Virginia, the Human Rights Commission is the entity that hears employment discrimination cases. They can be contacted at 304-558-2626 (voice) or 888-676-5546 (voice). Also see http://www.wvf.state.wv.us/wvhrc/.

- For more information on Title I, contact the appropriate EEOC field office in your geographic area. Publications and information on EEOC-enforced laws may be obtained by calling 800-669-3362 (voice) or 800-800-3302 (TTY).
- For more information on how to accommodate a specific individual with a disability, contact the Job Accommodation Network at 800-526-7234 (voice/TTY). Also see http://askjan.org.

Title II: State and Local Government-Funded Programs and Services
(including public transportation and non-profit service providers)

- Requires that state and local governments give people with disabilities an equal opportunity to benefit from their programs, services and activities (e.g., public education, employment, transportation, recreation, health care, social services, courts, voting and town meetings).[10]
  - Those covered under Title II are required to follow specific architectural standards in new construction and when doing alterations to their existing buildings. Government entities must make sure that people with disabilities are not excluded from government services, programs or activities just because buildings built before the ADA are not accessible. If the building is not accessible, the services they offer must be (e.g., by offering the same programs and services at an alternate location that is accessible).[11]
  - Accessibility is not limited to access for those who use a wheelchair or otherwise have difficulty with mobility. It includes access to effective communication for those who are deaf or hard of hearing, are blind or have low vision, and/or have speech difficulties.
  - Public agencies are not required to take actions that would result in undue financial and administrative burdens.[11] They are required to make reasonable modifications to policies, practices and procedures where necessary to avoid discrimination, unless they can demonstrate that doing so would fundamentally alter the nature of the services, programs or activities being provided.[12]
- Requires public transportation services, such as city buses, rail transit and subways, to be accessible to people with disabilities. They must comply with accessibility standards in newly purchased vehicles and provide paratransit services where they operate fixed route bus or rail systems (unless it would result in an undue burden).[13] Paratransit services supplement public transit fixed route systems by providing door-to-door transportation for persons with disabilities who can't use a fixed route service.[14]

Related resources:[15]

- Complaints related to Title II violations may be filed with the U.S. Department of Justice within 180 days of the date of discrimination. Contact the U.S. Department of Justice, Civil Rights Division, Disability Rights Section—NYAV, 800-514-0301 (voice) or 800-514-0383 (TTY). Also see http://www.justice.gov/crt/.
- Questions and complaints about public transportation should be directed to the Office of Civil Rights, Federal Transit Administration U.S. Department of Transportation, 888-446-4511 (voice/TTY). Also see www.fta.dot.gov/ada.

Title III: Public Accommodations

- Covers businesses and nonprofit service providers that are public accommodations. Public accommodations are defined as private entities that own, lease, lease to or operate facilities such as restaurants, retail stores,

hotels, movie theaters, private schools, convention centers, doctors' offices, homeless shelters, transportation depots, zoos, funeral homes, day care centers and recreation facilities including sports stadiums and fitness clubs. Transportation services provided by private entities are also considered public accommodations.

- Mandates that public accommodations comply with basic nondiscrimination requirements that prohibit exclusion, segregation and unequal treatment of people with disabilities, and has requirements related to architectural standards for new and modified buildings. For information on these requirements, go to www.ada.gov.[16]

Related resource:[17]

- For more information on Title III, contact the U.S. Department of Justice, Civil Rights Division, Disability Rights Section-NYAV, 800-514-0301 (voice) or 800-514-0383 (TTY). Also see http://www.justice.gov/crt/.

Title IV: Telecommunications

- Requires telephone companies to establish telecommunications relay services, 24 hours a day, seven days a week to allow callers with hearing and speech disabilities to communicate with each other through a third party communications assistant.[18] (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- Requires closed captioning of federally funded public service announcements.

Related resource:[19]

- For more information on Title IV, contact the Federal Communications Commission, 888-225-5322 (voice) or 888-835-5322 (TTY). Also see www.fcc.gov/cgb/dro.

Title V: Miscellaneous Items

- Clarifies that states and the U.S. Congress are covered by all provisions of the ADA.
- Provides for recovery of legal fees for successful proceedings pursuant to the ADA.
- Establishes a mechanism for technical assistance, along with instructions to many federal agencies required to implement/enforce the ADA.[20]

What is the Fair Housing Act?[21]

The Fair Housing Act (FHA), as amended in 1988 (first passed in 1968), prohibits housing discrimination on the basis of race, color, religion, sex, disability, familial status and national origin. It is unlawful to discriminate in selling or renting housing or to deny a dwelling to a buyer or renter because of a disability. The FHA also addresses issues such as financing, zoning, new construction design and advertising. West Virginia passed a Fair Housing Act in 1992 and amended it in 2006.[22]

The chart below describes in brief the Federal FHA and West Virginia's Fair Housing Act and related resources.

Federal FHA:

- Applies to housing owned/financed by the federal government or housing projects having loans insured by the federal government that include four or more multifamily units with an elevator (if no elevator exists, all ground floor units of four or more).

- Requires owners of housing facilities to make reasonable exceptions in their policies to afford people with disabilities equal housing opportunities. For example, if the housing project has a no pet policy, the landlord would have to modify this policy if the tenant is a person who is blind and uses a service animal.
- Requires landlords of existing facilities to allow tenants with disabilities to make reasonable access-related modifications to their private living space, as well as common use spaces in older buildings. It does not require landlords to pay for changes requested by a person with a disability.
- Requires standards for new multifamily housing in buildings that are ready for first occupancy after March 13, 1991 and have an elevator and four or more units: public and common areas must be accessible to persons with disabilities; doors and hallways must be wide enough for wheelchairs. All units must have an accessible route into and through the unit; accessible light switches, electrical outlets, thermostats and other environmental controls; reinforced bathroom walls to allow later installation of grab bars; and kitchens and bathrooms that can be used by people in wheelchairs. If a building with four or more units has no elevator and will be ready for first occupancy after March 13, 1991, these standards apply to ground floor units. See www.hud.gov/offices/fheo/FHLaws/yourrights.cfm for more information.

West Virginia's Fair Housing Act:

- States have the right to make their laws stricter than federal regulations, but they must, at least, offer the same protections as the Federal FHA.
- West Virginia has nine protected classes, adding blindness and ancestry to the seven protected classes within the federal legislation. The West Virginia Human Rights Commission lists 10 protected classes, adding age.
- The authority and responsibility for administering the WV Fair Housing Act is with the WV Human Rights Commission, which is required by law to investigate fair housing complaints and enforce the fair housing laws of the state.

Related resources:

- There are several ways to file a fair housing complaint. Use the form available through the U.S. Department of Housing and Urban Development's (HUD) website at www.hud.gov/complaints/housediscrim.cfm; call HUD at 800-669-9777; or print a form, complete and mail it to the Office of Fair Housing and Equal Opportunity, HUD, Room 5204, 451 Seventh St. SW, Washington, DC 20410. In West Virginia, call the WV Human Rights Commission in Charleston at 304-558-2616 or 888-676-5546. The Fair Housing Initiatives Program (FHIP) at the Northern West Virginia Center for Independent Living can also be contacted at 304-296-6091. For more information on requirements, technical guidance questions and answers, go to www.FairHousingFIRST.org or call 888-341-7781 (voice/TTY).

What is the Air Carrier Access Act?

Congress passed the Air Carrier Access Act (ACAA) in 1986. In 1990, the U.S. Department of Transportation implemented provisions of the ACAA by publishing regulations to minimize problems that travelers with disabilities face as they try to access public domestic or foreign air carriers.[23] Requirements address an array of issues, including boarding assistance and certain accessibility features in newly built aircraft and new or altered airport facilities.[24] ACAA prohibits discrimination due to disability, except if the individual would endanger the health or safety of other passengers. Other exceptions exist for planes with fewer than 30 seats where available boarding chairs cannot be used in the limited space of a smaller plane. This act also covers individuals with a temporary disability (e.g., a broken leg).[25]

ACAA related resources:

- If you want to file a complaint related to access to air travel, you have two resources. Each airline is required to have a Complaints Resolution Official available to resolve disagreements between passengers and the airline. If that avenue is not effective, complaints can be filed with the Aviation Consumer Protection Division, U.S. Department of Transportation, 800-778-4838 (voice) or 800-455-9880 (TTY) or through http://airconsumer.ost.dot.gov.[26]

What is the Civil Rights of Institutionalized Persons Act?

The Civil Rights of Institutionalized Persons Act (CRIPA) authorizes the U.S. Attorney General to investigate conditions of confinement at state and local government institutions such as prisons, jails, detention centers, juvenile correctional facilities, publically-operated nursing homes and institutions for individuals who have psychiatric or developmental disabilities. It does not apply to private facilities. Its purpose is to uncover and correct serious problems that put the health and safety of people in these institutions in danger. The Attorney General does not have authority under this act to investigate isolated incidents or to represent individual institutionalized persons. However, the Attorney General may initiate civil law suits where there is reasonable cause to believe that conditions are so "egregious or flagrant," that they are subjecting residents to "grievous harm" and that they are part of a "pattern or practice" of resistance to residents' full enjoyment of constitutional or federal rights, including Title II of the ADA and section 504 of the Rehabilitation Act (see below).[27]

CRIPA related resource:[28]

- For more information, or to bring a related issue to the attention of the Attorney General, contact the U.S. Department of Justice, Civil Rights Division, 877-218-5228 (voice/TTY) or through www.usdoj.gov/crt/split.

What is The Rehabilitation Act of 1973?

The Rehabilitation Act of 1973, often called the Rehab Act,[29] prohibits discrimination on the basis of disability in programs conducted by federal agencies, programs receiving federal financial assistance, in federal employment and in the employment practices of federal contractors. Standards for determining employment discrimination under this act are the same as those in the ADA, Title I.[30]

Section 501 of the Rehab Act focuses on affirmative action and nondiscrimination in employment by federal agencies. *Section 503* requires affirmative action by federal government contractors and subcontractors. *Section 504* requires that no qualified individual with a disability "shall be excluded from, denied the benefits of, or be subjected to discrimination under" any programs or activity that either receives federal financial assistance or is conducted by any executive agency or the United States Postal Service.[31]

The Rehab Act covers nearly all government entities, colleges, universities and trade schools, along with many private schools, day care centers and most health care facilities. Each federal agency has its own regulations that apply to its programs, including providing reasonable accommodations for employees with disabilities, program accessibility, effective communication and accessibility requirements for new construction and alterations.[32]

Section 508 of the Rehab Act has accessibility requirements for electronic and information technology used by the federal government. This section requires federal government websites to be usable by people who are blind or have low vision and/or who are deaf or hard of hearing. These sites can be operated in a variety of ways and do not rely on a single sense or ability of the user.[33]

(Some Rehabilitation Act requirements are discussed in *Tools to Increase Access. Physical Accessibility Checklist for Existing Facilities.*)

Rehabilitation Act related resources:[34]

- Section 501: See resources under the ADA, Title I.
- Section 503: Contact the Office of Federal Contract Compliance Programs, U.S. Department of Labor, 202-693-0106 (voice/TTY) or through www.dol.gov/ofccp/.
- Section 504: Contact the U.S. Department of Justice, Civil Rights Division, Disability Rights Section—NYAV, 800-514-0301 (voice) or 800-514-0383 (TTY) or through www.ada.gov.
- Section 508: Contact the U.S. General Services Administration, Office of Government Wide Policy, IT Accessibility and Workforce Division (ITAW), 202-501-4906 (voice/TTY) or www.gsa.gov/section508.

What is the Architectural Barriers Act?

The Architectural Barriers Act (ABA) of 1968 states that buildings and facilities that are designed, constructed or altered with federal funds, or leased by a federal agency, must comply with the federal standards for physical accessibility. ABA requirements are limited to architectural standards in new and altered buildings and in newly leased facilities. It does not cover the activities conducted in these buildings.[35]

ABA related resource:[36]

- For more information or to file a complaint, contact the U.S. Architectural and Transportation Barriers Compliance Board, 800-872-2253 (voice) or 800-993-2822 (TTY) or www.access-board.gov.

What is the Individuals with Disabilities Education Act?

The Individuals with Disabilities Education Act (IDEA), first enacted in 1990,[37] requires public schools to make available to all eligible children with disabilities[38] a free and appropriate public education in the least restrictive environment and specific to their individual needs.[39]

IDEA requires schools to develop an individualized education program (IEP) that reflects the individual needs of these eligible children. This plan must be developed by a team of knowledgeable persons and must be reviewed annually. Not all children with disabilities are eligible for IEP services. The child must, by reason of the disability, need special education and related services in order to receive services under IDEA. Related services include any specialized transportation, assistive technology, speech therapy, counseling and occupational/physical therapy services needed in order to receive and benefit from a public education. If parents disagree with the proposed IEP, they can request a due process hearing and review by an independent hearing officer.[40]

IDEA related resources:[41]

- For more information, contact the Office of Special Education and Rehabilitative Services, U.S. Department of Education, 202-245-7468 (voice/TTY) or www.ed.gov/about/offices/list/osers/osep.
- Your local school district likely has a special education program which offers information about IEPs and related services available in its schools.

Questions to consider:

1. What does your agency have to do to make your services accessible to clients as per the requirements of civil rights disability laws (particularly the ADA, Title II and Section 504 of the Rehabilitation Act)?
2. What has your experience been in interacting with clients with disabilities who indicated they have been discriminated against in some way due to a disability (or you suspect were discriminated against even if they don't disclose discrimination)?
3. Were you able to help these clients understand that they may have been discriminated against and identify and connect them with resources to help them address the discrimination? If yes, what are examples? If not, why? What were the challenges?

Return to page C1.2 of this module to the six scenarios. The following are the answers to the questions posed in those scenarios.

1. If the nursing home is a public facility or provides services on behalf of the state or local government, its residents are protected through the *Civil Rights of Institutionalized Persons Act (CRIPA)*. The Attorney General does not investigate individual cases, but will **follow up with "flagrant conditions" that cause "grievous harm" to residents**. Contact the U.S. Department of Justice, Civil Rights Division.

2. The federal *Fair Housing Act (FHA)* requires owners of housing facilities owned/financed/insured by the federal government to **make reasonable exceptions in their policies to afford people with disabilities equal housing opportunities.** *The West Virginia FHA* has similar stipulations. The Department of Housing and Urban Development (HUD) is a federal resource. The WV Human Rights Commission and the Fair Housing Initiatives Program (FHIP), a program of the Northern West Virginia Center for Independent Living, are two West Virginia resources.

3. For agencies that are state/local government funded, *Title II of the Americans with Disabilities Act (ADA)* requires that **if the building is not accessible, the services your agency offers must be.** So, for example, your agency could offer the person services at an alternate accessible location (services that are equivalent to those offered at the main location in terms of quality and provided in a comparable safe, welcoming and supportive environment). If your agency receives federal financial assistance, *Section 504 of the Rehabilitation Act* would also apply, requiring that no qualified individual with a disability be excluded from or denied the benefits offered by your agency.

4. According to *Title I of the ADA,* **your agency's legal obligation to this person would depend on if she is the most qualified applicant for the job and whether your agency could make reasonable accommodations without undue hardship.** For example, could this person fulfill the job duties at another office location that is accessible? Would the cost of renting/using this accessible location cause undue hardship for the agency? **Whether your agency employs more than 15 staff members would also influence its obligation.** If your program receives federal funds, the *Rehabilitation Act, Section 504*, could also be applied in this situation.

5. According to *Title I of the ADA*, "an employer **may not make a pre-employment inquiry on an application form or in an interview as to whether, or to what extent, an individual has a disability. The employer may ask a job applicant whether he or she can perform particular job functions.** If the applicant has a disability *known* to the employer, the employer may ask how he or she can perform job functions that the employer considers difficult or impossible to perform because of the disability, and whether an accommodation would be needed. A job offer may be conditioned

on the results of a medical examination, provided that the examination is required for all entering employees in the same job category regardless of disability, and that the information obtained is handled according to confidentiality requirements specified in the Act. After an employee enters on duty, all medical examinations and inquiries must be job related and necessary for conducting the employer's business."[42]

6. Through the *Individuals with Disabilities Education Act (IDEA)*, the child would likely be **eligible for free public education specific to her needs** and provided in the least restrictive environment. To ensure the appropriateness of the education provided, schools are required to develop an individualized education program (IEP) for each student.

These questions can be considered by individual readers and/or discussed among agency employees and with representatives from partnering agencies.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

You are not expected to have memorized the information about disability laws, but rather to be able to locate reference information (e.g., when a client thinks she has been discriminated against by her employer due to a disability) and then be able to review the law with others (e.g., clients and other staff).

1. The Americans with Disabilities Act (ADA) prohibits discrimination on what basis? *See page C1.3.*
2. The ADA, Title I: Employment, applies to employers with how many employees? What does it require of these employers? What persons with disabilities qualify under Title I? *See page C1.3.*
3. What does the ADA, Title II, require of state and local government funded agencies regarding the programs, services and activities they offer? What does it require related to architectural standards? What does it require related to public transportation services? *See page C1.4.*
4. How does the ADA, Title III, define public accommodations? What does Title III prohibit in public accommodations? *See pages C1.4–C1.5.*
5. What does the ADA, Title IV, require of telephone companies? What does it require related to federally funded public service announcements? *See page C1.5.*
6. The federal Fair Housing Act (FHA) prohibits housing discrimination on the basis of what seven protected classes? What does it require of owners/landlords? What protected classes does the West Virginia Fair Housing Act include, in addition to those covered by the federal FHA? *See pages C1.5–C1.6.*
7. What problems does the Air Carrier Access Act (ACAA) seek to address for persons with disabilities? *See page C1.6.*
8. What does the Civil Rights of Institutionalized Persons Act (CRIPA) authorize the U.S. Attorney General to do and what is its purpose? *See page C1.7.*
9. What types of discrimination does the Rehabilitation Act prohibit? What do Sections 501, 503, 504 and 508 of this act respectively address? *See page C1.8.*
10. What does the Architectural Barriers Act (ABA) require related to federally funded or leased buildings and

facilities? *See page C1.8.*

11. What does the Individuals with Disabilities Education Act (IDEA) require of public schools, up through grade 12? *See page C1.8.*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the term "clients" is primarily used in this module.

[2]U.S. Department of Justice, Civil Rights Division, Disability Rights Section, *A guide to disability rights law* (2005, updated 2006), http://www.ada.gov/cguide.htm. This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]U.S. Department of Justice.

[4]U.S. Department of Justice.

[5]Having a "record of" refers to having a history of being a person with a disability or being misdiagnosed or misclassified as having a disability when the person does not. As cited in J. Brennan, *The disability law handbook* (DBTAC Southwest ADA Center, 2009), through http://dlrp.org/html/publications/.

[6]U.S. Department of Justice.

[7]Brennan.

[8]U.S. Department of Justice. Undue hardship means "an action that requires significant difficulty or expense when considered in relation to factors such as a business's size, financial resources, and the nature and structure of its operations."

[9]U.S. Department of Justice, except for the West Virginia specific information.

[10]U.S. Department of Justice.

[11]U.S. Department of Justice (bullet).

[12]U.S. Department of Justice (bullet).

[13]U.S. Department of Justice (first two sentences in bullet).

[14]Drawn from Brennan.

[15]U.S. Department of Justice (bullets).

[16]U.S. Department of Justice (bullets).

[17]U.S. Department of Justice (bullet).

[18]U.S. Department of Justice (bullet).

[19]U.S. Department of Justice (bullet).

[20]Bullets drawn from Work World—Empowerment through Decision Support Technology, *Americans with Disabilities Act*, http://www.workworld.org/wwwebhelp/americans_with_disabilities_act_ada_.htm.

[21]Section drawn from U.S. Department of Justice, except for West Virginia specific information.

[22]See *WV State Code, Chapter 5, article 11-A (WVC§5-11A)* through http://www.legis.state.wv.us/WVCODE/code.cfm.

[23]Brennan (first two sentences of paragraph).

[24]U.S. Department of Justice.

[25]J. Brennan (last three sentences of paragraph).

[26]U.S. Department of Justice.

[27]U.S. Department of Justice (paragraph).

[28]U.S. Department of Justice.

[29]J. Brennan.

[30]U.S. Department of Justice.

[31]U.S. Department of Justice.

[32]Drawn from J. Brennan.

[33]Drawn from J. Brennan.

[34]J. Brennan and U.S. Department of Justice (bullets).

[35]J. Brennan (paragraph).

[36]J. Brennan (bullet).

[37]National Resource Center on AD/HD, IDEA, http://www.help4adhd.org/education/rights/idea.

[38]Infants and toddlers with disabilities (birth-2) and their families receive early intervention services under IDEA Part C. Children and youth (ages 3-21) receive special education and related services under IDEA Part B. As cited in U.S. Department of Education, *Building the legacy of IDEA 2004,* http://idea.ed.gov/.

[39]National Resource Center on AD/HD.

[40]U.S. Department of Justice (paragraph).

[41]U.S. Department of Justice (bullet).

[42]Equal Employment Opportunity Commission, *ADA: Questions and Answers,* http://www.eeoc.gov/facts/adaqa1.html.

Person First Language

This module seeks to assist service providers in using inclusive and respectful language that values people with disabilities.

Key Points

- Person first language places the focus on the person, not the disability. For example, "an individual with epilepsy" is a person-focused phrase, while "an epileptic person" is disability-focused. This shift in language eliminates labeling and instead helps us view individuals with disabilities with respect.
- Avoid using negative terms that stereotype, devalue or discriminate against persons with disabilities, such as "handicapped," "disabled," "special needs," etc. Use positive language that is not outdated or offensive.
- Person first language that is acceptable to individuals with disabilities can change over time. Also, some persons with disabilities may prefer terminology that is not person first language, while others find that person first language makes speaking and writing complicated. For these reasons, simply asking the person what terms they prefer is often the best course of action when speaking or referring to individuals with disabilities.
- You may have co-workers who don't use person first language. Some ways to encourage person first language would be to model appropriate terminology and to share this module with them. You can also encourage victims to speak up if they are uncomfortable with the language being used and feel it needs to be addressed.[1]

C2. Person First Language

Purpose

This module seeks to assist service providers in using inclusive and respectful language that values people with disabilities. The term "person first language" means communication that recognizes the person first, then the disability. Person first language is "an objective way of acknowledging, communicating and reporting about disabilities. It eliminates generalizations, assumptions and stereotypes."[2]

Objectives

After completing this module, participants will be able to:

- Describe how the words used to refer to persons with disabilities often focus on the disability rather than the individual;
- Discuss how outdated and offensive language perpetuates negative stereotypes of persons with disabilities and reinforces the attitudinal barriers they face; and
- Replace stereotypical and devaluing language related to individuals with disabilities with respectful and positive language.

Part 1: CORE KNOWLEDGE

Why person first language?

There are many social barriers to full community inclusion for people with disabilities. One of the greatest barriers is language. It is common in Western society to either refer to a person with a disability as a "disabled person" or to use all inclusive categories such as "the disabled" or "the handicapped." A person might also be described by their medical diagnosis (e.g., an epileptic). Not only can this language reflect a negative view of persons with disabilities, it can have a direct impact on how persons with disabilities perceive themselves and their worth in society. The term "handicapped" implies that someone is at a disadvantage. Service providers who view persons with disabilities as less able or less skilled may not encourage self-sufficiency with their clients who have disabilities or may unnecessarily modify their goals. Limited expectations can rob clients of their individuality and imply that they are their disability rather than what they really are—persons with disabilities.

Person first language places the focus on the person, not the disability. For example, "an individual with epilepsy" is a person-focused phrase, while "an epileptic person" is disability-focused. This shift in language helps us reject labeling and view individuals with disabilities as deserving of respect.[3] It recognizes that people are not defined by their disability anymore than they should be characterized solely by their hair color, race, gender, nationality, etc.[4,5]

FYI When interacting with persons with disabilities, ask yourself if the disability is even relevant to your conversation or needs to be mentioned when referring to them.[6]

What terms are inappropriate?

It is important to avoid using negative terms that stereotype, devalue or discriminate against persons with disabilities.[7] Here are a few examples:[8]

- "Handicapped" is an outdated term that can create negative images.[9] The word originates from an Old English game in which the losers were left with their "hands in their caps" and considered to be at a disadvantage.[10] It also is thought to refer to war veterans who held their caps in their hands as they begged for money.[11] In reality, a handicap is often a disadvantage that occurs as the result of a disability and environmental and/or attitudinal factors. For example, a person with a disability who uses a wheelchair is handicapped when he faces a set of stairs and there is no ramp for equal access. The stairs create the disadvantage, not the disability.
- "Disabled" is often used to describe something that is broken or injured. For example, a broken-down car may be described as a "disabled vehicle." People with disabilities, however, are not broken nor do they need to be fixed.[12]
- Words soliciting empathy such as "suffers with" or "afflicted with" have been used when describing people with disabilities.[13] People with disabilities are sometimes depicted as "heroes" for doing everyday activities. It also may be said that people with disabilities have to "fight to overcome their challenges," but more often the real fight is to be treated as equal to everyone else.
- The term "special needs" can generate pity. However, it is not the disability that makes a person special, but characteristics (e.g., talents, skills and individuality).[14]
- The words "normal," "healthy" or "whole" might be used when speaking about people without disabilities as compared to those with disabilities. These terms imply that people with disabilities are not normal, healthy or whole.[15] Another way to convey a similar message of inferiority compared to a person without a disability is saying someone is "mentally challenged," "physically challenged," or "cognitively challenged."

FYI Some legal terms used in state sex offense laws to describe persons with disabilities—for example, "incapacitated," "mentally defective" and "a person suffering from mental disease or defect"—clearly do not represent person first terminology. But, while these terms would not be our choice of language, they currently are in many laws. Although we must use these terms in this and other modules to explain state laws and their application, first responders are urged to avoid use of offensive legal terms in their interactions with victims. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault and Abuse.*)

What are examples of person first language?

The following chart provides examples of currently accepted person first language for specific disabilities and medical conditions, as well as very brief explanations of why the old descriptors are inappropriate.[16] *It is by no means a comprehensive chart of terms; you are encouraged to consider additional examples or determine whether the currently accepted terms listed are still the most appropriate to use.*

Outdated or Offensive Terms	Reasons	Currently Accepted Terms
• Deaf and dumb • Dumb	• Implies mental incapacitation • Simply because someone is deaf does not mean that they cannot speak	• Deaf person • Non-verbal • Hard of hearing • Person who does not speak • Unable to speak • Uses synthetic speech
• Hearing impaired • Hearing disability • Suffers a hearing loss	• Negative connotation of "impaired" and "suffers"	• Deaf • Hard of hearing
• Slurred speech • Unintelligible speech	• Stigmatizing	• Person with a communication disability • Person with slow speech
• Confined to a wheelchair • Wheelchair-bound	• Wheelchairs don't confine; they make people mobile	• Uses a wheelchair • Wheelchair user • Person who uses a wheelchair
• Cripple • Crippled	• Old English, meaning "to creep" • Also used to mean "inferior" • Dehumanizing	• Has a disability • Physical disability
• Deformed • Freak	• Implies repulsiveness, oddness • Dehumanizing	• Multiple disabilities • Severe disabilities
• Crazy • Insane • Psycho • Maniac • Nut Case	• Stigmatizing • Considered offensive • Reinforces negative stereotypes	• Behavioral disorder • Emotional disability • Person with a mental illness • Person with a psychiatric disability

• Retarded • Mentally defective • Slow or simple • Moron or Idiot	• Stigmatizing • Implies a person cannot learn	• Cognitive disability • Developmental disability (use "mental retardation" sparingly)
• Mongoloid	• Considered offensive	• Person with Down syndrome
• Stricken/Afflicted by MS	• Negative connotation of "afflicted" and "stricken"	• Person who has multiple sclerosis
• CP victim	• Cerebral palsy does not make a person a "victim"	• Person with cerebral palsy
• Epileptic	• Stigmatizing	• Person with epilepsy • Person with seizure disorder
• Fit	• Reinforces negative stereotypes	• Seizure
• Birth defect	• Implies there was something wrong with the birth	• Congenital disability
• Deinstitutionalized	• Stigmatizing • Groups people into one category • Not focused on individual	• Person who used to live in an institution
• Midget	• Outdated term • Considered offensive	• Person of short stature • Person with dwarfism

Are there exceptions to person first language "rules?"

Yes. Some groups of persons with disabilities have been vocal about choosing terms to describe themselves that are not person first terminology. For example, the community of Deaf people prefers to use deaf with a capital D to denote the Deaf culture and the Deaf community, not the hearing loss.[17] In some communities of the blind, "he's blind" or "person without sight" is preferred over he has "blindness."[18] Also, some persons with autism prefer "autistic person" rather than "person with autism."[19] People with disabilities who reject person first terminology may see it "as devaluing an important part of their identity and falsely suggesting that there is, somewhere in them, a person distinct from their condition."[20] Rather than viewing their condition (e.g., deafness, autism and blindness) as a disability, they may view it as a trait.[21]

In addition, some who write or speak about disabilities may reject person first terminology because they think it can make sentences long, repetitive and unwieldy.[22] They also may question if the use of this terminology changes attitudes and if, in fact, it draws more negative attention to the disability.[23]

While acknowledging these exceptions and criticisms, it is important to remember that the promotion of person first language in recent decades has facilitated a healthy debate. It has stimulated conversations about what terminology best represents persons with disabilities as valuable members of our communities with equal status to persons without disabilities. For service providers, familiarity with person first language can help them strive

to use language when speaking or referring to clients with disabilities that will lead to positive client outcomes (e.g., greater satisfaction with services provided, more rapid healing from trauma, increased self-esteem, more job productivity, etc.).

FYI According to Tim Harrington, in *The Ten Commandments of Communicating with People with Disabilities,*[24] terms for disabilities have changed over the years and probably will continue to do so. "That's why the best and usually most appreciated course of action is to ask the person what terms they prefer." In addition, Harrington said to keep it simple—the most common way we all prefer to be acknowledged is by our name.

Another recommendation is to listen to the language used by a person with a disability and take your cues from what is said.[25]

Questions to consider:

1. Think about examples of outdated or offensive terminology you have heard used in your work setting to describe people with disabilities. Did or could use of these terms impact service providers' interactions with, or their perceptions of, persons with disabilities? In what ways?

Here are two examples:

a. *A rape crisis center volunteer advocate tells her supervisor that she received a crisis hotline call from a "mental patient" at an inpatient psychiatric program. While the victim may, in fact, be dealing with a mental illness, the label of "mental patient" may limit the advocate's recognition of the many facets of the victim beyond her mental state: the trauma she has faced, the connection of her mental health with her experience of sexual assault, and her capacity to heal from the sexual assault.*[26] *Rather than criticizing the advocate for her terminology, the supervisor can point out why the term "mental patient" might be offensive, acknowledge that the advocate in no way meant to be offensive, and then discuss more acceptable terminology. (See Disabilities 101. Working with Victims with Mental Illnesses.)*

b. *A service provider receives a call from a nurse at the hospital saying he is needed to assist a "downs victim" of sexual assault. In the past, individuals with Down syndrome were referred to as "downs people" or "downs kids." By labeling a person a "downs victim," the service provider and the nurse might make several assumptions about the victim. For instance, they might assume that someone with Down syndrome will have significant cognitive limitations and lack the capacity to make his/her own decisions. However, because Down syndrome affects everyone differently, cognitive limitations could be significant to minimal. They might also assume that the difficulty the victim has in communicating is due to the Down syndrome, when in fact, it could be the victim's response to the trauma. Both of these assumptions could lead to a misunderstanding about the circumstances and needs of the victim, inappropriate service provision, and subsequently minimize the victim's autonomy in making decisions about his healing. (See Disabilities 101. Self-Advocacy and Persons with Disabilities.)*

2. When interacting with a sexual assault victim with a disability, what could you do to minimize the likelihood that your language will alienate the victim? Some suggestions are offered below. (See *Sexual Violence 101. Crisis Intervention.*)

- Refer to victims with disabilities by their names.
- Ask victims with disabilities open-ended questions about the assault and their circumstances/needs so that they can guide you in providing appropriate services and/or in making referrals. Ask them to tell you the best way to facilitate communication with them (e.g., they may use equipment such as word boards or speech synthesizers, need an interpreter or prefer to communicate through an intermediary who is familiar with their pattern of speech). If you are having difficulty understanding the person, don't pretend you

understand or assume you understand when you do not. Instead, listen patiently, paraphrase back what you think you heard and allow the person to confirm your understanding or to restate what she said.

- Listen carefully to what victims with disabilities say to learn what terminology is acceptable to them and evaluate if the disability is relevant to your conversation or needs to be mentioned when referring to them. For example, a victim who uses a wheelchair recounts to the service provider how the offender repeatedly took advantage of her limited mobility. She experienced the feelings of powerlessness and vulnerability because she was not able to defend herself. In this case, the victim's disability is relevant to the conversation. Also, the fact that she uses a wheelchair may impact which services she utilizes (e.g., she may prefer telephone rather than face-to-face support).
- Avoid terminology that is not person first. For example, don't refer to a person with a severe stutter as a "stutterer" or "stuttering person." Don't say her speech is unintelligible.
- Limit referencing a person's medical diagnosis as it can divert attention from her need for victim services. For example, don't refer to a victim who uses a wheelchair as a "quadriplegic" or a "quad."

3. Based on what you have learned in this module, what changes will you make in your terminology related to persons with disabilities?

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What is the purpose of using person first language when talking with or referring to people with disabilities? What are some examples of how person first language is different from disability-focused language? *See page C2.2.*
2. What terms should service providers avoid if they are using person first language to speak with or refer to persons with disabilities? Why? What are acceptable alternatives? *See pages C2.2–C2.4.*
3. What are some examples of exceptions to person first language "rules?" *See page C2.4.*
4. What is the best course of action when speaking with individual clients with disabilities to ensure that they are comfortable with the language used to refer to them? *See page C2.5.*

Part 2: DISCUSSION

Projected Time for Discussion

1.25 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their collaborative work with sexual violence victims with disabilities. The discussion could be incorporated into forums such as agency staff meetings, orientations and continuing education programs, as well as multi-agency meetings or trainings. Anticipated discussion outcomes include an increased understanding of barriers and challenges experienced by victims with disabilities; enhanced ways to create a welcoming environment through appropriately worded agency policies, procedures and materials; increased awareness of how the spoken and written language can promote respect for and understanding of persons with disabilities; and greater comfort and competency in interacting with and assisting victims who have disabilities.

Refer to the learning objectives at the beginning of this module for specific outcomes.

Preparation

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select the facilitator. The facilitator should be familiar with issues facing persons with disabilities in general and knowledgeable about person first language and its application.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion.
- Request that participants bring in copies of written materials from their respective agencies that refer to clients with disabilities (e.g., policies and procedures, training and informational materials and public awareness materials).
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges and table tents.

Suggested Activities and Questions

The words we use to describe persons with disabilities are often indicative of our attitudes towards them and can significantly influence our interactions with them. This discussion focuses on using person first language with individuals with disabilities who use our services to facilitate positive outcomes for them (e.g., rapid healing from trauma, increased self-esteem, more job productivity, etc.).

1. **Invite participants to identify/review the discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among the participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2. **In a large group setting, ask each participant to briefly discuss the extent to which person first language is used in their agency's materials.** *(5 minutes)*

3. **Ask participants to pair off and talk about examples** of when, in their interactions with clients with disabilities, a person's disability might be relevant to the conversation or needs to be mentioned when referring to them. Are there situations where their disability is not relevant? *(5 minutes)*

Follow with a large group discussion on this topic. *(5 minutes)*

4. **Ask participants to individually review the following scenario and then break into three small groups to discuss the subsequent questions.** *(10 minutes)*

In the course of the preliminary investigation of a sexual assault case occurring at a place of employment (both the victim and offender participate in a vocational training program at the local thrift store), the police investigator spoke with the 25-year old victim, her mother, the victim advocate, the nurse examiner who conducted the forensic medical examination, a representative from Adult Protective Services (APS), and a case manager with the vocational program. During those

conversations, the investigator referred repeatedly to both the victim and offender as "retarded," "mentally defective" and "simpleminded."

Questions:

a. What reaction do you think each person would have to the investigator's choice of words? What stereotypes do these words perpetuate? Why do you think the investigator used these particular terms? What impact do you think the use of these terms might have on the progression of the case and on the victim's recovery? What other terms could the investigator have used that would have been more acceptable?

b. What could the participating providers do to (1) minimize the damage done by the investigator's use of terminology; and (2) prevent this scenario from reoccurring? What could they do if a colleague uses inappropriate language?

c. The police investigator was the "bad guy" in this scenario. But recognize that any one of your community partners may find themselves in the position of the investigator and make inappropriate language choices. Also, your agency's policies may use outdated/offensive terminology. In what ways might community partners collaborate to encourage the use of positive and respectful language with persons with disabilities? How could local persons with disabilities be involved in this collaboration? (For example, they might help review agency publications to ensure person first terminology is used, or help develop training materials.)

5. **Facilitate a large group discussion, with each group reporting back its comments on the above questions.** For timing purposes, consider having the first group report back on (a), the second group on (b), and the third group on (c). *(30 minutes)*

6. **Closing.** Ask each participant to write down how the information gained from this module discussion will:

- Change the way they interact with individual clients;
- Change the way they partner with other agencies to assist clients; and
- Promote change in their agency's policies, practices or training programs.

Then facilitate a large group discussion on this topic. *(10 minutes)*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]United Cerebral Palsy, *People first language,* through http://www.ucp.org. This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]A. Logsdon, *Person first language –Focus on the person first is good etiquette,* through http://www.about.com/.

[4]K.S. Lawrence, *Guidelines for reporting and writing about people with disabilities* (Schiefelbush Institute, 1996). As cited E. Bass, *Speaking and writing about people with disabilities: Disability, handicap or challenge? What to call it and how to say it,* http://www.cloudnet.com/~edrbsass/edpeoplefirst.htm.

[5]There may be instances where a person with disability does view her/his disability as a defining trait. The key, however, is that only that person has the right to make this decision for her/himself.

[6]United Cerebral Palsy.

[7]United Cerebral Palsy.

[8]These bullets, with the exception of the last one, were drawn in part from K. Snow, *To ensure inclusion, freedom, respect for all, It's time to embrace people first language* (revised 2008), 2, through http://www.acdd.org/pfl.pdf.

[9]Drawn from Snow.

[10]*Miriam Webster Online Dictionary*, through http://www.merriam-webster.com/; and Snow.

[11]Drawn from Snow.

[12]Bullet from Snow.

[13]Drawn from Snow.

[14]Bullet from Snow.

[15]This bullet was drawn from National Center on Workforce and Disability, Institute for Community Inclusion, *Watch your language* (Boston, MA: University of Massachusetts), through http://www.onestops.info/subcategory.php?subcat_id=402. This article was originally adapted from material developed by Mid-Hudson Library System, Outreach Services Department, 103 Market Street, Poughkeepsie, NY 12601.

[16]The chart was excerpted/minimally adapted from the National Center on Workforce and Disability, Institute for Community Inclusion.

[17]J. Folkins, *Resource on person-first language, the language used to describe individuals with disabilities* (American Speech Language, Hearing Association, 1992), through http://www.asha.org/default.htm.

[18]Logsdon.

[19]See *Person-first language and autism, Neurodiversity and the prejudice of politically correct terminology*, through http://autismaspergerssyndrome.suite101.com/.

[20]Excerpted/adapted from Wikipedia, *People first language*, http://en.wikipedia.org/wiki/People-first_language.

[21]Excerpted/adapted from Wikipedia.

[22]C. Edwin Vaughan, *People-first language: An unholy crusade* (National Federation of the Blind, 1997), http://www.blind.net/. Also referenced in Wikipedia.

[23]Vaughn, in *People-first language: An unholy crusade*, noted that the awkwardness of the person first language called attention to a person as having some type of "marred identity" He drew the concept of "marred identity" from E. Goffman, Stigma: Notes on the management of spoiled identity (Englewood Cliffs, New Jersey: Prentice Hall, 1963).

[24]I. Ward & Associates, *The ten commandments of communicating with people with disabilities* (1994).

[25]Logsdon.

[26]In addition, although males and females are both victimized by sexual violence, most reported and unreported cases are females (see endnote in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

Tips for Communicating with Persons with Disabilities

This module offers service providers practical information for communicating with persons who have disabilities.[1] It seeks to build providers' confidence and skills in communicating with clients who have disabilities helping to create a welcoming and respectful environment for them to receive support and services.

Many of the modules in *Sexual Violence 101 and Disabilities 101* also explore communication considerations specific to sexual violence victims with disabilities.

Key Point

- This module offers general tips for communicating with persons with disabilities, as well as tips that are specific to persons with certain types of disabilities. The best way to apply these tips is not to memorize them and try to use them all in every interaction with persons with disabilities, but rather to pick and choose the ones which seem most appropriate for a specific situation.[2]

C3. Tips for Communicating with Persons with Disabilities

Purpose

This module offers practical information for communicating with persons who have disabilities. When service providers do not have frequent interactions with people with disabilities, they may feel uncomfortable communicating with them. They may also fear that they will impede communication by saying or doing something inappropriate or offensive. It is helpful to have some basic tips to follow when speaking to a person with any type of disability, while understanding that some disabilities require more specific communication accommodations. This module seeks to build service providers' confidence and skills in communicating with persons with disabilities, helping to create a welcoming and respectful environment for them to receive support and services.

This module provides general tips for communicating with persons with disabilities. It also includes specific considerations when interacting with sexual violence victims with disabilities. Many of the modules in *Sexual Violence 101 and Disabilities 101* explore these considerations in greater depth.

Objectives

Those who complete this module will be able to:

- Discuss tips for communicating with persons with various types of disabilities; and
- Identify challenges that service providers face related to communicating with persons with disabilities and strategies that can help them overcome these challenges.

DISABILITIES 101

Preparation

• Review *Disabilities 101. Person First Language.*

Part 1: CORE KNOWLEDGE

The best way to apply the communication tips offered in this module is not to memorize them and try to use them all in every interaction with persons with disabilities, but rather to pick and choose the ones which seem most appropriate for a specific situation.[3]

What are key general considerations when communicating with persons with disabilities?[4]

Communication involves speech, language and processing. Different types of disabilities impact communication differently. Cognitive disabilities, for example, impact the processing of information and not necessarily the speech. The same communication assistive device will not be appropriate for every type of disability.
A person who has a disability is a person who is entitled to the dignity, consideration, respect and rights you expect for yourself.
Do not be afraid to make a mistake when communicating with someone with a disability. Anticipate how you would react if you were in a similar situation.
Treat adults as adults. Address people with disabilities by their first names only when extending the same familiarity to all others present. Never patronize people with disabilities by patting them on the head or shoulder.
Take time to listen. If your agency has a policy regarding standard session times (e.g., one hour in length), adaptations may need to be made. Shorter sessions over longer periods may reduce frustration for some clients. Adapt to the individual; not everyone will need extra time.
Relax. If you don't know what to do, allow the person who has a disability to help guide you. Ask the person what support they need from you.
If you offer assistance and the person declines, do not insist. If it is accepted, ask how you can best help, and then follow their direction. Do not take over.
If someone with a disability is accompanied by another individual, address the person with the disability directly rather than speaking "through" the other person.
In general, if individuals are upset, they are more difficult to understand. For victims of sexual violence, it might be helpful to initially talk about something other than the trauma that they experienced to become familiar with their communication patterns. Sometimes working as a team can be helpful in trying to understand a client, as long as it is not embarrassing for the client—either by asking if there is someone the client trusts to assist or by involving someone else on your staff.
Speak naturally. It's fine to use common expressions like "I see" or "see you later" with a person who is blind, or "let's walk over here" with a person who uses a wheelchair.
When communicating with individuals who use a wheelchair, sit at their level. Do not touch the wheelchair and, if you inadvertently bump into their wheelchair, excuse yourself as you would if you bumped into another person. Wheelchairs and other mobility devices are often considered an extension of the person and should be treated as such.

Use terminology that places the person before the disability (instead of "an epileptic," use "a person with epilepsy"). Refer to the person first and then the situation, illness or disability—if that information is relevant to the conversation.[5] (See *Disabilities 101. Person First Language*.)

By being fully present to persons with disabilities, you can build rapport with them. If you show them you are caring and want to understand their situation, they will be more likely to open up to you. Do not make assumptions about a person's abilities and needs based on her appearance.[6]

Have a plan for the next steps in communicating. For example, consider in advance ways to respond in a variety of situations with clients, such as when someone calls for help in a crisis but cannot clearly communicate her needs.

Remember these keys to communication: (1) Be honest—It's acceptable to tell a person you do not understand the message she is trying to communicate to you; and (2) ask if there is anything you can do to make the interaction better.[7,8]

FYI These and other general tips are discussed in the 26-minute film and accompanying written material, *The Ten Commandments of Communicating with People with Disabilities* (I. Ward and Associates, 1994). It is available for loan through the Resource Center of the Corporation for National and Community Service at http://www.nationalserviceresources.org/. It is also used in *Part 2: Discussion* of this module.

FYI With sexual violence victims with disabilities, it is helpful to try to determine the relationship between the suspected offender and the victim. If the offender is the victim's caregiver, you will need to know what the relationship means to the victim in terms of practical and emotional issues.

What are some tips for communicating with individuals with cognitive disabilities that affect speech?[9]

A cognitive disability can impact a person's ability to (1) understand what they see and hear, and (2) interpret social cues and body language. A person with a cognitive disability "may have trouble learning new things, making generalizations from one situation to another and expressing themselves through spoken or written language."[10] A cognitive disability can be the result of brain trauma during birth or an accident or illness that affects the brain. For many clients with cognitive disabilities, communications with service providers and the actual service provision will be no different than for clients without disabilities. However, some clients' communication methods may be nonverbal—they may, for example, use gestures, diagrams or demonstrations. Some tips on communicating with persons with cognitive disabilities that affect speech are listed below.

Be respectful and patient. It may take more time to communicate with clients with cognitive disabilities than it does with other clients with whom you work.

Speak directly to the person, make eye contact before speaking and say the person's name often.

Individuals with cognitive disabilities might be very concrete in their thinking. Phrase questions and statements in a way that avoids ambiguity or confusion. Try to avoid idioms, clichés, expressions and technical terms. Use simple language (e.g., "a lot of feelings" instead of "overwhelmed").

Don't speak too fast.

Keep sentences short. Break complicated instructions or information into smaller parts (e.g., "tell me what happened" instead of "tell me what happened and who did it").

Avoid using leading or "yes and no" questions when communicating. If you are smiling and nodding when you ask a question, you may receive a nod and a smile, but no real information. People of all levels of ability can be led by the actions of another person.
If a person you are talking with has trouble focusing or staying on track, help her by rephrasing or repeating questions.
If the person is having trouble remembering dates or times, try using memory cues. For example, ask a sexual assault victim what was on TV when the assault occurred, if the assault happened near her bedtime or if it occurred on the day she went to church.
If you are unsure if a person understands what you are saying, ask her to repeat it in her own words.
Listen to all of the information the person provides and believe what you are told. Make every effort to get accurate information from the person with a cognitive disability before relying on information from others.
If what the person is telling you seems to be factually incorrect, consider if it is possible that she has misinterpreted your question.
For persons with a cognitive disability who are unable to communicate through oral language, work with them to identify their preferred method of communication (e.g., through body movements, sounds, communication boards, drawing, anatomically correct dolls or pictures, etc.). Determine the best way to accommodate their preferences. (See *Disabilities 101.Accommodating Persons with Disabilities*.)

FYI As in the general population, false disclosures of sexual assault are infrequent among victims with disabilities. It is more likely that a victim with a disability may retract a disclosure of victimization due to fear, confusion or pressure.

What are some tips for communicating with individuals with sensory disabilities?[11]

Speech
Be patient. Refrain from finishing words or completing sentences for others. Take your time. Ask for their preferred method of communication. Don't assume it will be through another person.
Talk to people with communication disabilities as you would talk to anyone else, not slower or emphasizing enunciation.
Ask the person for help, if needed, in communicating with her. If she uses a device such as a manual or electronic communication board, ask her how best to utilize it. If she does not have the preferred device with her, discuss how to accommodate her needs (e.g., obtain the device from another source). (See *Disabilities 101.Accommodating Persons with Disabilities*.)
If you do not understand what an individual is saying, do not pretend that you do. Tell her that you do not understand. Ask the person to repeat what she has said or perhaps spell out a word or two. Ask if writing it down is an option.
Rephrase back what you thought the person said, giving her an opportunity to correct or confirm your understanding.

Vision
Repeat your name to the person and introduce others by name and title each time you initiate contact until the person is familiar with each voice.
If new people enter the room, introduce them. Inform the person with the disability when someone is leaving the room.
If the person uses a service animal, do not pet or otherwise distract the animal without the person's permission.
Describe the layout of the room and all procedures in detail before they occur. You can use clock cues (e.g., "the chair is at 5:00") and point out obstacles in the path of travel such as planters, water fountains, etc.
It is appropriate to touch the person's arm lightly when you speak so she knows you are speaking to her.
Assist the person with completing any intake or treatment forms only after you have read the forms aloud in their entirety to her. Have forms and resources available in accessible formats such as large print or Braille, useable by a screen reader, or on audiotape.
Offer assistance if it seems needed. If accepted, ask the person how best to assist her. Do not attempt to physically 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 arm of the chair and allow her to seat herself.
Hearing
Find out how the person best communicates (e.g., speech/lip reading, writing, sign language or an interpreter).
If needed, provide a safe, trusted and qualified interpreter. The West Virginia Commission for the Deaf and Hard of Hearing maintains a statewide directory of interpreting service providers and references. They can be accessed at www.wvdhhr.org/wvcdhh under the Commission's resource section. If the person is a sexual violence victim, an interpreter who is also trained in the area of sexual violence would be ideal.
If there is an interpreter present, speak directly to the person who is deaf or hard of hearing and not to the interpreter. This approach may seem awkward as that person may need to focus on the interpreter and may not make eye contact with you. Communicate through writing if necessary and appropriate until the interpreter arrives.
If you do not know sign language, use paper and pencil. Don't be embarrassed to use this method—getting the message across is more important than the medium used. But remember that American Sign Language (ASL) is not spoken English, with unique sentence structure and other differences, so communicating through writing can be challenging for a person who uses ASL. Therefore it is critical that you reiterate back to the clients your understanding of their responses.
If the person reads lips, then the following communication tips may be helpful. • Approach the person from the front or signal your entry into the room. Identify who you are and make sure that you look directly at the person as you speak.

- Gain the attention of the person (e.g., by placing your hand lightly on the person's shoulder) before beginning to talk.
- Do not shout. Speak at your normal volume unless the person asks you to talk louder—hearing aids make sound louder, not clearer.
- Look directly at the person while speaking. Speak in a clear, expressive manner, but do not over-enunciate or exaggerate words.
- To make it easier for the individual to lip read, face the light source, speak clearly in a normal tone, keep your hands away from your face, and use short, simple sentences.
- Do not turn your back or walk around while talking. Note that if you look away, the person may assume the conversation is over.

If you decide to communicate through writing, don't talk while you are writing a message. The person cannot read your note and your lips at the same time.

What are some tips for communicating with persons with mental illnesses?[12]

(For detailed information on this topic, see *Disabilities 101. Working with Victims with Mental Illnesses.*)

Mental illness refers to a group of behavioral or psychological conditions that may "disrupt a person's thinking, feeling, moods and ability to relate to others."[13] These conditions may be categorized by anxiety, mood swings, depression and a loss of contact with reality and result in "a diminished capacity for coping with the ordinary demands of life." However, it is important to note that many mental illnesses are effectively managed with medications and other forms of therapies that result in recovery. Unfortunately, in spite of the progress made in treating mental illnesses, negative prejudice and stereotyping can be some of the most painful aspects of these disabilities.[14]

For clients with mental illnesses who are also victims of sexual violence, the trauma of the violence often adds additional stresses and challenges that need to be addressed by medical and mental health professionals. For example, someone on medication who has experienced trauma may need to be monitored closely for changes in her medical needs. Many service providers report working with significant numbers of sexual violence victims with mental illnesses; they can work collaboratively to offer holistic, victim-centered services. (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

Some tips on communicating with persons with mental illnesses are listed below.

Don't assume a person with a mental illness will be violent. People with mental illnesses do NOT have a greater propensity towards violence than anyone else.[15]

Approach the person in a calm, nonthreatening and reassuring manner. The person may be overwhelmed by delusions, paranoia or hallucinations and be afraid of or feel threatened by you.[16]

Help the person feel they are in control of/regaining control of the situation.

Hold conversations with the person in a setting free of distractions, with as few people present as possible.

Keep conversations simple and brief, being friendly and patient, but keep in mind that rational discussions may not be possible on some or all topics.

Be aware that individuals experiencing delusions, paranoia or hallucinations may be able to accurately provide information outside of their false system of thoughts, including details related to their sexual victimization.
If the person is agitated, but poses no immediate threat to anyone's safety, **allow her time to calm down before engaging her in conversation** or transition her to a safer/calmer conversation. Take breaks and offer to continue the conversation at another time as needed.
Break the speech pattern of those individuals who talk compulsively by interrupting them with simple questions (e.g., What is your birth date?).
Understand that hallucinations are real to individuals experiencing them, so don't try to convince them that their hallucinations do not exist. Reassuring them that they are safe is the most important aspect of providing support.
Acknowledge paranoia and delusions by empathizing with her feelings, but neither agree nor disagree with her statements.
Avoid excessive whispering, joking and laughing as these behaviors could be viewed as dangerous to someone with paranoia.
Avoid casually touching the person or standing too close.
Give simple instructions for what you ask the person to do.
Be honest. Being dishonest can increase a person's fears and suspicions. She will be able to figure out when you are not being honest.

Below are some common symptoms of different types of mental illnesses and what accommodations can be made to facilitate communication.[17]

Behavior/Characteristic	Adaptation
Confusion about what is real	Be straightforward and simple
Difficulty in concentrating	Be brief and repeat as necessary
Over stimulated	Limit input, don't require concentration
Poor judgment	Don't expect rational discussion
Preoccupation with internal world	Get the person's attention
Agitation	Recognize the agitation and if possible, transition to a safer/calmer conversation
Fluctuating emotions	Do not take words or actions personally
Fluctuating plans	Stick to one plan
Little empathy for others	Recognize this as a possible symptom of a mental illness
Withdrawal	Initiate conversation
Belief in delusions or hallucinations	Don't argue; respond to needs and feelings
Fear	Stay calm
Insecurity	Be caring and accepting

What are some tips for communicating with persons with autism?[18]

Be aware that "autism is a neurological disorder that affects the functioning of the brain." Although the effects vary greatly, autism may impact communication, social skills and processing information.
Know that the person may be socially awkward and have difficulty making eye contact and interpreting nonverbal cues, such as facial expressions, gestures and tone of voice.
If the person has difficulty in interpreting nonverbal cues, be clear, direct and specific in your communications.
Keep in mind that the person may be sensitive to touch, sounds, light or color.
Be patient, since the person may tend to focus on particular objects.
Be aware the person may quietly talk to herself frequently.

It is critical that sexual violence victims who have disabilities, just like those without disabilities, are empowered to make their own decisions about what they need to survive and heal from the sexual assault. Service providers, family and friends must avoid taking over and trying to "fix" them or their situations.[19] (See *Disabilities 101. Self-Advocacy and Victims with Disabilities.*)

Questions to Consider

- Think of a time when you felt uncomfortable interacting with a client because of a disability-related communication barrier. What was it about the situation that made you uncomfortable? What did you do or what could you have done to adjust and overcome the barrier?
- In your work, do you tend to interact more frequently with persons with specific types of disabilities? What do you find are the greatest challenges in communicating and creating a welcoming and respectful environment for persons with disabilities to receive support and services? What successes have you had in dealing with these challenges?
- Based on what you have learned in this module, what changes will you make in how you communicate with clients with the following disabilities:
  - Cognitive disabilities?
  - Sensory disabilities related to speech, vision and hearing?
  - Mental illnesses?
  - Autism?

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What are examples of general considerations when communicating with persons with disabilities? *See pages C3.2–C3.3.*
2. What are some tips for improving communication with individuals with cognitive disabilities who have difficulty in communicating? *See pages C3.3–C3.4.*

3. What are some suggestions for communicating with individuals with sensory disabilities (speech, vision and hearing)? *See pages C3.4–C3.6.*

4. Give some examples of tips for communicating with persons with mental illnesses. *See pages C3.6–C3.7.*

5. What are some tips for communicating with persons with autism? *See page C3.8.*

Part 2: DISCUSSION

Projected Time for Discussion
2.5 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their collaborative work with sexual violence victims with disabilities. The discussion could be incorporated into forums such as agency staff meetings, orientations and continuing education programs, as well as multi-agency meetings or trainings. Anticipated discussion outcomes include increased understanding of barriers and challenges experienced in communicating with victims with disabilities; identification of ways to enhance communication; and greater comfort and competency in interacting with victims with disabilities.

Refer to the learning objectives at the beginning of this module for specific outcomes for this module.

Planning for the Discussion

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- The facilitator should have knowledge about communicating with persons with disabilities and be familiar with the activity selected under the *Suggested Activities and Questions* section. If Activity #1 is selected, the film, *Ten Commandments of Communicating with People with Disabilities,* should be acquired for viewing. (In West Virginia, this film should be available on loan from the local rape crisis center.)
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion, as well as *Disabilities 101. Person First Language.*
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. The proper audiovisual equipment will be needed if the video/DVD will be shown. Optional items include name badges and table tents.

Suggested Activities and Questions

1. **Invite participants to identify/review the discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2. **Introduce the topic.** This discussion is geared toward helping participants identify what they find difficult in communicating with persons with various types of disabilities and to consider how to best apply the communication tips offered in *Part I: Core Knowledge* of this module to their work settings.

3. **Video/DVD presentation and discussion.** *(60 minutes)*

a. Arrange for the viewing of *The Ten Commandments of Communicating with People with Disabilities*. It includes a series of vignettes that, in a humorous way, demonstrate what not to do when communicating with people with disabilities while suggesting more appropriate alternatives.

b. Utilizing the resource guide available with the video/DVD, discuss how each of the suggested tips impacts working with victims with disabilities.

c. Identify which tips highlight areas of training needs of your colleagues/agencies and discuss ways in which those communication tips can be shared.

4. **Interactive exercise.** (This activity can be done independently of Activity #1.) *(60 minutes)*

a. The facilitator should read the following instructions to the group:

Although based on the game of charades, the purpose of this activity is not to successfully guess what is being communicated, but to experience and observe the potential frustration in the communication process. When communication is challenging, often either the sender or receiver of the message just gives up out of frustration. In the game of charades, the topics are inconsequential, such as movie titles or television shows. In communicating sexual victimization, the messages are personal and traumatic. In this version of charades, two volunteers are needed for each demonstration. One person (portraying a sexual violence victim with a disability) will convey messages to another member of the group (portraying a service provider) using limited verbal communication. The remaining members of the group will observe. The messages can be written by the remaining group members and given to the volunteer who is portraying the victim. The messages should include the type of disability that the victim has, identify the form of sexual victimization and detail the help that is needed. Just as there are a range of disabilities, also keep in mind the range of sex crimes (e.g., harassment, fondling, different forms of rape). In these scenarios, try to keep it realistic in terms of role playing as if the person were actually seeking your services.

After giving the group the instructions, facilitate the interactive exercise.

b. After 3 to 4 minutes of the exercise (or after the message is successfully communicated), end the scenario and as a group discuss the following questions:

   1. What aspects of the message made the communication difficult (type of disability, type of victimization, etc.)?

   2. What emotions did you observe—both verbally and non-verbally—on the part of the victim? What emotions were conveyed by the service provider?

   3. What assistive devices could have helped facilitate the communication? (Alphabet/communication board, interpreter, anatomically correct dolls, paper and pencil, etc.)

c. If there is time, a new "service provider" and "victim" can be selected for the exercise and communicate a new message that is provided by the group by repeating the above steps. Below are points to bring up during the discussion:

- Each person with a disability is different. Enter every interaction with an open mind and without assumptions.
- Just because someone has a communication disability does not mean they have an intellectual disability.
- Your tone and manner can impact communication. Your tone and facial expressions should match those of the person with whom you are communicating. For example, when speaking with an adult, do not use the same tone you would use when speaking with a child.

5. Ask the participants if they tend to interact more frequently in their work with persons with specific types of disabilities. Facilitate a discussion about what they see as the **greatest challenges in communicating and creating a welcoming and respectful environment for persons with disabilities to receive support and services**. Ask them to describe any *general* successes they have had in dealing with these challenges. *(15 minutes)*

6. **Closing.** Ask each participant to write down how the information gained from this module discussion will:

- Change the way they interact with individual clients;
- Change the way they partner with other agencies to assist clients; and
- Promote change in their agency's policies, practices or training programs.

Then facilitate a large group discussion on this topic. *(10 minutes)*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]Day One: The Sexual Assault and Trauma Resource Center, Rhode Island Coalition Against Domestic Violence and PAL: An Advocacy Organization for Families and People with Disabilities, *Is your agency prepared to ACT? Conversation modules to explore the intersection of violence and disability* (Advocacy Collaboration Training Initiative, 2004), Handout #1, 1.

[3]From Day One et al., Handout #1, 1.

[4]The material in this section was primarily excerpted/slightly adapted from Adaptive Environments Center, Inc., Fact sheet 3, Communicating with people with disabilities (1992), through http://www.adata.org/. Adaptive Environment Center, Inc. was authorized by the National Institute on Disability and Rehabilitation Research to develop information and materials on the Americans with Disabilities Act. Most of these tips are also mentioned in the film/accompanying written material, I. Ward & Associates, *The ten commandments of communicating with people with disabilities* (1994).

[5]Day One et al., 8.

[6]Day One et al., Handout #1, 1.

[7]Day One et al., 8.

[8]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims and clients are often referred to as female.

[9]Information in this section is primarily excerpted/slightly adapted from Wisconsin Coalition for Advocacy, Wisconsin Coalition Against Domestic Violence, Wisconsin Coalition Against Sexual Assault, and Independence First, *Cross training workbook: Violence against women with disabilities,* Appendix G: Screening and assessment information (Violence Against Women with Disabilities Project of Wisconsin, 2004), through http://www.disabilityrightswi.org/. Additional tips were drawn from Day One et al., Handout #1, 1. Note that all online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[10]S. Bruyere & T. Golden, *Working effectively with persons who have cognitive disabilities, Implementing the Americans with Disabilities Act series* (ILR Program on Employment and Disability, Cornell University, 1994).

[11]This section is excerpted/slightly adapted from several sources: Day One et al., Fact sheet 3, Communicating with people with disabilities; and Wisconsin Coalition for Advocacy et al.

[12]Drawn from NAMI NJ Law Enforcement Education Program, *The police response to mental illness crisis* (2008), http://www.naminj.org/programs/lee/lee.html. This publication was adapted in part from Police Executive Research Forum (PERF), The police response to people with mental illnesses (Washington, D.C., 1997).

[13]Mental illness "does not include simple intoxication, transitory reaction to drug ingestion, organic brain syndrome or developmental disability." PERF, 6.

[14]Drawn from NAMI NJ Law Enforcement Education Program, 2.

[15]PERF, 3.

[16]The remaining bullets in this section are from PERF, 8.

[17]Day One et al., Handout #1, 3. Originally adapted from R. Woollis, *When someone you love has a mental illness* (Texas Commission on Law Enforcement, 1997).

[18]Portland Community College, *Career and employment guide for job seekers and employees with disabilities and guide for employers: How to recruit, interview, hire and accommodate people with disabilities, Communications tips* (Portland, OR: 2003).

[19]Drawn from Day One et al. 10–11.

Accommodating Persons with Disabilities

This module provides suggestions and resources for service providers to assist persons with disabilities who need accommodations. Accommodations are often essential to enable sexual assault victims with disabilities to access and benefit from the programs and services available to them.[1]

Key Points

- "An accommodation" is a broad term that is used to describe a modification to goods, services and structures that allows for inclusion and participation by persons with disabilities. Accommodations discussed in this module are mainly modifications to goods and services rather than to structures. Some common accommodation tools to modify goods and services include: auxiliary aids and services that promote effective communication, assistive technology used to perform tasks that would otherwise be difficult or impossible due to a disability, and personal services that assist individuals with daily living tasks that they cannot accomplish on their own.
- In order to find out if accommodations are needed and what accommodations are appropriate, service providers must ask all clients what works best for them.

C4. Accommodating Persons with Disabilities

Purpose

This module provides suggestions and resources for service providers to assist individuals with disabilities who need accommodations. All the *Disabilities 101* modules in this toolkit to some extent incorporate issues pertinent to accommodations, because accommodations are often essential to enable sexual assault victims with disabilities to access and benefit from the programs and services available to them.

NOTE: This module is NOT intended to be a guide for meeting the requirements of the Americans with Disabilities Act (ADA) of 1990. The requirements under this law vary based on criteria such as, but not limited to, whether the entity is public or private, the nature of the business and how that business or service provider is funded. (See *Disabilities 101. Disability Laws.*) If a service provider is working towards full compliance with the ADA, it is recommended that they seek the assistance of a qualified individual who is trained in the regulations specific to their entity. The Disability and Business Technical Assistance Center (DBTAC), Mid-Atlantic ADA Center in Rockville, MD is a resource for addressing compliance issues related to the ADA. Call 800-949-4232 or go to www.adainfo.org for assistance.

Objectives

Those who complete this module will be able to:

- Discuss resources that enhance access to services for persons with disabilities;
- Recognize common tools, equipment and aids available to increase independence, facilitate communication and increase the ability of a person with disabilities to participate and/or benefit from programs and services; and
- Challenge the assumption that it is expensive and difficult to accommodate individuals with disabilities.

CORE KNOWLEDGE What are accommodations?

An "accommodation" is a broad term that is used to describe a modification to goods, services and structures that allows for inclusion and participation by persons with disabilities. Accommodations discussed in this module are mainly modifications to goods and services rather than to structures, such as an interior or exterior of an office. Some common accommodation tools to modify goods and services include:

- **Auxiliary aids and services** is a term used by the U.S. Department of Justice to describe a wide range of services and devices that promote effective communication.[2]
- **Assistive technology** (AT) refers to any device used to perform a task that would otherwise be difficult or impossible due to a disability. We all use AT devices every day. An electric can opener is easier to use for some than a hand-held can opener. Glasses make it possible for those with less than perfect vision to read. Computers and technology assist us in communicating and in gaining knowledge without physically leaving our current locations. There is some overlap between auxiliary aids and AT devices.
- **Personal services** refer to a wide range of services and providers available to assist individuals with daily living tasks that they cannot accomplish on their own (e.g., an attendant from a home health agency may assist a person with physical disabilities with bathing and dressing).

These accommodations can help equalize the opportunity for persons with disabilities to access your services.

How do you find out what accommodations a person needs?

A valuable resource available to service providers to learn how to accommodate a client's disability is the individual client.

> "The key to finding low-cost solutions is to foster open communication with the person needing the accommodation and to think broadly about the possibilities and resources available to them and to your organization. Each individual will have a unique approach to his or her own disability. Recognize that finding reasonable adaptations is a process of creative problem solving."[3]

It is important to note that not all people with similar disabilities will benefit from the same accommodation. The *Title II Technical Assistance Manual,* developed by the U.S. Department of Justice, provides an example as to why "one size doesn't fit all:"[4] Some individuals who were deaf at birth, or who lost their hearing before acquiring language, use sign language as their primary form of communication. They may be uncomfortable or not proficient with written English, thus making use of a notepad an ineffective tool for communication. Individuals who lose their hearing later in life, on the other hand, may not be familiar with sign language and can communicate effectively through writing. This example demonstrates why it is critical to **ask each individual what works best for them. What is effective for one could be ineffective for another**.[5] (See *Disabilities 101. Tips for Communicating with Persons with Disabilities.*)

FYI Those providing accommodations to sexual assault victims with disabilities must be trained to maintain the confidentiality of the information shared, with the exception of cases where mandatory reporting is required by the state. (See *Sexual Violence 101. Confidentiality* and *Sexual Violence 101. Mandatory Reporting.*)

It is also important that service providers have a basic understanding of sexual assault victimization and work to avoid inadvertently re-traumatizing victims. For example, those providing personal services should understand that victims may be very cautious, distrustful and even afraid of them at first and may prefer a provider of a specific gender. Providers may need to learn what triggers emotional distress for each victim (e.g., if they were

sexually assaulted by another caregiver, a victim may be anxious when someone new provides assistance with bathing, toileting and dressing). Providers also need to be efficient and caring, giving victims as much control as possible over how services are delivered. Interpreters must have the ability to dialogue about sexual victimization using accurate terms that avoid victim-blaming and to fully describe what is being discussed. They need to understand that it may be very difficult for victims to talk about the sexual violence. (See the *Sexual Violence 101 modules,* in particular *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

What are examples of auxiliary aids/services and AT devices?

The following chart offers some examples of (1) auxiliary aids and services designed to promote effective communication and (2) AT devices used to perform tasks that would otherwise be difficult or impossible due to a disability. Note that technology is constantly changing; over time, examples on this list may become obsolete as more technologically advanced equipment is developed.

Examples of Auxiliary Aids/Services	Examples of Assistive Technology (AT)
Assistive listening device that amplifies sound.	A **wheelchair**, whether manual or power, that enhances a person's mobility.
A **Brailler** that converts documents into Braille.	**Computer software** (e.g., screen reader programs) that allows for a person who is blind to use it through vocalization of the written word on the computer screen and/or use of Braille.
Large print materials, in at least 18 to 20 font, is best practice. It is important to determine what size font works best for a person with a visual disability.	**Speech synthesizer** that allows a person who has speech difficulties to type her message into computerized equipment that then vocalizes what she has typed.[6]
Captioning for televisions and visual presentations that can enhance visibility.	**Communication board or device**, accessed by a touch screen that can have words programmed into it.
A **TTY machine**, a telecommunication device often used when communicating with someone who is deaf, allows the user to type and receive messages instead of speaking into or listening on a phone.	A **talking watch** or **calculator** and **books on tape**.
Text messaging through cell phones is another economical way for a person who is deaf or hard of hearing to communicate.	A **flasher for a door bell** so an individual who is deaf will know that someone is at the door.
Video relay service uses a web camera and computer or video phone to transmit images to a video interpreter.	**Raised letters or Braille** on directional signage aids a person with a visual disability.

Qualified sign language interpreters aid in communication. Being able to sign does not guarantee that a person is a qualified interpreter. It does not certify that a person can process spoken communication into the proper signs, or that he or she possesses the proper skills to observe someone signing and change their signed or finger-spelled communication into spoken words. A qualified interpreter does not necessarily require certification; qualifications are linked more closely to the ability to interpret receptively and expressively.[7]	**Writing guides** are overlays that individuals with low vision can use for tasks. For example, a writing guide for check writing designates areas for dates, amounts of money and signatures.
Closed circuit television (CCTV) is a device that will enlarge text much like an overhead projector. Printed materials are placed on the magnifier, which enlarges and projects them onto a screen similar to a television.	A **magnifier**, for a television screen is placed on the floor in front of the television and magnifies the image.
A **tape recorder** can transform written documents, such as intake forms and agency policies, into an audio format that can be used by someone who is blind and does not read Braille.	A **decoder** helps individuals with older televisions have access to closed captioning. Most new televisions have decoder functions built into them.
	A **modified eating** utensil that allows individuals with limited use of their hands to feed themselves.

FYI "Professionals may assume that accommodating people with disabilities in their programs will be prohibitively expensive. **In fact, accommodations are often cost-free or quite inexpensive.** There is not always a need for accommodations, as many people with disabilities own the equipment they need for everyday life and will need only minimal assistance from others."[8]

What are examples of personal services?

As mentioned earlier, a variety of personal services are typically available in a community to assist individuals with the tasks of daily living. Tasks might include bathing, toileting, grooming, feeding and dressing oneself, getting in and out of bed, transferring in and out of a wheelchair, preparing meals, performing housework, taking medications, managing finances, communicating with others, going on errands and accessing activities outside of the home. Personal services are often coordinated by a range of community-based providers, depending upon the needs of the person with disabilities. Services are often provided by a spectrum of attendants, such as qualified certified nursing assistants (CNAs) for in-home care, housecleaning service employees for routine or seasonal cleaning, drivers for transportation services, senior nutrition program employees that prepare and deliver meals, advisors for financial management services, etc.

If your agency provides residential services, such as shelter or transitional housing, it is important to determine what resources are available within the community to meet your clients' needs for personal services. To ensure that persons with a disability can equally participate in all of the services you provide, meeting these basic needs is critical. Because of the personal nature of the services being provided, it is recommended that home health care agencies are utilized that allow individuals with disabilities to select their own attendants. Although agencies

provide training for the staff that perform these duties, the best training is that which is provided by the individual who needs the service.

What key resources for accommodations are available to persons with disabilities in West Virginia?

Auxiliary aids/services and AT devices:

- The **West Virginia Commission for the Deaf and Hard of Hearing** can assist in locating qualified interpreters (www.wvdhhr.org/wvcdhh or 866-461-3578).
- The Federal Communications Commission (FCC) uses the 711 dialing code for access to the national **Telecommunications Relay Services** (TRS). TRS enables persons who are deaf, hard of hearing or have a communication disability to use the telephone system via a text telephone (TTY) or other device to call persons with or without such disabilities who do not have a TTY.

  Example: Martha, who is deaf, wants to call her doctor using TRS because her doctor does not have a TTY. Martha can use her TTY to dial 711. She will automatically be connected to a TRS operator. Martha will give the operator her doctor's phone number and a message. The operator will place a call to Martha's doctor. The operator serves as a link for the call, relaying the text from Martha's TTY messages in voice to the doctor, and converting to text for Martha what the doctor says in response.

  For more on TRS or 711, go to http://www.fcc.gov/cgb/consumerfacts/trs.html and http://www.fcc.gov/cgb/consumerfacts/711.html.[9]
- The **West Virginia University Center for Excellence in Disabilities** (CED) operates a program called Powerful Tools for Living as part of the WV Assistive Technology Services project. Through this project, there are AT resource centers throughout the state that serve as AT loan libraries and demonstration centers. These centers provide individuals with the opportunity to learn about and try AT prior to purchase to ensure that the AT is effective in addressing their needs. They are also resources for the community at large when seeking AT resources. To learn more, go to www.cedwv.org or call 877-724-8244.
- Many individuals with disabilities live on very limited incomes and have difficulty affording the assistive technology they may need. The **West Virginia Division of Rehabilitation Services** operates an assistive technology revolving loan fund, funded by the state legislature, which provides low interest loans to qualified individuals with disabilities to purchase AT. For more information, go to www.wvdrs.org or call 800-642-8207.

  In addition, the **Centers for Independent Living** within the state operate a Community Living Services program that also provides funding to individuals with disabilities to purchase AT or pay for home modifications to improve accessibility. To locate service areas for the centers, go to www.mtstcil.org.
- Additional sources for purchasing simple solutions for AT needs are online stores such as **Maxi Aids** and **Independent Living Aids**. These companies provide aids to enhance independent living skills; www.maxiaids.com provides aids for all disabilities (800-522-6294) and www.IndependentLiving.com specializes in providing low vision and hearing loss aids (800-537-2118).

Personal services:

- The **WV Department of Health and Human Services** (DHHR) and the **Bureau of Senior Services** (BOSS) provide resources for personal assistance services. Qualified individuals may be able to gain in-home personal assistance services through two Medicaid waiver programs, one for persons with intellectual

disabilities and one for seniors and persons with other disabilities. Go to www.wvseniorservices.org or call 877-987-3646.

- Those who do not qualify for the federally funded Medicaid programs may be eligible to receive support from a state funded personal assistance service called the Ron Yost Personal Assistance Services Program. Go to www.wvsilc.org for information on the **WV Statewide Independent Living Council** at or call 304-766-4624.

How can access to services be improved when structural barriers exist?

Although this module is not intended to address structural barriers, the following modifications are relatively inexpensive and easy to implement and can help to improve overall access to your services:

- A portable ramp can help if a few steps limit access to your agency.
- Rearranging tables, display racks, desks or other furnishings can increase space for individuals who use a wheelchair.
- A shower chair can increase independence for someone who may have difficulty standing to shower.
- Lowering shelves or racks holding printed materials or supplies can improve access.
- Providing services at an alternate, accessible location enables persons with physical disabilities to utilize your services.
- Putting blocks under a table to raise it up can allow someone using a power chair or wheelchair to fit comfortably at the table.

For additional information on taking the next steps in addressing physical barriers to services, the DBTAC, Mid-Atlantic ADA Center is a resource (see contact information on page *C4.1* of this module). (Also see *Tools to Increase Access. Physical Accessibility Checklist for Existing Facilities*.)

Questions to consider:

1. What types of accommodations does your agency make?
2. What accommodations could be easily implemented to make your agency more accessible to sexual violence victims with disabilities?
3. What steps need to be taken to implement the process and acquire these accommodations?
4. What can your agency do to facilitate creative problem solving with every victim with a disability to identify any needed and appropriate accommodations?

(Also see *Tools to Increase Access. Programmatic and Policy Accessibility Checklist, Tools to Increase Access. Readiness to Serve Victims with Disabilities: A Review of Intake Practices,* and *Tools to Increase Access. Developing a Transition Plan.*)

These questions can be considered by individual readers and/or discussed with other agency employees.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer for each question.

1. What is an accommodation? *See page C4.2.*
2. In order to determine if accommodations are needed for a client and, if so, what accommodations are appropriate, what is a critical step for service providers to take? *See page C4.2.*
3. What accommodation tools are described in this module? *See page C4.2.*
4. What are examples of each of those tools? *See pages C4.3–C4.4.*
5. What resources for accommodations are available to persons with disabilities? *See pages C4.5–C4.6.*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]The Americans with Disabilities Act, *Title II technical assistance manual* II–7.1000, Equally effective communication, through http://www.ada.gov/taman2.html. This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]Mobility International USA, *Helpful tips for accommodating people with disabilities,* http://www.miusa.org/idd/IDDresourcecenter/hrtoolbox/helptipstxt/view.

[4]Title II technical assistance manual II–7.1100, Primary considerations.

[5]Title II technical assistance manual II–7.1100, Primary considerations.

[6]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

[7]Title II technical assistance manual, II–7.1200, Qualified interpreters.

[8]Mobility International USA.

[9]The information about TRS and 711 was drawn from these websites.

Working with Victims with Mental Illnesses

This module provides service providers with general information to assist them in serving sexual violence victims who have a mental illness.[1]

Key Points

- A mental illness is a medical condition that causes a mild to severe disruption in a person's thinking, emotions, mood, ability to relate to others and daily functioning. There are many types of mental illnesses; they can be temporary or chronic in nature and usually are treated with medications and other forms of therapy.[2] Persons with mental illnesses are at higher risk of sexual victimization than the general population.
- Service providers should simply clarify with victims their needs and desired assistance and offer accommodations as necessary, rather than making assumptions about the root causes of behaviors (e.g., that they are reactions to sexual violence or indicative of a mental health issue). Service providers' responses must stay within the scope of their professional role and level of expertise.
- Victims who have a mental illness may face barriers in accessing services. Service providers should consider that —
  - Responders' misconceptions about mental illnesses can prevent victims from being taken seriously. Service providers must address their own fears and discomforts about working with persons with this type of disability before engaging with them.
  - Caregivers may be offenders. Service providers can help victims who are abused by their caregiver plan for safety and differentiate between healthy and unhealthy relationships with caregivers, as well as support victims in addressing their needs.
  - The perceived lack of credibility of these victims' accounts of what occurred is a key reason why sex offenders target this population and why these victims are reluctant to come forward. When they do come forward, service providers must treat them with the same respect and empathy as they do with any other victim.
  - Being able to trust service providers may be difficult for some victims (e.g., those with feelings of paranoia or anxiety). Maintaining the confidentiality of victim information—unless there is a need for a mandatory report—is one way that service providers can build trust and help victims move toward recovery.
  - Sexual violence may exacerbate some types of mental illnesses.
- Victims with mental illnesses should be aware of the potential consequences of disclosing sexual violence (e.g., changes in mental health treatment, loss of a caregiver or even institutionalization). Service providers can aid victims in considering their options.

C5. Working with Victims with Mental Illnesses

Purpose

A 24-year-old female Army officer discloses to you that she was sexually assaulted several months ago while she was at a military rehabilitation center—she was injured in combat, losing a foot. She was also dealing with post-traumatic stress and depression. She hasn't reported the assault—the perpetrator was another patient who told her that nobody would believe her since she was a "nut case." She doesn't want him to "drag her reputation through the mud" or jeopardize her career. She is calling mainly because she is scared that since the assault, her overall feeling of despair is intensifying.[3]

Service providers outside of the mental health field assist sexual violence victims who also have a mental illness. This module offers basic information and guidance on the initial response to these victims, while urging service providers to stay within the scope of their professional role and skill level when they respond.

As illustrated in the scenario above, sex offenders often target individuals who have a mental illness. These individuals may be less willing or able to report sexual violence. If they do disclose victimization, their account of what happened may be questioned. Unfortunately, the stigma associated with mental illnesses may lead these victims to do without the vital help they need. This module can be a tool for service providers to explore how to counter this stigma in their work. Ultimately, a service provider's goal when responding to sexual assault victims is not to determine whether or not victims have a mental illness, but how to best offer them support and accommodate their needs so they can deal with their reactions to the violence and begin to heal.

Objectives

Those completing this module will be able to:

- Discuss what mental illness is and its prevalence in the United States;
- Describe the risk of sexual victimization for persons who have a mental illness;
- Identify behaviors that may be indicative of a mental illness and possible accommodations to enable victims coping with such behaviors to discuss and address their needs; and
- Discuss barriers to accessing services that victims who have a mental illness may face and related considerations for service providers.

Preparation

- Review *Disabilities 101. Tips for Communicating with Persons with Disabilities*.

Part 1: CORE KNOWEDGE

What is a mental illness?

A mental illness is a medical condition (which can be temporary or chronic) that causes a mild to severe disruption in a person's thinking, emotions, mood, ability to relate to others and daily functioning. It often results in a diminished capacity for coping with the ordinary demands of life and can cause reactions to distress that society considers extreme. It can be treated, in many instances very successfully, with medications and other forms of therapy. It is *not* the result of personal weakness, lack of character, poor upbringing or a lack of intelligence.[4]

There are many different conditions recognized by health professionals as mental illnesses. A few examples include clinical anxiety, depression, mania, post-traumatic stress and schizophrenia.[5] Mental health professionals typically

refer to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) to diagnose these conditions.[6,7]

FYI Service providers outside of the mental health field do not need to be experts on mental illnesses. It is not their role to attempt to make clinical diagnoses or rule out the possibility that a victim may have a psychological condition. However, when providers increase their knowledge and comfort level in working with victims who have a mental illness and overcome associated misconceptions, they are better positioned to help these victims achieve their goals.

FYI Keep in mind that a victim who has a mental illness is not defined by that disability. When working with a victim with a mental illness, always ask yourself and the victim if the disability is even relevant to your conversation. (See *Disabilities 101. Person First Language*.)

What is the prevalence of mental illnesses in the United States?

An estimated 26 percent of Americans ages 18 and older—about one in four adults—are diagnosed with a mental disability in a given year.[8] A much smaller proportion of the U.S. population—about 6 percent or 1 in 17—experience serious mental illnesses that cause a severe disruption in functioning.[9]

FYI Individuals can experience multiple co-occurring medical conditions. For example, a person may have anxiety and depression. A person with cerebral palsy may experience post-traumatic stress. Someone with schizophrenia may be deaf.

How prevalent is the sexual victimization of persons with mental illnesses?

In the U.S., one in six women and one in 33 men has been the victim of an attempted or completed rape in their lifetime.[10] (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors.*) Studies reveal much higher rates of victimization for persons with mental illnesses:

- One study showed that 87 percent of a sample of individuals with severe mental illnesses had been sexually or physically assaulted within their lifetime. The women in this study were 16 times more likely to report having been the victim of a violent crime in the past year than women from a general population sample.[11]
- Sexual abuse in childhood is associated with higher rates of mental illnesses, poorer outcomes for mental health treatment and re-victimization as adults.[12] Higher rates of childhood sexual abuse are reported by adolescents and adults with diagnosed mental illnesses and range from 6 to 50 percent, whereas general population studies of reported rates of childhood sexual abuse range from 13 to 17 percent for women and 2.5 to 5 percent for men.[13]

What behaviors are indicative of a mental illness? How do service providers accommodate victims displaying these behaviors?

There are some common indicators that an individual may have a mental illness. Each indicator in the chart below is defined by a group of behaviors. Service providers may observe these behaviors as they interact with victims or victims may disclose them. However, some of these behaviors may actually be reactions a victim has to sexual violence. (See *Sexual Violence 101. Crisis Intervention, Sexual Violence 101. Indicators of Sexual Violence* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*) With this in mind, **service providers must avoid making assumptions about root causes of behaviors and simply clarify with victims their circumstances, needs and desired assistance.** They can also offer accommodations to aid these victims in discussing and addressing their needs (see the following chart for examples).

Remember that the response in each case depends on the situation. (See *Sexual Violence 101. Crisis Intervention* and *Sexual Violence 101. Safety Planning.*)

FYI The suggestions for accommodations listed below build upon tips cited in *Disabilities 101. Tips for Communicating with Persons with Disabilities.* They are intended to guide service providers as they do initial intake or crisis intervention with clients who have been sexually victimized. A referral for mental health treatment may be warranted in some instances. *Reviewing these suggestions is not a substitute for the specialized training a mental health professional receives to be able to diagnose and treat persons with specific mental illnesses.* Also see the end of *Part 1: Core Knowledge* and *Part 2: Discussion* for case scenarios and dialogue about accommodations and considerations.[14]

Anxiety: characterized by being constantly on edge, restless and agitated, and/or having seemingly excessive intrusive thoughts, obsessive fears and/or ruminations about a traumatic event.

Possible accommodations during the initial response: Talk with the person in an environment as free from distractions as possible. Help her calm down; be accepting of her feeling of anxiety and believe she can overcome it. Ask her simple questions to help break any patterns of compulsive talking (e.g., about obsessive fears). Note that, initially, it may be difficult for her to separate her fears from reality. Work with her to build a trusting relationship before challenging her reality. Discuss what she wants to do to get through her fears and help her identify her needs for assistance. Be aware that if she is very agitated, the conversation may need to continue at another time.

Depression: characterized by pervasive feelings of hopelessness and despair, unshakable feelings of worthlessness and inadequacy, withdrawal from others and/or the inability to engage in productive activity. May manifest as physical symptoms (fatigue, stomach pain or sleep disturbances) and emotional symptoms (inability to concentrate, irritability or low mood).

Possible accommodations during the initial response: Convey acceptance, caring and hope to the person. Initiate conversation if needed. Help her identify ways to regain control of the situation, identify her needs and develop a plan to address these needs.

Disorientation: characterized by a dazed expression, memory loss and/or inability to give the date or time, identify current location, recall recent events and/or understand what is happening.

Related to disorientation is **dissociation**, a mental process that causes a lack of connection in a person's thoughts, memory and sense of identity. With severe dissociation, a person may appear distant or catatonic and have little memory of the dissociation.[15]

Possible accommodations during the initial response: Talk with the person in an environment as free from distractions as possible. Get her attention. Initiate conversation if needed. Be brief, simple and repeat as necessary. Attempt to identify her needs for assistance. Be patient but aware that discussion may not be possible at this time.

Hallucinations or delusions: characterized by hearing voices, seeing visions, delusional thinking and/or excessive preoccupation with an idea or thought. Often associated with severe mental illnesses. Also common with persons under the influence of drugs or alcohol.

Possible accommodations during the initial response: Be accepting, calm, straightforward, caring, nonthreatening and reassuring. Keep the conversation simple and brief. Be aware that rational discussion may not be possible on some or all topics. Don't argue or try to differentiate her hallucination or delusion from reality; instead, respond to her feelings and needs and help her identify what assistance she would like to address her needs. If she is agitated but poses no immediate threat to anyone's safety, allow her time to calm down before engaging her in conversation, or transition her to a safer/calmer conversation. Take breaks as needed.

Mania: characterized by expansive or irritable mood, inflated self-esteem, decreased need for sleep; increased energy; racing thoughts; feelings of invulnerability; poor judgment; heightened sex drive and impulsive sexual acts; and/or denial that anything is wrong. Associated with the use of some substances. A person with bi-polar illness may cycle between feelings of depression and mania.

Possible accommodations during the initial response (also see above under "Depression"): Be straightforward. Get the person's attention if needed. Ask simple questions to break the pattern of racing thoughts. If she is over-stimulated, don't pressure her to concentrate. Don't expect a rational discussion. If she is agitated but poses no immediate threat to anyone's safety, allow her time to calm down before engaging her in conversation, or transition her to a safer/calmer conversation. Take breaks as needed. Help her in identifying her feelings and needs and in developing a realistic plan to address those needs.

Substance abuse: When presented with a life stressor such as sexual victimization, many individuals self-medicate with drugs or alcohol to help them temporarily lessen the pain and other negative feelings.[16] Persons with specific mental illnesses have an increased risk for substance abuse.[17] Substance abuse may aggravate a pre-existing mental illness and reactions to sexual violence.

Possible accommodations during the initial response: Approach the person in a calm, nonthreatening and reassuring manner. Keep the conversation simple, brief and focused. Help her identify her needs and create a plan to address those needs. If she is under the influence of alcohol or drugs, recognize that she may not be able to have a rational conversation and may need to continue talking at another time. If she is agitated but poses no immediate threat to anyone's safety, allow her time to calm down before engaging her in conversation. Do not attempt to force her into treatment.

Suicidal thoughts: characterized by talking about suicide, including remarks such as "I wish I were dead or hadn't been born;" obtaining items that could be used to commit suicide, such as a gun or pills; withdrawing from social contact and wanting to be left alone; dramatic mood swings, such as being emotionally high one day and deeply discouraged the next; being preoccupied with death, dying or violence; feeling trapped or hopeless about a situation; abusing alcohol or drugs; changing normal routines, including eating or sleeping patterns; risky or self-destructive behaviors, such as driving recklessly; giving away belongings or getting affairs in order; saying goodbye to people as if they won't be seen again; and/or acting out of character, such as becoming very outgoing after having been shy. Although most persons with suicidal thoughts do not attempt or commit suicide, the extent of suicidal thoughts should be evaluated and re-evaluated as circumstances require (e.g., if a client who has talked to you about suicide in the past now tells you she has a written suicide plan and has acquired the means to commit suicide).[18] Studies indicate that more than 90 percent of persons who commit suicide have a diagnosable mental disability,[19] most commonly depression or substance abuse.[20] It is not the disability itself that increases the risk of suicide, but the combination of a mental illness and life stressors.[21]

Possible accommodations during the initial response: Ask the person about her suicidal thoughts. Asking won't push her into doing something self-destructive; rather, it offers her a chance to talk about her thoughts and may reduce the risk of acting on these thoughts.[22] If she is at imminent risk of suicide or just made an attempt, seek immediate emergency assistance according to your agency's policies and stay with her until help arrives.[23] If risk is not imminent, offer to assist her in developing a plan for her safety. (See *Sexual Violence 101. Crisis Intervention* and *Sexual Violence 101. Safety Planning.*)

What barriers to accessing services may victims who have a mental illness face? What are related considerations for service providers?

See the chart below. Keep in mind that the focus of a service provider's initial response to a disclosure of sexual violence should be to offer support, validation, information, crisis intervention and hope as needed for the victim to heal. Mental illnesses may influence the type of accommodations needed, as discussed above, but they should not be the focus of the response unless it is the victim's choice.

People with mental illnesses face significant stigma and discrimination. While progress has been made in the treatment and public awareness of mental illnesses, the stigma related to this form of disability still results in prejudice and stereotyping. For example, the media often portrays individuals with mental illnesses as "scary" or "dangerous," yet fails to recognize they are much more likely to be the victims of a crime. Another example is that a prosecutor may not pursue charges because he views the victim's account as unreliable solely because she has schizophrenia.

How to help: Service providers must address their own fears and discomforts about working with these victims before engaging with them. Their ongoing support for victims with mental illnesses is critical to facilitate healing, regardless of community reactions and criminal justice outcomes. (See *Disabilities 101. Person First Language* and *Disabilities 101. Tips for Communicating with Persons with Disabilities*.)

Persons with mental illnesses may be sexually assaulted by a caregiver. They may be reliant on others to carry out the tasks of daily living that they cannot accomplish on their own. Sex offenders who are caregivers may take advantage of this imbalance of power and victimize their charges. They may be able to "get away" with their crime by convincing their victims that sexually abusive behavior is a legitimate component of their caregiving responsibilities (e.g., by saying they were just bathing the person's genital areas). They may persuade their victims that what they think happened was in fact a nightmare or hallucination or that the victims were too intoxicated or medicated to remember events correctly. (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors.*)

How to help: Service providers can help victims of sexual violence perpetrated by caregivers consider their safety risks and options. They can help victims understand the differences between healthy and unhealthy relationships with caregivers, as well as support victims in addressing their needs to the extent possible. (See *Sexual Violence 101. Safety Planning.*) Depending upon the circumstances, service providers may be required to report the victimization to local authorities. (See *Sexual Violence 101. Mandatory Reporting*.)

The credibility of the victim's account of sexual violence is often questioned. Offenders may be able to keep victims with mental illnesses from seeking help or reporting by telling them that no one will believe them. If victims do disclose sexual violence to others, offenders very likely will attack the credibility of their account of what occurred. Sex offenders often target people with mental illnesses because they recognize that their claims of sexual violence may be ignored or discounted by investigating authorities and the courts.

How to help: Service providers must remember that it is not their responsibility to determine the credibility of victims' accounts of sexual victimization. If the case is one requiring a mandated report, it is sufficient that there is a suspicion that sexual violence occurred. (See *Sexual Violence 101. Mandatory Reporting*.) When a victim with a mental illness does come forward, she deserves to be treated with the same respect and empathy as any other victim. When service providers ignore, immediately discount or question a disclosure of sexual assault, they are re-victimizing the victim. Even individuals who are experiencing delusions or hallucinations may be able to provide accurate information related to their sexual victimization.

FYI Although it is not common, it is possible that a person could hallucinate that they were sexually assaulted and be unable to separate the hallucination from reality. Regardless of the evidence in such a case, service providers should recognize that the person believes the assault occurred and may be traumatized. They can offer support to the person to deal with the impact of the trauma she is experiencing and assist her with her related needs (crisis intervention, safety planning, linking her with mental health treatment if permitted and warranted, etc.). (See *Sexual Violence 101. Understanding and Responding to Emotional Trauma.*)

Being able to trust service providers may be difficult for some victims. Helping a victim in need infers a sharing of problems, concerns and anxieties. This sharing cannot be done without trust between the victim and the service provider. That trust is built upon mutual respect and the understanding that discussions are confidential. However, gaining trust is sometimes difficult when working with a person who has feelings of paranoia, anxiety and/or a history of being abused or discounted by others.

How to help: Service providers must demonstrate they are trustworthy by maintaining the confidentiality of information that victims share with them, unless the case requires a mandatory report or the victim consents to releasing the information to specific individuals or agencies. (See *Sexual Violence 101. Mandatory Reporting* and *Sexual Violence 101. Confidentiality.*) Service providers should:

- Not assume that a victim lacks competency to make her own decisions or needs a guardian. In West Virginia, only the courts have the power to make these determinations for residents. (See *Disabilities 101. Guardianship and Conservatorship.*)
- Not assume that the victim's information should automatically be shared with her guardian—in reality, service providers and victims must assess this need on an individual case basis.
- Not assume that it is necessary to involve a mental health treatment provider.

Being able to trust service providers may be the first step for a victim towards gaining the confidence and resources needed to make a report or to recover.

A mental illness may exacerbate a victim's reactions to sexual violence (e.g., triggering depression, anxiety, hallucinations, dissociation or suicide attempts).

How to help: Service providers can help victims realize that a mental illness may intensify their reactions to the sexual assault and discuss the options available that may help relieve their symptoms, including utilizing local mental health resources. Note that victims may or may not already be working with a local mental health provider and may or may not welcome their interventions. (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

If victims appear to be a danger to themselves or others, they may require immediate emergency assistance. Service providers should follow their agency's policies regarding specific actions to take in these situations. (See *Sexual Violence 101. Mandatory Reporting* and *Sexual Violence 101. Crisis Intervention.* Also see the previous section in this module on suicidal thoughts and possible accommodations.)

The fact that a victim has a mental illness may influence the consequences that she faces when she discloses sexual violence, such as having her abusive caregiver taken away and her independence reduced, changing mental health treatment and/or even being institutionalized (e.g., because she is perceived as being a threat to herself/others and/or unable to live on her own).

How to help: Service providers can encourage victims with mental illnesses to discuss their concerns and options regarding the potential consequences of disclosing/reporting. For example, a victim may disclose a sexual assault along with increased anxiety and substance abuse, but be reluctant to talk with a mental health provider because she doesn't want to increase her medication or participate in inpatient treatment. The service provider can help the victim consider her needs and options related to self-care.

DISABILITIES 101

To close *Part 1: Core Knowledge*, let's return to the scenario that opened this module and discuss how service providers might respond. Here's the scenario:

> *A 24-year-old female Army officer discloses to you that she was sexually assaulted several months ago while she was at a military rehabilitation center—she was injured in combat, losing a foot. She was also dealing with post-traumatic stress and depression. She hasn't reported the assault—the perpetrator was another patient who told her that nobody would believe her since she was a "nut case." She doesn't want him to "drag her reputation through the mud" or jeopardize her career. She is calling mainly because she is scared that since the assault, her overall feeling of despair is intensifying.*

A service provider's initial response to this victim might include:

- Validating her for seeking help, regardless of whether she reports the assault to law enforcement;
- Asking her what assistance she would like, explaining the agency's services and any limitations;
- Asking her if she feels safe (from the offender or if there is a danger of self-harm);
- If she reports that she doesn't feel safe from self-harm, follow agency policy for activating immediate emergency assistance;
- Asking her to talk more about her reactions to the victimization and her related feelings, fears and concerns;
- Asking her what she would like to do to deal with these feelings, fears and concerns and what would help her to regain control of the situation;
- Discussing available options to address her needs (including her contacting a counselor or mental health provider to further explore how to deal with the despair);
- Discussing if she requires accommodations to address her needs and to access resources; and
- If she permits, helping her plan for her future safety and the next steps in addressing her concerns.

(For more specific discussion on initial responses, see *Sexual Violence 101. Understanding and Addressing Emotional Trauma, Sexual Violence 101. Crisis Intervention* and *Sexual Violence 101. Safety Planning*.)

Even if you do not complete *Part 2: Discussion* of this module as part of a group dialogue, it may be helpful to review the activities in that section, especially those with the case scenarios. They provide the opportunity to practice responding in different situations to persons who may have a mental illness and to think about how to accommodate their needs.

FYI It may be helpful for those agencies that do not have in-house mental health expertise to partner with a local mental health provider, particularly one with experience in working with sexual violence victims. When agencies partner in this way, they help staff recognize their agency's scope of service and limitations in assisting victims with mental illnesses, as well as to know if and when to reach out to an outside mental health provider for specialized assistance (e.g., for consultation to guide their own response to a victim or to connect an interested victim to appropriate treatment services).

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What types of disruptions can a mental illness cause? What are examples of different types of mental illnesses? *See page C5.2.*
2. One in how many people suffers from a serious mental illness? *See page C5.3.*
3. Is the prevalence of sexual victimization among persons with mental illnesses less than, equal to or greater than it is among the general population? *See page C5.3.*
4. What are examples of common indicators of various mental illnesses and possible accommodations victims might need? *See pages C5.4–C5.5.*
5. What should service providers do if a victim is suicidal? *See page C5.5.*
6. What are examples of societal misconceptions about mental illnesses that might impact sexual assault victims? *See page C5.6.*
7. What can a service provider do to assist persons with mental illnesses who were victimized by their caregivers? *See page C5.6.*
8. What are examples of how the issue of credibility can influence a community's response to a person with a mental illness who discloses sexual assault? How can a service provider help a victim deal with credibility issues? *See page C5.6.*
9. How might a mental illness influence a victim's reactions to sexual violence? How can a service provider help? *See page C5.7.*
10. What are examples of potential negative consequences for a person with a mental illness who discloses or reports sexual victimization? How can a service provider help? *See page C5.7.*

West Virginia Resources/Services for Persons with Mental Illnesses

STATE MENTAL HEALTH AGENCY

Division for Adult Mental Health
Bureau for Behavioral Health and Health Facilities
Department of Health and Human Resources
Phone: 304-558-0627
Fax: 304-558-1008
E-mail: obhs@wvdhhr.org
Internet: www.wvdhhr.org/bhhf/adultmh.asp

The Division for Adult Mental Health provides information about admission, care, treatment, release and patient follow-up in public or private psychiatric residential facilities in West Virginia.

STATE SUBSTANCE ABUSE AGENCY

Division of Alcoholism and Drug Abuse
Bureau for Behavioral Services and Health Facilities
Department of Health and Human Resources
Phone: 304-558-0627
Fax: 304-558-1008
E-mail: obhs@wvdhhr.org
Internet: http://www.wvdhhr.org/bhhf/ada.asp

The Division of Alcoholism and Drug Abuse provides information about the treatment and care of substance abuse disorders in West Virginia.

ADVOCACY

NAMI West Virginia
Phone: 304-342-0497
Toll-free: 800-598-5653
Fax: 304-342-0499
E-mail: namiwv@aol.com
Internet: www.namiwv.org

The National Alliance on Mental Illness (NAMI) maintains a helpline for information on mental illnesses and referrals to local groups. Local self-help groups have support and advocacy components and offer education and information about community services for families and individuals.

FAMILY SUPPORT

Mountain State Parents, Children and Adolescent Network
Phone: 304-233-5399
Toll-free: 800-244-5385
Fax: 304-233-3847
E-mail: ttoothman@mspcan.org
Internet: www.mspcan.org

This statewide, family-run organization provides support and information to families of children and adolescents with serious emotional disorders.

STATE PROTECTION AND ADVOCACY AGENCY

West Virginia Advocates, Inc.
Litton Building, Fourth Floor
Phone: 304-346-0847 (TDD)
Toll-free: 800-950-5250 (Nationwide/TDD)
Fax: 304-346-0867
Internet: www.wvadvocates.org

Spanish language assistance available.

West Virginia Advocates, Inc. is the federally mandated protection and advocacy agency for the rights of people with disabilities in West Virginia. It provides advocacy services and investigates reports of abuse and neglect that arise during the transportation or admission to facilities that care for or treat individuals with disabilities, during residency in them or within 90 days after discharge from them.

INVESTIGATION OF FRAUD AND MISTREATMENT

WV Medicaid Fraud Control Unit (MFCU)
Office of Inspector General, Department of Health and Human Resources
Phone: 304-558-1858
Fax: 304-558-3498
Tipline: 888-372-8398
Internet: http://www.wvdhhr.org/oig/mfcu/

The MFCU investigates complaints of alleged fraud and mistreatment of patients in facilities receiving payment from medical programs of the state.

ADVOCACY

West Virginia Mental Health Consumers' Association
Phone: 304-345-7312
Toll-free: 800-598-8847
Fax: 304-414-2416
Internet: www.wvmhca.org

Statewide consumer organizations are run by and for consumers of mental health services and promote consumer empowerment. They provide information about mental health and other support services at the state level and are active in addressing and advocating for mental health system issues.

LOCAL SOURCES OF INFORMATION

Also consider local resources. Your area mental health center and other branches of city or county government may be able to help. For example, your local board of education office might have information about help for children and the agency for the aging might know about services for senior citizens. Also, family physicians or area hospitals may be able to make referrals. For legal advice, contact the local bar association or go to www.findlegalhelp.org. The library and telephone yellow pages may offer applicable resource lists.

National/Regional Resources for Persons with Mental Illnesses

Centers for Medicare and Medicaid Services (CMS)
Phone: 410-786-3000
Toll-free: 877-267-2323
TDD: 866-226-1819
E-mail: question@CMS.gov
Internet: www.CMS.gov

CMS, a component of the U.S. Department of Health and Human Services, addresses patient complaints about treatment facilities that receive Medicare and Medicaid funding (e.g., see its Beneficiary Complaint Response Program). Concerns may also be shared with staff at West Virginia's regional office for CMS:

Philadelphia Regional Office (Region 3)
Centers for Medicare and Medicaid Services
Phone: 215-861-4140
Fax: 215-861-4140
Internet: www.CMS.gov/RegionalOffices/04_RO3.asp

National Mental Health Consumers' Self-Help Clearinghouse
Phone: 215-751-1810
Toll-free: 800-553-4KEY (539)
Fax: 215-636-6312
E-mail: info@mhselfhelp.org
Internet: www.mhselfhelp.org

This clearinghouse promotes and helps to develop consumer-run self-help groups across the country. Technical assistance and materials are available on such topics as organizing groups, fundraising, leadership development, incorporating, public relations, advocacy and networking.

Consumer Organization and Networking Technical Assistance Center (CONTAC)
Phone: 304-345-7312
Toll-free: 888-825-TECH (8324)
Fax: 304-345-7303
E-mail: usacontac@contac.org
Internet: www.contac.org

CONTAC is a resource center for consumers/survivors and consumer-run organizations. Services and products include informational materials, on-site training and skill-building curricula, electronic and other communication capabilities, networking, and customized activities promoting self-help, recovery, leadership, business management and empowerment.

Mental Health America Resource Center
Phone: 703-684-7722
Toll-free: 800-969-6642
TDD: 800-433-5959
Fax: 703-684-5968
E-mail: infoctr@nmha.org
Internet: www.nmha.org

Mental Health America (formerly the National Mental Health Association) maintains a referral and information center and can help you locate local chapters. These local groups have information about community services and engage in national and state level advocacy.

National Empowerment Center
Phone: 978-685-1494
Toll-free: 800-769-3728
Fax: 978-681-6426
E-mail: info4@power2u.org
Internet: www.power2u.org

This center, run by mental health consumers, carries a message of recovery, empowerment, hope and healing to people who have been diagnosed with a mental illness. It provides information and referrals to consumer resources and offers technical assistance to individuals and groups involved in consumer empowerment activities.

ADDITIONAL NATIONAL ONLINE RESOURCES

National Alliance on Mental Illness (NAMI)
www.nami.org

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

National Suicide Prevention Lifeline (24 hour)
www.suicidepreventionlifeline.org
1-800-273-TALK (8255)
Calls are routed to the nearest crisis center in a national network of more than 140 crisis centers.

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov

Part 2: DISCUSSION

Projected Time for Discussion
2 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their work with sexual violence victims. It could be incorporated into forums such as agency staff meetings as well as volunteer meetings or trainings. Anticipated discussion outcomes include skill building and increased understanding of service providers' roles in working with sexual violence victims who have mental illnesses.

Refer to the learning objectives at the beginning of this module for specific outcomes for this module.

Planning

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator. The facilitator should have expertise in responding to persons with mental illnesses who are also victims of sexual violence.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion, as well as *Disabilities 101. Tips for Communicating with Persons with Disabilities*.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges and table tents.

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the scenarios. There are no right or wrong responses, only different approaches.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue. The purpose of the role play scenarios is to provide an opportunity to practice new skills and obtain constructive feedback.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2. Invite participants to share their general experiences in working persons with mental illnesses, as well as with sexual violence victims with mental illnesses. *(15 minutes)*

a. What are common issues and challenges?

b. What unique issues and challenges arise when interacting with victims with specific mental illnesses?

c. Does your agency have in-house expertise on mental health issues and/or partnerships in the community? Describe.

d. What additional actions or resources would be helpful to improve your agency's capacity to effectively serve these victims?

3. Have participants break into small groups and assign each group one or more of the scenarios below. **Ask each group to consider the issues and challenges specific to that scenario and then outline how they would respond to that victim** (what they would say, discuss, share and ask). Remember the focus is on the initial response during intake or crisis intervention. Be careful not to step beyond your professional role within your agency. Each small group should select a recorder to take notes and a reporter to report back to the large group. (10 to 15 minutes per scenario; time will vary depend on how may scenarios each group reviews)

Scenario 1

A 23-year old woman was sexually assaulted by her pastor, whom she was seeing regularly to talk about her severe anxiety. Her fears are "smothering her"—she can't stop thinking that she will have an anxiety attack and die if she sees the pastor again, that she will get AIDS and die, that she will have to face the humiliation of a sexually transmitted infection, that she will become pregnant, that the congregation will rally behind the pastor and ostracize her, that the pastor's wife will think she was trying to seduce him, that her parents will literally die of embarrassment, etc. What do you do to help?

Scenario 2

A 15-year-old male calls you and discloses that he woke up in the middle of the night last evening to find his step-father fondling his penis. He is humiliated by what happened and says that he wants to kill his step-father and will do so if tries to touch him again. Although he wants to leave home, he feels he must stay there to protect his sister from his step-father. He admits that since the attack, he has tried to calm himself by taking more anti-depression medication than he is prescribed. He also has been cutting himself and obsessively washing to rid himself of the" feeling of his step-father's touch," to the point where his skin is raw and bleeding. He refuses to tell you his name, the step-father's name or where he lives. What do you do to help?

Scenario 3

A 30-year old woman with chronic depression discloses a history of child and adult sexual victimization. She has sporadically sought mental health treatment and frequently stops taking her anti-depression medications due to negative side effects. She self-medicates with alcohol. She has a great sense of humor, which helps her cope, especially when she sees her 45-year-old brother who sexually abused her throughout her childhood. She has never confronted him or disclosed his abuse to any family member; he maintains power over her by constantly putting her down. She worries about whether he has abused other children. She is a frequent caller to your agency (so you are aware of her circumstances), reaching out when she has flashbacks, bouts of self-loathing, interactions with her brother, or is intoxicated. She often feels suicidal. What do you do to help?

Scenario 4

A 50-year-old man tells you he has been fired from his job after he disclosed to his supervisor that "ever since he had that 'problem with the IRS' a few years ago, tax auditors have blackmailed him to perform oral sex on them, threatening to start an IRS investigation on him unless he meets their demands." Ultimately, he lost his job because he refused mental health treatment (and still does not want it). He reported the incidences to law enforcement, but they "didn't believe him." His family and friends have "abandoned" him because they "think he is crazy" and he is now close to losing his home. He is desperate for someone to believe him and do something about "the blackmail by the IRS." What can you do to help?

4. As a large group, **facilitate a review and discussion of issues, challenges and appropriate responses for each scenario**. Ask a reporter from each assigned group to report back and then use the below "scenario considerations" to help guide discussions. *(10 minutes per scenario, for a total of 40 minutes)*

Scenario 1: Considerations

Validate the victim for seeking help. Help her calm down as needed so she can engage in a conversation with you. Ask what assistance she would like from you/your agency, briefly explaining your agency's services and limitations. If it was a recent assault, let her know that she can go to the local hospital for a sexual assault forensic medical examination to address her concerns about her health (e.g., get emergency contraception to prevent pregnancy and preventative treatment for sexually transmitted infections) and have evidence gathered. Discuss her options to report to law enforcement. Aid her in understanding that she is experiencing common reactions to being sexually assaulted, but her reactions may be more intense and intrusive due to her anxiety. Ask her what she has done in the past to get through these feelings and help her plan how she will use these and other tactics to deal with her current concerns. If she is at a point that she can discern her anxiety from reality, talk with her about replacing her fears with facts (e.g., it is unlikely she would die from an anxiety attack, that she will contract AIDS or a sexually transmitted infection or die from these conditions, or become pregnant). Discuss with her that sexual assault is always the fault of the perpetrator; nothing she did provoked his assault. Help her prepare for the reality that some people may make assumptions about what happened, not wanting to consider that they misplaced their trust in the pastor. She can't control what other people think, just how she deals with their opinions. Help her plan how she wants to deal with these situations, including identifying who she can turn to for support.

Scenario 2: Considerations

Validate the victim for seeking help and ask what assistance he would like from you/your agency, briefly explaining your agency's services and limitations. Share with him the common feelings that victims of sexual violence experience, such as humiliation, pain and fear, and let him know the abuse was not his fault and that he can heal from it. Let him know that, like him, some victims self-medicate and self-mutilate to divert emotional pain. Some obsessively try to wash the touch of the perpetrator off of their bodies. Discuss with him healthier options available for dealing with these feelings. Talk with him about his safety and that of his sister and his options for protection, as well as potential consequences of retaliation against the offender—and help him develop a plan for safety if he permits. Help him identify persons whom he can turn to for support (e.g., a counselor, teacher, relative, friend, etc.). Explain what will happen if he reports the abuse to Child Protective Services (CPS) or law enforcement and provide him with the contact information. Let him know he and his sister deserve to be safe from his step-father and that you would like to make a report if he would provide you with the pertinent contact information (even though he may refuse to provide it). Explain that he can also go to the local hospital to address any health concerns (e.g., if he gets an infection from the obsessive washing).

Scenario 3: Considerations

This scenario deviates from the others in that the victim has previously disclosed sexual violence to your agency, but she frequently calls in crisis. Trauma caused by sexual victimization is rarely a one-time event, but rather can be repeatedly triggered throughout one's lifetime. Depression intensifies traumatic reactions for this victim. Each crisis call from a frequent caller needs to be treated as a new crisis requiring the development of a new action plan (even if the plan ends up being similar for each crisis).

Validate her for seeking help (she already is aware of your agency's services) and focus on providing crisis intervention to help her deal with her suicidal thoughts, self-loathing and fears produced by the flashbacks. Ask her if she is actively planning to kill herself and has the means (if so, seek immediate emergency assistance). Ask

her about her drug/alcohol use. Help her determine how she will get through the current crisis, reminding her that she has gotten through crises before and can again. Aid her in developing a plan to become more stable (this plan may include her contacting her mental health provider to discuss medications and crisis needs). Encourage her to call again if she is in crisis, as well as to interact with and seek help from her support system (her counselor, doctor, a support group, friends, etc.).

Scenario 4: Considerations

Regardless of whether the events the man describes actually happened or are a hallucination/distortion of reality, you can validate him for seeking help and let him know you understand he believes the sexual violence occurred. Ask what assistance he would like from you/your agency, briefly explaining your agency's services and limitations. Assure him that by contacting law enforcement he has warned the community about this problem. It may be useful if a law enforcement detective explains to him why his case was closed/what evidence was lacking (offer to connect him with the law enforcement agency). Ask him what he would like to do to deal with this trauma in his life. Offer to help him explore his options and make a plan for rebuilding a support system, his emotional health, financial stability, housing, etc. You can offer information about available counseling and mental health services (e.g., he might be more receptive to ongoing therapy or a support group than psychiatric care). Recognize, however, that he may not be able to have a rational discussion about what he is experiencing, whether or not he has a mental illness.

5. **Closing.** Ask participants what they learned from this module and how they will apply the lessons learned to their practice settings. *(10 minutes)*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]Paragraph drawn from National Alliance on Mental Illness (NAMI), *Mental illness facts* (Arlington, VA, accessed May 12, 2010), through http://www.nami.org/. Note that all online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female. Note, however, that this reference to female victims does not imply that most persons who have mental illnesses are women—statistics on gender vary depending on the type of mental illness. Discussion of these statistics is beyond the scope of this module.

[4]Paragraph drawn from NAMI.

[5]Drawn in part from WebMD, *Types of mental illness* (2009), http://www.webmd.com/mental-health/mental-health-types-illness.

[6]Another publication that is sometimes referred to classify mental illnesses is the International classification of diseases by the World Health Organization.

[7]In addition to mental illness, the *DSM* classification system speaks to other mental disabilities. For instance, it identifies autism and intellectual disabilities (also referred to as mental retardation) as forms of developmental disabilities, not mental illnesses. Autism affects brain functioning; it may impact communication and social skills, and can cause extreme sensitivity to physical contact (as cited in Autism Defined Net, Autism defined (2010), http://autismdefined.net/). An intellectual disability is characterized by a significantly below-average score on a test of mental ability or intelligence and limited daily living skills (as cited in NAMI; and Centers for Disease Control and Prevention, *Intellectual disabilities* (Atlanta, GE, 2005), http://www.cdc.gov/ncbddd/dd/ddmr.htm).

[8]R. Kessler, W. Chiu, O. Demler & E. Walters, Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Co-morbidity Survey replication, *Arch Gen Psychiatry* 62(6) (2005), 617-27. Note that the term "mental disabilities" in this article is inclusive of more conditions than just mental illnesses.

[9]Kessler, Chiu, Demler & Walters.

[10]P. Tjaden & N. Thoennes, *Prevalence, incidence and consequences of the violence against women: Findings from the National Violence Against Women Survey* (Washington, DC: National Institute of Justice and Altanta, GE: Centers for Disease Control and Prevention, 1998), http://www.ncjrs.gov/pdffiles/172837.pdf.

[11]L. Goodman, M. Salyers, K. Mueser, S. Rosenberg, M. Swartz, S. Essock, et al., Recent victimization in women and men with severe mental illness: Prevalence and correlates, *Journal of Traumatic Stress,* 14(4) (2001), 615-632. As cited in Kentucky Association of Sexual Assault Programs, Recognizing Sexual Victimization of Persons with Disabilities (2007), http://kyasap.brinkster.net/Portals/0/pdfs/pro%20guide%20pages/RecognizDisabilPg14.pdf.

[12]A. Clayton, Sexual abuse and mental health sequelae, *Primary Psychiatry* (2010), http://www.primarypsychiatry.com/aspx/articledetail.aspx?articleid=682. This article provides information about multiple studies that support this statement, as well as additional comments of the author.

[13]J. Coverdale & S. Turbott, Sexual and physical abuse of chronically ill psychiatric outpatients compared with a matched sample of medical outpatients, *Journal of Nervous and Mental Disease,* 188(7) (2000), 440-445; S. Friedman, L. Smith, D. Fogel, et al., The incidence and influence of early traumatic life events in patients with panic disorder: A comparison with other psychiatric outpatients, *Journal of Anxiety Disorders,* 16(3) (2002), 259-272; and S. Dinwiddie, A. Health, M. Dunne, et al., Early sexual abuse and lifetime psychopathology: A co-twin–control study, *Psychological Medicine,* 30(1) (2000), 41-52.As cited in Clayton.

[14]For more information on the following symptoms and behaviors, see the *Diagnostic and statistical manual of mental disorders* (DSM) by the American Psychiatric Association.

[15]With the exception of the last sentence, drawn from Mental Health America, Factsheet: *Dissociation and dissociative disorders* (Alexandria, VA, 2010), http://www.nmha.org/go/dissociation.

[16]For more on sexual violence and substance abuse, see Wisconsin Coalition Against Sexual Assault, *Sexual violence and substance abuse, information sheet series* (Madison, WI: 2000), http://www.prandicenter.org/Resources/sexual%20assault%20and%20substance.pdf.

[17]For example, the risk for persons who have experienced a major depressive episode is about 4 percent more than for the general population; almost 15 percent more for those who have had a manic episode; and about 10 percent more for those who have schizophrenia. From the National Institute of Mental Health, as cited in National Drug Intelligence Center, *Drug abuse and mental illness fast facts* (Johnstown, PA: U.S. Department of Justice, 2004), http://www.justice.gov/ndic/pubs7/7343/index.htm.

[18]M. Gliatto & A. Rai, Evaluation and treatment of patients with suicidal ideation, *American Family Physician* (1999), http://www.aafp.org/afp/990315ap/1500.html.

[19]E. Moscicki, Identification of suicide risk factors using epidemiologic studies, Psychiatric Clinics of North America, 20 (1997), 499-517. As cited in Gliatto & Rai.

[20]Gliatto & Rai.

[21]C. Rich, D. Young & R. Fowler, San Diego suicide study. I. Young vs. old subjects, *Archives of General Psychiatry,* 43 (1986), 577-82; and Moscicki. As cited in Gliatto & Rai.

[22]Gliatto & Rai.

[23]Mayo Foundation for Medical Education and Research, *Suicide: What to do when someone is suicidal* (2010), http://www.mayoclinic.com/health/suicide/MH00058.

Self-Advocacy and Victims with Disabilities

This module discusses the importance of encouraging individuals with disabilities to build their self-advocacy skills to gain independence and control of their lives. If they are victims of sexual violence, self-advocacy can be critical to their recovery and to regaining a sense of power in their lives.[1]

Key Points

- As self-advocates, individuals speak up for themselves, make their voices heard and views known, make their own choices and advocate for their rights. Education and experience empower individuals to gain life skills that promote self-determination (making choices on one's own without the interference of others), independence and, ultimately, self-advocacy.
- Factors that are likely to prevent a person from obtaining skills that promote self-advocacy include:[2] Lack of opportunities for peer education and support; lack of access to information on self-advocacy, self-determination and leadership development; lack of opportunities to make decisions and take risks; low expectations of their capacity to know what is best for them and how to get their needs met; [3] and the existence of societal attitudes that marginalize or devalue people with disabilities. A key factor for people with disabilities to overcome these barriers and become self-advocates is self-awareness—knowing their strengths, their challenges and how their disabilities affect both them and how they interact with others.
- The "dignity of risk" means respecting individuals' choices, as long as their actions are not harmful to themselves or others.[4] Not allowing individuals to take risks means denying a basic educational tool in life—learning from experience and using that knowledge in future opportunities.
- Service providers can teach and/or support persons with disabilities in building their self-advocacy skills. It is crucial for service providers to work *with* the individual to develop knowledge, not *for* the person. [5] Working with the individual supports the goals of independence and self-advocacy. This approach is similar to the victim-centered approach used in the sexual violence field, where the focus is on supporting victims in the decisions they make. Because victimization often involves the sense of a loss of power, supporting victims in their actions, rather than acting on their behalf, helps them regain control.

C6. Self-Advocacy and Victims with Disabilities

Purpose

This module discusses the importance of encouraging individuals with disabilities to build their self-advocacy skills to gain more control of their lives. Self-advocacy education can be a key factor to helping them live as independently as possible. This education—encompassing topics such as life skills, sexuality education, accommodations and accessing resources—can empower persons with disabilities to make informed choices, advocate for their rights and reduce their isolation and their risk of exploitation. If they are victims of sexual violence, self-advocacy can be critical to their recovery and to regaining power in their lives.

To support clients with disabilities in becoming self-advocates, service providers can work from an empowerment model. This model assumes that those seeking help are competent individuals who need understanding, information,

support and resources in order to make changes in their lives.[6] People with disabilities are assumed to be responsible for their own decisions.[7] Service providers can offer assistance to help these clients uncover their abilities and make informed choices, to the extent possible and as they are ready.[8] This person-centered model is also the foundation for the sexual assault victim advocacy movement and its approach to working with victims.

Objectives

Those completing this module will be able to:

- Define self-advocacy;
- Recognize the importance of empowerment and self-determination to sexual violence victims with disabilities as they become self-advocates;
- Identify barriers restricting self-advocacy for persons with disabilities; and
- Describe ways that service providers can promote self-advocacy, empowerment and the dignity of risk in their interactions with victims with disabilities.

CORE KNOWLEDGE What is self-advocacy?

Self-advocacy is about people being in control of their own environments. Education and experience enable individuals to gain life skills that promote independence and self-advocacy. As self-advocates, individuals speak up for themselves, make their voices heard and views known, make their own choices and advocate for their rights. Inherent in the concept of self-advocacy is the belief that all individuals have rights and should be treated with respect (e.g., not like children if they are adults).[9]

Gaining skills related to self-determination—making choices on one's own, without the interference of others—enables people with disabilities to be better self-advocates. Examples of these skills include decision making, problem solving, goal setting and personal control. These skills aid individuals in "knowing when and how to approach others to negotiate desired goals" and "building mutual understanding and trust, fulfillment and productivity."[10] Often, self-advocacy calls for some degree of self-disclosure and risk to reach the goal of mutual understanding.[11] For example, a self-advocate with a cognitive disability may risk having her credibility questioned when disclosing her disability.[12]

FYI Self-advocacy for sexual violence victims with disabilities may involve persistence in obtaining help from service agencies and providers. For example, it could include challenging people in positions of authority who minimize sexually abusive behavior by a caregiver as an "unintentional touch."

What is the connection between self-advocacy and the disability rights movement?

The following is a very brief and broad explanation. People with disabilities historically had few opportunities to exercise choice[13]—very often, they were labeled, their perceived deficits and differences were emphasized, and decisions about how they lived were made by professionals and caregivers. Additionally, public policies addressed the needs of persons with disabilities "in ways often shaped by stereotypes of dependency."[14] For example, the lifelong institutionalization of people with developmental disabilities was common, based on the belief that these individuals could not live on their own, but needed to be cared for and protected.

Thankfully, social and legal reform since the 1960s has made it less likely that people are defined by their disabilities and instead viewed as individuals first, capable of making their own decisions. (See *Disabilities 101. Person First Language*.) However, societal discrimination against persons with disabilities and misconceptions about them still exist. Self-advocacy is a tool that people with disabilities can use to counter discrimination and misconceptions.

FYI An online source for further information and resources is the American Association on Intellectual and Developmental Disabilities, *The Self-Advocacy Movement,* http://www.aamr.org.[15] Also see R. Pennell, Self-Determination and Self-Advocacy: Shifting the Power, *Journal of Disability Policy Studies*, 11(4) (2001), available through http://www.worksupport.com.

What barriers hinder self-advocacy?

Service providers must recognize factors that are likely to prevent a person from obtaining the skills that promote self-determination and independence. These factors include, but are not limited to:[16]

- Lack of opportunities for peer education and support;
- Lack of access to information on self-advocacy, self-determination and the leadership development process;
- Lack of opportunities to exercise choice and take risks;
- Low expectations of the capacity of individuals with disabilities to know what is best for them and how to get their needs met, which fosters the stereotype of helplessness and often results in overprotection;[17] and
- The existence of societal attitudes that marginalize or devalue people with disabilities, which can minimize the positive outcomes of self-advocacy efforts.

FYI Additional barriers to self-advocacy for persons with disabilities who have been sexually victimized are the lack of knowledge of available resources related to victimization and the lack of support for reporting the crime because perpetrators may be family members, acquaintances or caregivers. (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors*.)

How can individuals overcome barriers to self-advocacy?

A key factor to becoming a self-advocate is self-awareness. People with disabilities need to know their strengths and challenges, as well as how their disabilities affect both them and their interactions with others. It is difficult to work through challenges if individuals don't understand the causes or lack the self-awareness to understand their own behaviors. Armed with sufficient self-understanding, people are better able to advocate for their needs in ways that help others understand and respond. Some examples include:

- Often, when someone seeks services from an agency, the initial contact information is obtained in an office waiting area filled with multiple potential distractions (e.g., noise from a television, radio, ringing phones or others having conversations). If individuals have cognitive disabilities that make it difficult to focus or concentrate and they know that distractions such as these are problems for them, they can request a quiet area to review and answer questions. (See *Tools to Increase Access. Readiness to Serve Victims with Disabilities: A Review of Intake Practices*.)
- Some people with cerebral palsy (CP) react abruptly to touch due to muscle spasms and an over-active startle reflex. If a victim of sexual violence who has CP is having a forensic medical exam and knows that her body responds in this way to touch, she can communicate this fact to the examiner so that adequate time is given for her muscle spasms to stop before trying to continue with the exam. Her disclosure about periodic muscle spasms can also avoid the possibility of this reaction being misinterpreted (e.g., as aggression if she unintentionally kicks the examiner). The victim can also ask the examiner to tell her when and where she is about to touch her during the exam in order to help minimize her involuntary reactions. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

- Cold examining tables and equipment may also cause muscle spasms for persons with a spinal cord injury; many people with spinal cord injuries have difficulty controlling their body temperatures. If a sexual assault victim with a spinal cord injury shares this information with the medical staff conducting an exam, she will have more success in advocating for the accommodations needed to minimize her discomfort. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

What is the "dignity of risk"?

The dignity of risk means respecting an individual's choices, as long as her actions are not harmful to herself or others.[18] (See *Sexual Violence 101. Mandatory Reporting.*) The concept of informed consent is an important component of risk taking. It helps individuals understand the consequences of their actions so they are guided in decision making, but can still choose what is desired.[19]

Not allowing individuals to take risks creates barriers to self-advocacy. People with disabilities need to have confidence that they can survive a failure. We all periodically fail at things we try, learn from those failures and then move on. Often, people with disabilities are over-protected and lack the opportunities to learn from failures and understand the consequences of poor choices. For many individuals with disabilities, decisions to take on new experiences are often influenced more by the degree of risk involved rather than the opportunities afforded by the experience itself. Unfortunately, if people are repeatedly told to avoid all new and potentially risky behaviors, they never have the chance to test the true limits of their capabilities.[20] By supporting the dignity of risk, service providers can help to combat learned helplessness and bolster self-respect, empowerment and hope.[21]

A common challenge faced by persons with cognitive disabilities is in their interpersonal relationships. For example, an overly protective parent/caregiver may prefer that the person with the disability not date to ensure protection from sexual victimization. Finding a balance between vulnerability and healthy sexuality is an example of the dignity of risk. That balance includes providing opportunities for the individual to meet others socially and risking the chance that some of those relationships may not be the ones the parent/caregiver would have chosen for her. It can also include offering sexuality education to help the person make informed decisions and reduce the risk of sexual exploitation.

How can service providers teach and support skills that lead to self-advocacy?

Service providers can teach persons with disabilities self-determination skills that reduce their isolation and provide them with the tools to take greater control over their own lives.[22] It is crucial for service providers to always work *with* the individual to develop knowledge, not *for* the person.[23] Working with the individual supports the goals of independence and self-advocacy. In reality, however, if a person with a disability is using the services of an agency on a very limited basis, service providers may not have the opportunity or time to really teach self-advocacy skills' development. In those instances, a service provider's primary role is to provide support and to respect the client's right to make her own decisions in her own time. This approach is similar to the victim-centered approach used in the sexual violence field, where the focus is on supporting victims in the decisions they make. Because victimization often involves the sense of a loss of power and control, supporting a victim in her actions—rather than acting on her behalf—helps her regain control in her life.

Service providers can also maximize every opportunity within their service delivery system to promote the principles of self determination, regardless of a victim's degree of disability. For example, they can provide a victim with as much information as possible in any given situation to help her gain the knowledge needed to make informed choices about services, along with the knowledge of the potential consequences of her choices. To avoid information overload, however, service providers can ask a victim if she would like the information, the extent of information she wants and how she would like to receive it. A victim, for instance, might prefer to have a service provider give a brief overview of the information available, review a brochure with more details on her

own and then call the provider if she has questions at a later point. It is important that agency leadership review their policies and procedures to ensure that client choices are not unintentionally limited by agency procedures. (See *Tools to Increase Access. Readiness to Serve Victims with Disabilities: A Review of Intake Practices* and *Disabilities 101. Tips for Communicating with Persons with Disabilities*.)

(See *Disabilities 101. Guardianship and Conservatorship* for a discussion on promoting self-determination to the extent possible with persons with disabilities who have guardians or conservators.)

Resources

Many resources are available to assist service providers in teaching or supporting victims with disabilities in self-advocacy skills development. A few are listed below.

People First is a national movement that teaches individuals with intellectual disabilities about self-advocacy. There are several People First groups in West Virginia. For information, go to http://www.peoplefirstwv.org/ or call 304-422-3151 or 877-334-6581.

The **Speak Up! Guide**, published by STIR (Steps Towards Independence and Responsibility) and **Shifting the Power,** are both projects of the Clinical Center for the Study of Development and Learning, University of North Carolina at Chapel Hill. Call 919-966-5171 for information. The full guide, as well as individual chapters, can be accessed through http://www.selfdeterminationak.org/toolkit/speak_up_guide/.

Partners in Policy Making is a competency-based leadership training for adults with developmental disabilities and parents of young children with disabilities. This program provides information, training and resources so that people with disabilities may be empowered to use their voices to influence decision makers. In West Virginia, the Developmental Disabilities Council occasionally offers Partners in Policy Making classes in Charleston. For information, go to http://www.ddc.wv.gov or call 304-558-0416 (voice) or 304-558-2376 (TDD).

One of the core services offered through the **Centers for Independent Living** (CILs) is teaching self help/self-advocacy skills development. To identify service areas, contact the West Virginia Statewide Independent Living Council at 304-766-4624 or visit http://www.wvsilc.org.

West Virginia Advocates is a federally funded organization that works to protect the human and civil rights of persons with disabilities. For information, call 800-950-5250 or visit http://www.WVAdvocates.org.

Legal Aid of West Virginia provides free advocacy services for civil legal problems and offers long-term care ombudsmen and behavioral health advocacy. For information, call 866-255-4370 or visit http://www.lawv.net.

West Virginia Mental Health Consumers' Association provides an array of services and supports for individuals with mental illnesses. These include leadership development, self-advocacy skills training, advocacy and support. For information, call 800-598-8847 or visit http://www.wvmhca.org.

The ***Advocacy Empowerment Wheel***, adapted by the Missouri Coalition Against Domestic and Sexual Violence from the *Power and Control Wheel* developed by the Domestic Abuse Intervention Project (Duluth, MN), summarizes in a visual way the steps that service providers can take to empower clients experiencing interpersonal violence. These steps include respecting client autonomy, acknowledging the injustice of the crime, believing and validating their experiences, respecting confidentiality, promoting access to community services and helping them plan for future safety.[24] This wheel is provided as an attachment to this module and is also available online through http://www.ncdsv.org/publications_wheel.html.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What is self-advocacy for persons with disabilities? *See page C6.2.*
2. On what topics/skill areas should persons with disabilities receive education in order to be successful self-advocates? *See page C6.2.*
3. What barriers can prevent a person from obtaining the skills that promote self-advocacy? How can these barriers be overcome? *See pages C6.3–C6.4.*
4. What is the "dignity of risk" and why is it an important component of self-advocacy? *See page C6.4.*
5. What can service providers do to teach and/or support victim with disabilities in building their self-advocacy skills? *See pages C6.4–C6.5.*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]Drawn in part from J. Johnson, Leadership and self-determination, *Focus on Autism and Other Developmental Disabilities,* 14(1) (1999), 4–16.

[3]This factor is from B. Mitchell, Who chooses?, *National Dissemination Center for Children and Disabilities transition summary,* 5 (1988), as included in STIR (Steps Towards Independence and Responsibility) and Shifting the Power, Speak up! guide (Chapel Hill, NC: Clinical Center for the Study of Development and Learning, University of North Carolina), 18–22, access through http://www.selfdeterminationak.org/toolkit/speak_up_guide/.

[4]Drawn from Day One: The Sexual Assault and Trauma Resource Center, Rhode Island Coalition Against Domestic Violence and PAL: An Advocacy Organization for Families and People with Disabilities, Is your agency prepared to ACT? Conversation modules to explore the intersection of violence and disability (Advocacy Collaboration Training Initiative, 2004), 16.

[5]Day One et al., 9-10, 39.

[6]Day One et al., 39.

[7]Day One et al., 39.

[8]Drawn from Day One et al., 39.

[9]P. Mitchell, The Impact of self-advocacy on families, *Disability & Society,* 12(1) (1997), 43–56.

[10]S. Shore, *Ask and tell: Self-advocacy and disclosure for people on the autism spectrum* (Shawnee Mission, KS: Autism Asperger Publishing Company, 2004).

[11]Shore.

[12]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims and clients are often referred to as female.

[13]R. Scotch, *Good will to civil rights: Transforming federal disability policy* (Philadelphia, PA: Temple, University Press, 1984). As cited in B. Mitchell.

[14]Scotch.

[15]This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[16]Bullets drawn in part from Johnson.

[17]Bullet drawn from B. Mitchell.

[18]Drawn from Day One et al., 16. Also see Government of the District of Columbia, Department of Disability Services, *Choice and dignity of risk, slide presentation*, through http://dds.dc.gov/dds (see provider training policies).

[19]Day One et al., 16.

[20]B. Mitchell.

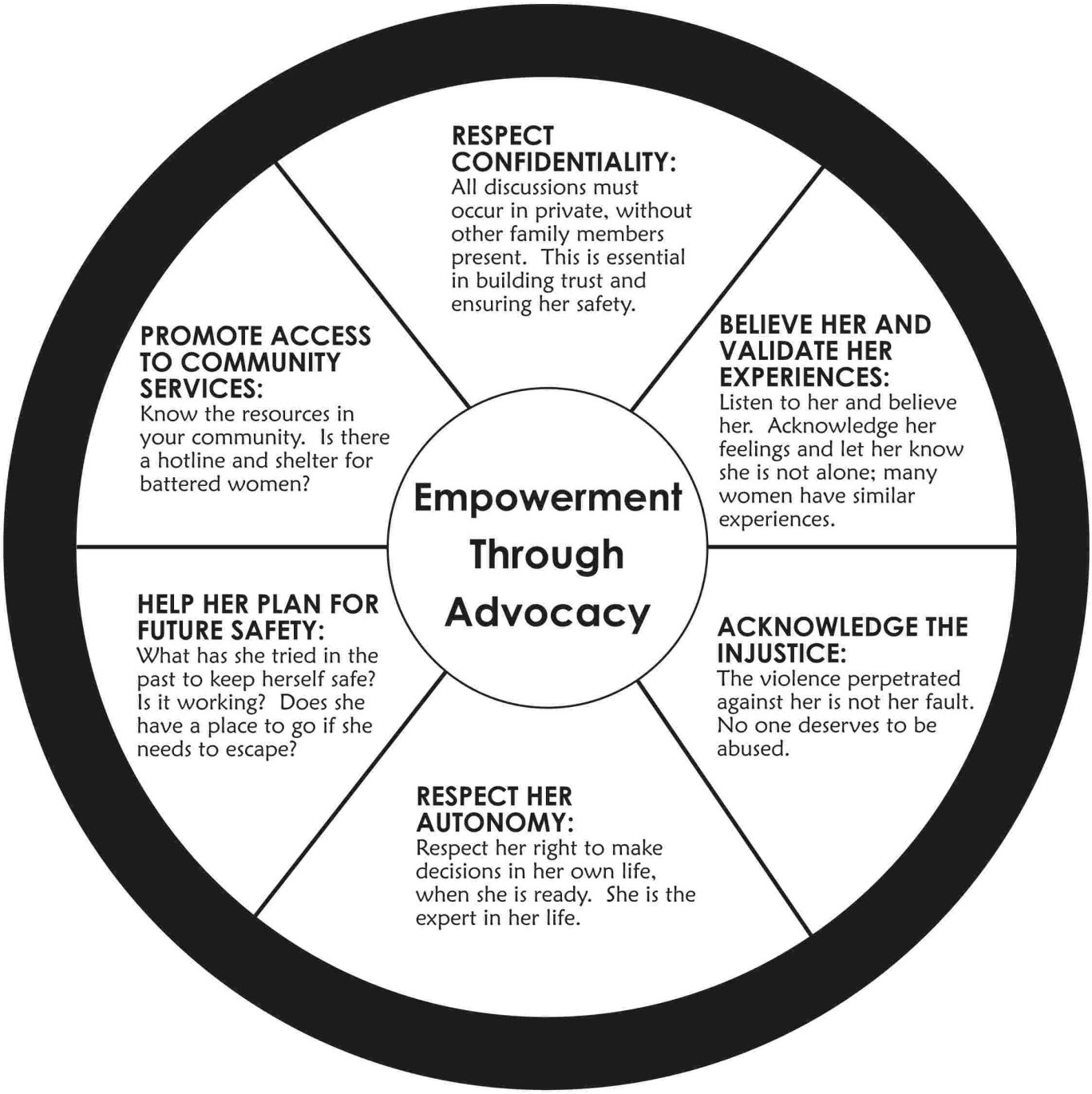
[21]C. Parsons, *The dignity of risk: Challenges of moving* on (paper presented in 2007 at the Mental Health Services Conference in Melbourne, Australia).

[22]P. Schloss, S. Alper & D. Jayne, Self determination for persons with disabilities: Choice, risk and dignity, *Exceptional Children*, 3 (1993), 215–25.

[23]Day One et al., 9-10, 39.

[24]This wheel is distributed by the National Center on Domestic and Sexual Violence through http://www.ncdsv.org/. This site also provides access to other wheels that have been developed based on the original wheel.

ADVOCACY EMPOWERMENT WHEEL



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Guardianship and Conservatorship

This module offers a basic overview on working with adults who have or may need a guardian and/or conservator to make personal and/or financial decisions on their behalf, and includes West Virginia laws pertaining to guardianship and conservatorship.[1]

Key Points

- *If an adult in West Virginia lacks the ability to make personal and/or financial decisions, it may be determined by the court that they are a "protected person"* and need a guardian and/or conservator to be appointed to make these decisions on their behalf. A *guardian* is a person appointed by the circuit court who is responsible for the personal affairs of a protected person. A conservator is a person appointed by the circuit court who is responsible for managing the estate and financial affairs of a protected person. The terms and conditions of the court order of appointment will indicate the scope and limitations of the guardianship/conservatorship.
- *In order for a guardian or conservator to be appointed, a petition must be filed in circuit court* in the county where the potentially protected person resides. Any interested person may file this petition. A hearing is scheduled within 60 days of the petition being filed.
- *Based upon information presented during the hearing, the court determines* if the individual is to be considered a protected person; the person's limitations; development of the person's maximum self-reliance and independence; whether a guardian and/or conservator should be appointed; the type of guardian and/or conservator and specific areas of protection, management and assistance to be granted; the suitability of the proposed guardian and/or conservator; and the length and other terms and conditions of the order. Prior to appointment, the guardian/conservator must complete mandatory training. The court monitors the appointment through periodic reports by the guardian/conservator. *This process is intended to pursue the least intrusive type of appointment necessary to meet the person's needs.*
- *Providers should view guardians/conservators as partners in assisting clients to meet their self-identified needs* (according to the terms and conditions of their appointment), unless there is reason to think otherwise.
- *If providers suspect abuse or neglect of a protected person by their guardian/conservator,* they are required to report their suspicions to their local Department of Health and Human Resources (DHHR) or the statewide hotline at 800-352-6513. If they suspect a crime has been committed against a protected person, they should call local law enforcement. If they think a protected person is in imminent danger, they should call 911. If they suspect a guardian/conservator is not acting in a protected person's best interest, they can contact the circuit court that appointed the guardian/conservator or a private attorney for information on options. In cases in which DHHR is the appointed guardian, service providers can also contact their local DHHR.
- *If a client has a guardian/conservator, service providers must clarify the terms and conditions of the appointment.* Service providers need this information before making decisions to release client information to a guardian/conservator. They also must consider whether they need the permission of the guardian/conservator to release client information to other providers or to provide specific services to the client.

C7. Guardianship and Conservatorship

Purpose

You received a call last week regarding Beth, a vibrant 26-year-old with a cognitive disability. You arranged to meet with her today. When you go out into your reception area, Beth is there with an older gentleman whom she introduces as her guardian. You want to speak to Beth alone. Legally, can you? What do you do?[2]

The above scenario is one illustration of why it is important for service providers to have general knowledge about guardianship and conservatorship, as they may work with adults with disabilities who have, or may be in need of, a guardian and/or conservator. There are times when adults, due to "mental impairments,"[3] are no longer able to make their own decisions; in some situations, a guardian and/or conservator may be appointed to make decisions on their behalf. The West Virginia Guardianship and Conservatorship Act,[4] originally enacted in 1994, outlines the circumstances under which a guardian and/or conservator may be appropriate, the process for a guardian and/or conservator to be appointed, and the duties and responsibilities of an appointee. The role of the guardian is distinguished from the role of a conservator by the nature of the decisions each is authorized to make. Guardians are authorized to make certain *personal* decisions, while conservators are authorized to make *financial* decisions.

Service providers should be able to connect clients who have questions or needs related to guardianship and conservatorship to the appropriate resources. When clients already have a guardian/conservator, providers need to know how the involvement of a guardian/conservator can potentially impact service delivery and ways to work collaboratively with the guardian/conservator and the client to address the client's self-identified needs. For clients who are sexual assault victims, providers must realize the inherent power that the guardian/conservator has over the dependent person and that this power could be used to manipulate and take advantage of that person. Critical safety issues to consider include the scope of confidentiality of client information and what to do if there are suspicions that a guardian/conservator is mistreating a client or not acting in a client's best interest.[5]

Objectives

Those who complete this module will be able to:

- Understand the differences between guardianship and conservatorship;
- Understand the process and criteria for appointing guardians and conservators, as well as determining their respective duties;
- Describe how to collaborate with clients with disabilities and their guardians and conservators to meet clients' self-identified needs; and
- Discuss potential safety concerns for persons with disabilities who have guardians and conservators.

CORE KNOWLEDGE

What definitions are important to know related to guardianship and conservatorship?[6]

PROTECTED PERSON: An adult individual, 18 years of age or older, who has been found by the circuit court, because of mental impairment, to be unable to receive and evaluate information effectively, or to respond to people, events and environments to such an extent that the individual lacks the capacity to: (a) meet the essential requirements for his or her health, care, safety, habilitation[7] or therapeutic needs without the assistance or

protection of a guardian; OR (b) manage property or financial affairs, or to provide for his or her support or for the support of legal dependents without the assistance or protection of a conservator. This assessment is called a competency evaluation and is performed by the circuit court judge.

GUARDIAN: A person appointed by the circuit court who is responsible for the *personal affairs* of a protected person. Responsibilities of a guardian may include making personal decisions for the protected person such as deciding where the person will live, how meals and daily care will be provided, and how healthcare will be provided.

Guardianship may be full or limited. A limited guardian has only those responsibilities for the personal affairs of a protected person as specified in the order of appointment. A limited guardianship generally occurs when the court determines that a protected person needs a guardian for a specific purpose, but is capable of addressing some of the essential requirements for her or his health, care or safety. The court can also appoint a temporary guardian if it finds that an immediate need exists—the temporary guardian has only those powers and duties specifically set forth in the order of appointment and only for a limited time.[8]

CONSERVATOR: A person appointed by the circuit court to be responsible for managing the *estate and financial affairs* of a protected person. Conservator responsibilities may include controlling the protected person's assets, paying bills and managing property.[9] Like guardianship, conservatorship may be full or limited, as well as temporary.[10]

FYI *The West Virginia Social Services Manual, Guardianship Services* indicates that incompetence is a legal determination that individuals lack the ability to understand the nature and effects of their acts and, as a result, are unable to manage their business affairs or are unable to care for their physical well-being, thereby resulting in substantial risk of harm.[11]

What are the responsibilities of a guardian/conservator?

In order for a guardian/conservator to be appointed, a petition requesting this type of appointment must be filed with the circuit court (see pages *C7.4–C7.5*). If, during the guardianship/conservatorship hearing, the court determines that the adult meets the definition of a "protected person" under the Guardianship and Conservatorship Act, a guardian/conservator may be appointed to assist the protected person with her/his decisions. The court determines the specific terms and conditions of the appointment—it is the responsibility of the guardian or conservator to honor those terms and conditions. As noted earlier, the authority of the guardian/conservator may extend to all personal/financial decisions affecting the protected person or may be limited in scope or duration. *The court typically pursues the least intrusive type of appointment necessary to meet the individual's needs. The appointment should promote the protected person's self-reliance and independence.*[12]

To determine the responsibilities of a guardian/conservator for a particular individual, it is necessary to review the order of appointment for that individual. Note, however, that in addition to the specific terms and conditions of their appointment, the state code outlines general mandated requirements and responsibilities both for guardians and conservators. For details, refer to *WVC§44A-3-1 through 3–10*.

FYI **A guardian/conservator is entitled to reasonable compensation** as allowed by the court from the protected person's estate. However, the frequency and amount of compensation must be approved by the court.

Who is qualified to serve as a guardian or conservator?

Any adult may be appointed by the court to serve as a guardian and/or conservator, provided that the court determines that the individual is capable of providing a suitable program of guardianship and/or conservatorship for the protected person. Frequently the same person is appointed as guardian and conservator. However, the court can appoint different people to fill these positions if it is determined that it would be in the protected

person's best interests.[13] Also, the court may, after determining it to be in the best interest of the protected person, appoint co-guardians, co-conservators or both.[14]

In the event that a family member, friend or other qualified person is not available to be appointed by the court, the law specifies other agencies and entities the court can designate to assume these responsibilities. Examples of these agencies include the West Virginia Department of Health and Human Resources (DHHR), Adult Protective Services (APS), and certain state licensed non-profit entities. DHHR may be appointed to serve as a guardian in instances where no one else is equally or better qualified, but this agency is not allowed by law to be a conservator. When there is no one else equally or better qualified to serve as conservator, the sheriff of the county where the petition was filed may be appointed.[15]

NOTE: Persons employed by or affiliated with any public agency, entity or facility (including nursing home employees) that is providing substantial services or financial assistance to a protected person are not eligible to serve as a guardian or conservator to that person.

FYI Persons being considered by a court for appointment as a guardian and/or conservator are required to provide information regarding any crime other than traffic offenses for which they were convicted. The court or mental hygiene commissioner also may order a background check to be conducted by the state police or county sheriff. The court will then consider this information in determining a person's fitness to be appointed as a guardian/conservator.

There are no specific educational requirements in order to be considered for appointment as a guardian/conservator. It is only necessary that persons being considered demonstrate that they are capable of performing the duties of guardianship or conservatorship.

What is the process for determining the need for and extent of guardianship and/or conservatorship?

This section discusses filing a petition to appoint a guardian/conservator, the initial hearing, mandatory training for guardians/conservators and the order of appointment.

FILING A PETITION: In general, the process begins when someone makes an official request (files a petition) to the circuit court to appoint a guardian/conservator for a potentially protected person. There is a $110 filing fee (some jurisdictions waive this cost when DHHR is the petitioner).[16] The petition must be filed with the circuit court clerk in the county where the potentially protected person resides, unless the person has been admitted to a health care or correctional facility in another county. In this situation, the petition should be filed in the county where the facility is located.

Any interested person may file a petition to request the appointment of a guardian/conservator. Individuals specifically identified in the state code as persons who may file include: the potentially protected person; a person who is responsible for that individual's care/custody; the facility providing care to the individual; a person the potentially protected individual has nominated to serve as guardian/conservator; DHHR; or any other interested person. When it is believed a guardian/conservator is needed and no one is available or willing to file the petition, DHHR may file.

A petition to appoint a guardian/conservator must contain the following information:

- Petitioner's name, address and relationship to the potentially protected person;
- Potentially protected person's name, address, gender, race, height and eye color;
- Names and addresses of the potentially protected person's nearest known living relatives;
- Name and address of any individual or facility who is responsible for the potentially protected person's care or custody and a detailed list of things they do for the person's benefit;
- Name and address of the potentially protected person's living will or medical power of attorney representative or appointed healthcare surrogate, and a detailed list of things they do for the person's benefit (copies of these documents should be attached to the petition if available);
- Name, address and phone number of the petitioner's attorney;
- If the potentially protected person will be able to attend the hearing and, if not, why;
- Extent of guardianship/conservatorship requested, reasons why and specific areas of protection or assistance requested;
- Name and address of the guardian/conservator the petitioner proposes;
- If the proposed guardian/conservator is an individual, the petition should include the proposed guardian's/conservator's address, age, occupation and relationship to the potentially protected person (it should also include the same information for the individual the potentially protected person has nominated as guardian/conservator, if different from the one being proposed by the petitioner);
- Name and address of any current guardian/conservator already acting on the potentially protected person's behalf;
- The names and criminal histories of any individual proposed, nominated or acting as a guardian/conservator, as listed on this form, who has ever been convicted of a criminal offense other than a traffic offense;
- An evaluation report by a licensed physician or psychologist documenting the nature, type and extent of the protected person's incapacity (its primary purpose is to provide evidence as to whether an individual meets the definition of protected person under the law and the scope of protection and assistance needed[17]); and
- A statement of financial resources, for conservatorship only (listing the protected person's social security number, approximate value of real and personal property and the anticipated annual income and other receipts[18]).

FYI See http://www.state.wv.us/wvsca/rules/conservator/gcindex.htm for **links to forms used in guardian/conservator cases** in state circuit courts. Forms are also available at local circuit court clerks' offices.

INITIAL HEARING: A hearing is scheduled by the circuit court within 60 days of the petition being filed. The potentially protected person (and caregiver as appropriate) will receive a notice of the date, time and place of the hearing, a copy of the petition and a copy of the doctor's evaluation not less than 14 days before the hearing.[19] The court will appoint legal counsel for the person, taking into consideration the person's preferences if they are known.[20]

It is the responsibility of the court to determine, based on the information presented during the hearing:

- If the individual is to be considered a protected person under the law;
- The limitations of the protected person;
- The development of the person's maximum self-reliance and independence and the availability of less restrictive alternatives, including the extent to which it is necessary to protect the person from neglect, exploitation or abuse;
- Whether a guardian and/or conservator should be appointed;
- The type of guardian and/or conservator and specific areas of protection, management and assistance to be granted;
- The suitability of the proposed guardian and/or conservator; and
- The length and other terms and conditions of the order.

FYI Note that a court finding that persons only exercised poor judgment in caring for themselves/their property is not enough to qualify them as protected persons.[21]

It is the appointed legal counsel's role to determine whether a guardian and/or conservator is needed, tailor the guardian's/conservator's role to the person's specific needs, ensure that the individual with the greatest interest in the potentially protected person is appointed guardian/conservator and ensure that proper living arrangements and placement are considered. Legal counsel should also ensure that any bond required by the court is adequate—posting of bonds is at the court's discretion and *usually not required* of a guardian,[22] but typically *is required* of a conservator.[23] The bond provides a way for the court to safeguard the protected person's assets—the court's order of appointment will indicate the amount and type of bond, if applicable.[24]

The appointed legal counsel should interview the potentially protected person to determine the person's needs and wishes, conduct an investigation to determine if a guardian/conservator is needed, and make recommendations as to who would be the best guardian/conservator for the person and what would be suitable living arrangements/placement.[25]

MANDATORY TRAINING: Any guardian/conservator named at the conclusion of the petition hearing is typically required to complete mandated training (coordinated by the WV Court of Appeals) within 30 days of the court's determination . Upon completion, the court can issue the order of appointment.[26]

ORDER OF APPOINTMENT: Once the court has determined that a guardian/conservator is necessary and a guardian/conservator has been appointed, the appointed individual is charged with the responsibility of acting in accordance with the specific terms and conditions established by the court.

How can service providers collaborate with clients with disabilities and their guardians/conservators to meet the clients' self-identified needs?

Some examples of simple steps that service providers can take:

- To the extent possible, speak directly with clients, rather than to or through their guardian/conservator. Encourage them to do the same with you.
- Endeavor to find out what clients need (as opposed to what their guardians/conservators want) and base services provided on those needs to the extent possible. If appropriate (e.g., if clients have the capacity/comfort

level to communicate with you), speak separately with them and their guardians/conservators to further assess needs, as well as with both clients and their guardians/conservators present.

- Quickly find out what accommodations are necessary to maximize the capacity of clients to access services and communicate with you and others. Provide or coordinate accommodations to the extent possible. (See *Disabilities 101. Accommodating Persons with Disabilities*.)
- View guardians/conservators as partners in assisting clients, unless there is reason to think otherwise. Give them time to ask questions, share information and provide input.
- Find out the terms and conditions of the guardianship/conservatorship and discuss with clients the impact of those terms on service provision.
- Ask clients how their disabilities may impact service delivery and brainstorm ways to overcome obstacles to receiving services. Ask their guardians/conservators for input on this issue.
- Let clients know you are available if they would like to further discuss their situation, your agency's services or other services in the community. Extend the same invitation to their guardians/conservators.

Applying the Knowledge. Let's apply these strategies to answer the questions in the scenario at the beginning of this module—

> *Beth, a 26-year-old woman with a cognitive disability, and her guardian are waiting in your agency's reception area for Beth's intake meeting with you. Can you legally talk with Beth alone, and if so, what can you do to make this happen?*

Note that your answers as the service provider may be influenced by the specifics of the client's situation. In general, guardians usually don't seek to restrict conversations that protected persons have with others, unless it is a condition of their appointment, such as restricted interaction with an abusive family member. However, keep in mind that in cases where the guardians themselves are abusive, they are unlikely to want the protected persons to speak alone to providers because they could be incriminated. Service providers should make it a standard practice to observe verbal/nonverbal interactions between clients and their guardian, as these observations may identify potentially abusive behaviors.

In Beth's case, she and/or her guardian may immediately provide some clues regarding the level of involvement the guardian usually has in these types of appointments. For example, when the receptionist calls Beth to go to your office, just Beth comes in. She explains to you that her guardian drove her to the office and will wait in the reception area during the appointment unless he is needed. As a courtesy, you or Beth could let the guardian know about how long the intake will be and let him know if he will be needed. Another possibility is that Beth and her guardian both go into your office when called and Beth explains that her guardian usually sits in on appointments to provide emotional support and/or help her communicate with/understand the service provider. (If the guardian is the one doing the explaining, also assess if Beth really wants/needs this support and assistance.) In this case, you can describe the intake process to both and the fact that you typically speak in private with the client during some or all of this process. You can ask Beth if she has any questions, if she is comfortable with the process as explained and if there are any accommodations she needs during the intake meeting (e.g., she may indicate she wants/needs the guardian present throughout). You can ask the guardian if he has any questions and find out more if needed about the conditions of the guardianship. It is possible he may express concerns about a private meeting (e.g., because he thinks Beth won't understand the questions or be able to answer them appropriately). The three of you can discuss how to address these concerns in a way that best honors Beth's wishes and accommodates her needs.

(See the other *Disability 101* modules for ways to enhance your interactions with victims with disabilities.)

What are potential safety concerns for persons with disabilities who have guardians/conservators?

The vast majority of guardians and conservators act in the best interests of the persons they are appointed to care for and protect (as per the terms and conditions of their court appointments) and are not abusive to them. However, persons with disabilities are particularly vulnerable to being manipulated and taken advantage of by less conscientious guardians/conservators because of the power guardians/conservators may have over them and their personal affairs. (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors* and *Sexual Violence 101. Indicators of Sexual Violence*.)

Service providers should take action if they suspect persons with disabilities are being abused or neglected by their guardians/conservators. If providers suspect abuse or neglect of a protected person by a guardian/conservator, they are required to report their suspicions to their local DHHR (go to http://www.wvdhhr.org/ to find contact information) or the statewide DHHR 24-hour hotline at 800-352-6513. If they suspect a crime has been committed against a protected person by a guardian/conservator (e.g., physical/sexual assault or theft), they should contact local law enforcement. If they think a protected person is in imminent danger, they should call 911 for immediate assistance. (See *Sexual Violence 101. Mandatory Reporting* and *Sexual Violence 101. Crisis Intervention*.)

Service providers may suspect a guardian/conservator is not acting in a protected person's best interest. Guardians/conservators are subject to the jurisdiction of the circuit court that appointed them. They can be removed for not acting in the protected person's best interests or not following court terms and conditions. (One way the courts monitor compliance with terms and conditions is by requiring periodic reports from guardians/conservators.) Guardianships and conservatorships can be modified for a number of reasons, including a change in the protected person's medical status or financial circumstances. Guardians and conservators can also be removed or limited in their duties if they become incapacitated in some way themselves. Legal action to remove a guardian and conservator is a serious step that may be appropriate in some cases.[27] For information on what clients can do in these instances, contact the circuit court that appointed the guardian/conservator (for contact information see http://www.state.wv.us/wvsca/circuits/map.htm) or an attorney (for referrals, contact Legal Aid of West Virginia at www.lawv.net or 866-255-4370). In cases in which DHHR is appointed the guardian, service providers can also contact their local DHHR for more information on options for protected persons.

Service providers may be unclear about whether client information is confidential when a client is a protected person and has a guardian/conservator. The extent of confidentiality of client information will depend on the terms and conditions of the guardianship/conservatorship. In the case of full guardianship, the guardian is most likely able to access client information. If the guardianship is limited, and many are as courts strive to place protected persons in the least restrictive environment possible, client information may be protected to some extent from the guardian. Those who are conservators only should not have access to client information unless it involves the client's finances.

To clarify whether client information is confidential, providers must find out if clients with disabilities have guardians/conservators and the terms and conditions of their appointments. They can ask clients during their initial contact if they have a guardian/conservator (in many cases, a client will share this information freely or it may be evident because a guardian/conservator or someone who knows that there is a guardian/conservator may call/come in for services with the client). If they answer affirmatively, providers should take the next step to ask clients or those accompanying them about the terms and conditions of the guardianship/conservatorship. In addition to asking about terms and conditions, providers should request to see a certified copy of the court

order appointing the guardian/conservator. Alternatively, they can seek to access the court order through the circuit court in which the guardianship/conservatorship was petitioned. Although documents related to a guardianship/conservatorship proceeding are not considered public records, the protected person and her/his attorney may inspect or copy the file and others may petition the court for permission to inspect/copy the file. Upon good cause shown, the court/mental hygiene commissioner may grant another party this permission.

Providers need information about the terms and conditions of a guardianship/conservatorship before making a decision to release that client's information to a guardian/conservator. They also must consider whether they need the permission of the guardian/conservator to release information to other providers or to provide specific services to the client (e.g., non-acute medical care, intake services, mental health counseling and transportation). If providers have questions about confidentiality in these cases, they or their agencies can seek legal advice. (See *Sexual Violence 101. Confidentiality.*)

Questions to consider:

1. What has your overall experience been in interacting with clients with disabilities who have a guardian/conservator, and more specifically, with sexual assault victims with disabilities who have a guardian/conservator?
2. Does your agency have any policies/procedures that guide your interactions with clients and their guardian/conservator?
3. What are the challenges of working with clients who have a guardian/conservator? Is meeting a client's self-identified needs problematic? How does the involvement of the guardian/conservator impact service delivery?

These questions can be considered by individual readers and/or discussed among agency employees and with representatives from partnering agencies.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. According to the WV Guardianship and Conservatorship Act, what is a protected person? What is a guardian? What is a conservator? *See pages C7.2–C7.3.*
2. What are the responsibilities of a guardian and a conservator? *See page C7.3.*
3. Are guardians/conservators compensated for carrying out their appointed duties? *See page C7.3.*
4. Who is qualified to serve as a guardian or conservator? *See pages C7.3– C7.4.*
5. In what situations is DHHR appointed to serve as guardian and the county sheriff appointed to serve as conservator for a protected person? *See page C7.4.*
6. Who may file a petition to request the appointment of a guardian and/or conservator? Where is the petition filed? Is there a fee for filing the petition? *See page C7.4.*
7. What information does a petitioner need to provide about the potentially protected person? *See page C7.5.*
8. What does the court seek to determine during the initial hearing? *See pages C7.5–C7.6.*

9. What are some examples of how service providers can collaborate with clients with disabilities and their guardians/conservators to meet the clients' self-identified needs? *See pages C7.6–C7.7.*

10. What should providers do if they suspect abuse or neglect of a protected person by their guardian/conservator? If they suspect a crime has been committed against a protected person by their guardian/conservator? If they think a protected person is in imminent danger? If they suspect a guardian/conservator is not acting in a protected person's best interest? *See page C7.8.*

11. How do service providers determine if a client's information is confidential when a client is a protected person and has a guardian/conservator? *See pages C7.8–C7.9.*

Funding was provided by Grant No. 2006-FW-AX-K001 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this module are those of the authors and do not necessarily reflect the views of the U.S. Department of Justice, Office on Violence Against Women.

[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module.

[2]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

[3]Note that some legal terms used in the state law on guardianship and conservatorship—"mental impairment" for example (*West Virginia Code, Chapter* 44A. 1-4 or *WVC§44A-1-4*)—may seem outdated. (See *Disabilities 101. Person First Language.*) We use this term here solely to reflect the definition of a potential "protected person" under the law.

[4]See *West Virginia Code, Chapter 44A (WVC§44A), West Virginia Guardianship and Conservatorship Act,* http://www.legis.state.wv.us/WVCODE/Code.cfm?chap=44A&art=1. This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles. WV Department of Health and Human Resources, Social services manual, guardianship services, was also referred to during this module's development.

[5]Note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[6]The definitions are drawn from *WVC§44A-1-4*.

[7]"Habilitation needs" in this context means the person's needs related to being able to function in society.

[8]West Virginia guardian and conservator handbook, A guide for court-appointed guardians and conservators, 2.

[9]*WVC§44A-1-8(k)*: A conservator shall not be appointed when the protected person's total assets are worth less than two thousand dollars or the protected person's income is: (1) from the Social Security Administration and a representative payee has been appointed to act in the best interest of the individual; (2) from Medicaid and the only income distributed to the individual is the personal account allotment; or (3) less than 50 dollars per month or 600 dollars per year. In these instances, the guardian, representative payee or health care facility, if there is no other person or entity, shall manage the personal care account or assets.

[10]*West Virginia guardian and conservator handbook, A guide for court-appointed guardians and conservators,* 2.

[11]WV Department of Health and Human Resources, 1.

[12]WV Department of Health and Human Resources, 1.

[13]Last two lines in paragraph, Appalachian Legal Aid, *Guardianship/conservatorship:What do I need to know* (Charleston, WV), http://www.wvlegalservices.org/guardcon.pdf.

[14]*WVC§44A-1-8(b).*

[15]Appalachian Legal Aid.

[16]*West Virginia guardian and conservator handbook,* 4. The fee was $110 as of the 2010 writing of this module. If a guardian/conservator is appointed by the court, filing fees may be reimbursed to the individual who filed from the protected person's estate, if funds are available.

[17]*West Virginia guardian and conservator handbook,* 20. The court, for good cause shown, may grant leave to file the petition without an evaluation report. However, it must order that the appropriate assessment and a report be prepared and filed.

[18]*West Virginia guardian and conservator handbook,* 20.

[19]*Guardianship/conservatorship:What do I need to know.*

[20]Paragraph from *Guardianship/conservatorship:What do I need to know*.

[21]*Guardianship/conservatorship:What do I need to know.*

[22]*WVC§44A-1-9*.

[23]*Unless the conservator is a bank or trust company.West Virginia guardian and conservator handbook,* 10.

[24]*West Virginia guardian and conservator handbook,* 10–11, as drawn from WVC§44A-1-9. In making the determination about the amount of a bond, the court considers: the value of the estate, annual income and other receipts that are within the conservator's control; the extent to which the estate has been deposited under an arrangement that requires a court order for removal; whether an order has been entered that waives the requirement that accountings be filed or that the accountings be presented less frequently than once a year; the extent to which income and receipts are paid directly to a facility responsible for the protected person's care and protection; the extent to which the income and receipts are from state or federal programs that require periodic accountings; whether a guardian has been appointed, and if so, whether the guardian has presented reports as required, and whether the conservator was appointed pursuant to a nomination which requested that bond be waived.

[25]Above two paragraphs from *Guardianship/conservatorship:What do I need to know.*

[26]*WVC§44A-1-10* and *West Virginia guardian and conservator handbook,* 6 and 10.

[27]Paragraph from Washington State Department of Social and Health Services, *Guardianship basics—Frequently asked questions,* http://www.aasa.dshs.wa.gov/pubinfo/legal/guardianship.htm.

WV S.A.F.E. TRAINING & COLLABORATION toolkit

SERVING SEXUAL VIOLENCE VICTIMS WITH DISABILITIES

A project of the

West Virginia Sexual Assault Free Environment (WV S.A.F.E.) Partnership

WV S.A.F.E. Partners:

West Virginia Foundation for Rape Information and Services (WVFRIS)

West Virginia Department of Health and Human Resources (WVDHHR)

Northern West Virginia Center for Independent Living (NWVCIL)

Fall 2010

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WV S.A.F.E. Training and Collaboration Toolkit— Serving Sexual Violence Victims with Disabilities

D. Tools to Increase Access

Funding was provided by Grant No. 2006-FW-AX-K001 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this toolkit are those of the authors and do not necessarily reflect the views of the U.S. Department of Justice, Office on Violence Against Women.

Forward

Service providers are finally recognizing the intersection of two issues: the prevalence of persons with disabilities who are sexually victimized and the prevalence of sexual violence victims who have disabilities. Although one in the same, the response to sexual violence victims who have disabilities may differ depending on their point of entry into the service delivery system. Sexual violence service providers have not been adequately trained in serving victims with disabilities. Disability service providers have not been trained in responding to sexual violence. There has been a lack of recognition that a coordinated community response is needed to ensure that the social service system (collectively comprised of the local, regional and state agencies that serve victims on the local level) effectively and equally meets the needs of these individuals. In West Virginia, through this project, we are bringing together service providers who aid sexual violence victims with those who serve persons with disabilities. Our goal is to increase the access victims with disabilities have to services. It is important to acknowledge that "getting to this place" did not happen overnight; rather, it required consciousness-raising and community organizing by dedicated activists. In essence, "getting to this place" is the story of two social movements—the anti-sexual violence movement and the disability rights movement—maturing into a "second wave" of activism and joining together to address needs of previously underserved populations.

The beginnings for both movements grew from the 1950s to the 1970s when minority groups—most notably African Americans, gays and lesbians, women and people with disabilities—began ardently fighting to secure their civil rights. Early in the women's rights movement, women began to speak out about their personal experiences of sexual violence. In the decades to follow, tremendous progress was made toward supporting sexual violence victims. Rape crisis programs were established in counties throughout the United States to offer crisis intervention, support and advocacy for victims, as well as community awareness and prevention. A significant body of literature and research emerged that increased public concern about sexual violence. Legislative changes—including the enactment of state laws to ensure victim rights and federal laws such as the Rape Control Act in 1975 and the Violence Against Women Act of 1994—were enacted that have increased the efficacy of the criminal justice and medical community responses to sexual violence.[1]

Encouraged particularly by the civil rights and women's rights movements, large-scale cross-disability rights activism began in the late 1960s with the goal of ending social oppression. That oppression kept children with disabilities out of the public schools and sanctioned discrimination against adults with disabilities in employment, housing and public accommodations. As part of this movement, the independent living movement emerged to support the choice of living in the community for people with even the most severe disabilities. The first independent living center opened in 1972; by the beginning of 2000, there were hundreds of such centers across the country and the world. In the meantime, a series of landmark court decisions and legislative changes—including the enactment of the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act of 1975 and the Americans with Disabilities Act of 1990—secured for individuals with disabilities unprecedented access to their civil rights.[2]

These victories for the two movements, as critical as they were, have not ended sexual violence or discrimination against persons with disabilities.[3] There is still a great need for continued activism. By coming together in localities across the country, as we are beginning to do in West Virginia, these movements are able to take the important next steps of educating one another and combining their resources to create positive systems change for sexual assault victims with disabilities. We hope you find the *West Virginia S.A.F.E. Training and Collaboration Toolkit: Serving Sexual Violence Victims with Disabilities* to be a useful resource to facilitate this cross-training and improve the response and partnerships across agencies and movements in your community.

Acknowledgements

The work of creating a toolkit involves the expertise and assistance of numerous individuals. The WV S.A.F.E. partnership is grateful to the individuals listed below for their contributions in the creation of this toolkit.

Project Partners and Primary Authors

Each of the three project partners coordinated the writing of the modules (in conjunction with the Project Consultant) within the sections pertinent to their disciplines. Each partner reviewed all of the modules during the development and pilot phases of the project. After each module was piloted and then reviewed and approved by the Office on Violence Against Women, the modules were then edited by the Toolkit Project Coordinator and Project Consultant.

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Participating Pilot Site Agencies in Marion, Ohio and Preston Counties:

- Russell Nesbitt Services
- Sexual Assault Help Center
- Task Force on Domestic Violence, "HOPE", Inc.
- Rape and Domestic Violence Information Center
- Northern West Virginia Center for Independent Living
- West Virginia Department of Health and Human Resources (Marion, Ohio and Preston counties)

Special thanks go to *Amy Loder* (Office on Violence Against Women); *Michelle Wakeley, Nikki Godfrey, Betty Irvin, Whitney Boutelle,* and *Emma Wright* (contributing authors); *Susie Layne, Wade Samples, Marion Vessels, Mark Derry, Teresa Tarr* and *Suzanne Messenger* (technical assistance with legal and policy components), West Virginia Foundation for Rape Information and Services staff and *Kathy Littel* (proofreading); *Carol Grimes* of Grimes Grafix (graphic designer) and to all of the survivors of sexual violence and women with disabilities who helped guide this work—both through this project and in creating the professional history of the individuals cited on this page. This toolkit is dedicated to ensuring that your shared experiences will help make for a better service delivery system for others.

WV S.A.F.E. Training and Collaboration Toolkit—Serving Sexual Violence Victims with Disabilities[4]

This toolkit offers guidance for service providers on working collaboratively to integrate accessible services for sexual violence victims with disabilities into the existing social service delivery system. *The purpose is to provide the information and resources needed to begin the process of collaborating and cross-training among relevant agencies. Using the tools in the toolkit, agencies can build their capacity to offer responsive, accessible services to sexual violence victims with disabilities.* The toolkit's focus is on adult and adolescent victims with disabilities.

The concept for and contents of this toolkit evolved over a four-year period from the work of a project coordinated by several West Virginia statewide/regional agencies and piloted by local agencies from three counties. Although the toolkit is written for a West Virginia audience, other states and communities are welcome to adapt the materials to meet their needs.

This *User's Guide* explains the toolkit's features and organization as well as the pilot project.

Toolkit Features

The toolkit's main feature is a collection of educational modules intended to:

- **Facilitate dialogue and collaboration among partnering agencies** to improve the accessibility and appropriateness of services across systems for sexual violence victims with disabilities (see the *Collaboration 101* modules);
- **Build individual providers' knowledge** related to fundamental issues in providing accessible and responsive services to sexual violence victims with disabilities (see *Disabilities 101* and *Sexual Violence 101* modules); and
- **Provide tools to facilitate assessment and planning by individual agencies** to improve the accessibility and appropriateness of their services for sexual violence victims with disabilities (see the *Tools to Increase Access* modules).

The toolkit was developed with the recognition that both individual and partnering agencies will adapt the toolkit materials to assist them in providing accessible and appropriate services to sexual violence victims with disabilities. NOTE:

- Individuals and agencies can use all of the modules and materials or select only the modules and materials that address their specific needs.
- Individuals and agencies can decide the sequencing of the modules that meets their needs, depending on factors such as the types of services each agency provides, who will be trained (designated or all staff, volunteers, students, board members), etc.
- Collaborative groups can decide the selection and sequencing of the modules to utilize based on the partnering service providers, strengths and gaps in the current response, level of existing collaboration among service agencies, issues that need to be addressed, etc.
- Individual agencies and partnerships may wish to add information and discussions on other pertinent issues not addressed through the modules.

Because the toolkit is available online, those using it can benefit from new material that may periodically be added. The toolkit can be accessed at http://www.fris.org/ to check for updates.

Background: Toolkit Development

In 2006, the West Virginia Foundation for Rape Information and Services (FRIS) received a grant from the U.S. Department of Justice, Office on Violence Against Women (OVW) to examine and implement changes to local and state systems that respond to women with disabilities and deaf women who are victims of sexual assault. Entitled *West Virginia Sexual Assault Free Environment* (WV S.A.F.E.), the resulting collaboration consists of three core team partner agencies: FRIS, the West Virginia Department of Health and Human Resources (DHHR) and the Northern West Virginia Center for Independent Living (NWVCIL).[5]

This collaborative's broad mission is to identify and address state and local gaps and barriers in services and policies that impede the provision of effective, accessible and seamless services to survivors of sexual assault among women with disabilities and deaf women. The shared vision is:

> *".. [C]reating permanent systems change at all levels of the sexual assault and disability systems and state policy in which effective services for women with disabilities and deaf women are fully integrated into the existing structure of victim services and advocacy."*

The statewide partnership, and subsequent participation of their counterparts in three counties (Marion, Ohio and Preston counties), conducted needs assessments and developed a strategic plan. The plan included the following short-term goals and objectives:

1. Foster collaboration among local service providers who interact with survivors with disabilities (to overcome fragmentation of services). Objectives: Coordinate and implement on-going partnership meetings and formalize collaborative processes among pilot site partners.
2. Build a sustainable common knowledge base among local service providers and among statewide partnering agencies. Objectives: Develop and implement a capacity building plan to strengthen the knowledge base and sustainable practices.
3. Ensure services and supports are accessible and responsive to the needs of women with disabilities and deaf women. Objectives: Assess accessibility with pilot site and state partners and implement prioritized components of accessibility transition plans.

The toolkit is the result of the sustainable cross-training component of this four-year project. Note that the materials are applicable to serving all adult/adolescent victims of sexual violence (recognizing the vast majority are women) and that the term "persons with disabilities" became inclusive of deaf persons, unless otherwise indicated.

Note also that while a limited number of agencies officially partnered in this pilot project, the benefit to victims can increase when the partnership is welcoming of any agency that might provide services to victims with disabilities. To that end, longer-term goals include: expanding local pilot site partnerships to include all points of entry into the service delivery system for victims with disabilities; improving the accessibility of those points of entry; providing ongoing capacity building opportunities; and replicating this systems-change model in additional counties in West Virginia.

Toolkit Organization

Toolkit Components. The toolkit offers a set of four separate components: *A. Collaboration 101, B. Sexual Violence 101, C. Disabilities 101* and *D. Tools to Increase Access*. Each component is comprised of a series of informational modules.

Structure of the modules within each component. The individual modules within these components are primarily organized into two main sections: *Core Knowledge* and *Discussion*. Some modules include both sections while others include only the *Core Knowledge* or the *Discussion* section. Several of the *Tools to Increase Access* use a checklist, rather than a narrative format. All of the remaining modules include a cover page featuring a brief overview and the key points. Each also includes an introduction describing the purpose, objectives and any preparation needed.

- ***Core Knowledge:*** Depending on the content, the *Core Knowledge* section provides basic information on the topic. It may also include *Test Your Knowledge* questions to evaluate what was learned. These can be useful both for the reader and for supervisors who may choose to use the questions to gauge the knowledge of staff and volunteers.

  The *Core Knowledge* section is intended for individual use—e.g., for self-paced learning, one-on-one training of employees such as agency orientation or continuing education, volunteer trainings, review prior to an agency or multi-agency discussion, etc.

- ***Discussion:*** The *Discussion* section is designed for use in a group setting, either within an agency or with outside partnerships. Each *Discussion* section indicates the estimated time frame for the dialogue and the preparation needed, if any; describes suggested activities and questions (targeted to create a common knowledge base, improve agency response and build collaboration); and ends with a closing assessment of what was learned during the discussion and changes providers/agencies plan to make as a result of the discussion.

- ***Resources:*** Some modules also include related forms and/or other sample materials.

The modules were developed to maximize agencies' finite resources for in-house and multi-agency training. To that end, an effort was made to offer *Core Knowledge* sections that simplified complex topics as much as possible. It is a delicate balance to find a format in which the information provided can be easily understood but that provides enough detail to assist the reader in offering responsive assistance to victims with disabilities. As appropriate in each *Core Knowledge* and *Discussion* section, guided probes and case scenarios are included to assist service providers in applying the information to impact service delivery changes both within their own agencies and their communities.

Cross-referencing of modules. The modules were generally developed so they can be used independently of one another; however, a few make reference to other modules as prerequisites. Reference to other modules is also made throughout the modules so the reader can easily gain further knowledge on a particular topic.

Terminology used. Across all modules, the following should be noted:

- Agencies that interact with sexual violence victims and persons with disabilities typically refer to the individuals they serve as "clients," "consumers" and/or "victims." For convenience, "victims" and "clients" are primarily used.

- The terms "sexual violence" and "sexual assault" generally will be used to encompass sexual assault, sexual abuse and other forms of sexual violence.

- In recognition that the vast majority of victims of sexual violence are female and the vast majority of offenders are male,[6] individual victims are often referred to using female pronouns and individual offenders are often referred to using male pronouns. This use of pronouns in no way implies that males are not victims of sexual violence or that females are not offenders; it is written in this format solely for the ease of reading the material.

Reproduction of materials. The non-commercial use and adaptation of these modules to increase knowledge about serving sexual violence victims with disabilities is permitted. Please credit any material used from this toolkit to the West Virginia Sexual Assault Free Environment (WV S.A.F.E.) project, a partnership of the West Virginia Foundation for Rape Information and Services, the Northern West Virginia Center for Independent Living and the West Virginia Department of Health and Human Resources (2010).

Funding was provided by Grant No. 2006-FW-AX-K001 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this toolkit are those of the authors and do not necessarily reflect the views of the U.S. Department of Justice, Office on Violence Against Women.

Project partners welcome the non-commercial use of this toolkit to increase knowledge about serving sexual violence victims with disabilities in any community, and adaptation for use in other states and communities as needed, without the need for permission. We do request that any material used from this module be credited to the West Virginia Sexual Assault Free Environment (WV S.A.F.E.) project, a partnership of the West Virginia Foundation for Rape Information and Services, the Northern West Virginia Center for independent Living and the West Virginia Department of Health and Human Resources (2010). Questions about the project should be directed to the West Virginia Foundation for Rape Information and Services at www.fris.org.

[1]This paragraph was drawn primarily from California Coalition Against Sexual Assault, *A vision to end sexual assault—The CALCASA strategic forum report* (2001), as well as J. Meyers, *History of sexual assault prevention efforts* (Colorado Coalition Against Sexual Assault, 2000) and P. Poskins, *History of the anti-rape movement in Illinois*. All can be accessed through http://new.vawnet.org/category/index_pages.php ?category_id=576.

[2]This paragraph was drawn from University of California Berkley, *Introduction: The disability rights and independent living movement* (last updated 2010), through http://bancroft.berkeley.edu/collections/drilm/index.html.

[3]Adapted from University of California Berkley.

[4]Note that the format used in this *User's Guide* was in part modeled after the Office for Victims of Crime's *Sexual assault advocate/counselor training, trainer's manual* (Office of Justice Programs, U.S. Department of Justice), https://www.ovcttac.gov/saact/index.cfm.

[5]An additional partner, the West Virginia University Center for Excellence in Disabilities, participated in the first two years of the project.

[6]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (C. Rennison, Rape and sexual assault: Reporting to police and medical attention, 1992–2000 (Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2002), 1, http://bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=92; and P. Tjaden & N. Thoennes, *Prevalence, incidence and consequences of violence against women: Findings from the National Violence Against Women Survey* (Washington, DC: National Institute of Justice, Office of Justice Programs, U.S. Department of Justice, 1998), 2–4, http://www.ojp.usdoj.gov/nij/publications/welcome.htm. Regarding sex offenders, males make up the vast majority, but females also commit sexual crimes. In 1994, less than 1 percent of all incarcerated rape and sexual assault offenders were female (L. Greenfeld, *Sex offenses and offenders: An analysis of data on rape and sexual assault, U.S. Department of Justice, Bureau of Justice Statistics* (Washington, DC: 1997). As cited in R. Freeman-Longo, *Myths and facts about sex offenders* (Center for Sex Offender Management, 2000), http://www.csom.org/pubs.

Programmatic and Policy Accessibility Checklist

This module offers a checklist designed to assess the accessibility of an agency's programs and services.

D1. Programmatic and Policy Accessibility Checklist

Purpose

This checklist is designed to assess the accessibility of an agency's programs and services for people with disabilities. (To assess physical/structural barriers to accessibility, see *Tools to Increase Access. Physical Accessibility Checklist for Existing Facilities*.) It is NOT intended to determine or imply compliance with the Americans with Disabilities Act (ADA). (See *Disabilities 101. Disability Laws*.)

Agencies can use this tool to assess their use of best practices to assure equal access to services for clients with disabilities.[1] It can help them create more welcoming environments by identifying ways to modify policies and practices, redesign programs and enhance services to allow persons with disabilities to fully benefit. When access to services is limited, creative strategies related to programs and policies can increase accessibility outside of structural changes. Such strategies may include providing services in alternate or integrated settings; taking services to clients; adapting equipment; providing communication assistance; increasing staff capacity through training and knowledge of disability-specific resources; and including persons with disabilities in identifying barriers and strategies for increasing access. (See the *Disabilities 101* modules.)

The information gathered from this checklist can be useful when creating a plan to increase the accessibility of your agency's services. (See *Tools to Increase Access. Developing a Transition Plan*.)

In compiling this tool, the West Virginia Sexual Assault Free Environment (WV S.A.F.E.) project drew from multiple resources, as cited in the endnote section.[2]

Preparation

Consider in advance of completing this checklist what your agency will do with the results. It is recommended that agencies seek qualified technical support and guidance to review their assessment results and make recommendations to increase the accessibility of their services to clients with disabilities. Inquire if a local disability agency has the capacity to provide this support. Contact the regional Disability and Business Technical Assistance Center (DBTAC)-Mid Atlantic ADA Center at 301-217-0124 (V/TTY) or go to www.adainfo.org for recommendations of resources to provide this support. DBTAC-Mid Atlantic also sponsors the West Virginia ADA Coalition, which has members who may be available to offer this type of assistance. Contact the WV ADA Coalition at 800-946-9471 V/TTY or go to www.wvadacoalition.org/.

PROGRAMMATIC AND POLICY ACCESSIBILITY CHECKLIST

Assessment Information

Agency Name: _____

City: _____ County: _____

Type of Service Agency: _____

Date(s) of Assessment: _____

Name of Reviewer(s): _____

_____

_____

1. Policy Accessibility

NOTE: "Unk" stands for "Unknown" and "N/A" stands for "Not Applicable."

	Yes	No	Unk	N/A
1A. Does the agency have a policy stating its commitment and intent to comply with the Americans with Disabilities Act (ADA Compliance Policy)? (Obtain a copy.)	☐	☐	☐	☐
1A.1. Has the agency conducted a self-evaluation for compliance with the ADA?	☐	☐	☐	☐
1A.2. If "Yes" to 1A.1., has the agency developed a transition plan for compliance?	☐	☐	☐	☐
1A.3. If "Yes" to 1A.2., describe in the "Comments" section the agency's stage in the process of implementing the plan. Obtain a copy of the transition plan.				

Comments:

	Yes	No	Unk	N/A
1B. Does the agency require sub-contractors to comply with the ADA? A subcontractor could include individuals the agency utilizes for direct services (e.g., a psychologist who provides psychological evaluations) or for any other contractual relationship in which the agency engages.	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
1C. Does the agency have a designated staff person (single point of contact) responsible for coordinating and providing resources and information related to the agency's ADA compliance, policies and available accommodations?	☐	☐	☐	☐

1C.1. If "Yes," describe the qualifications of the staff person and their training on ADA compliance policies in the "Comments" section.

Comments:

	Yes	No	Unk	N/A
1D. Does the agency have a written policy on how to request a policy, practice or procedure modification? (If "Yes," obtain a copy.)	☐	☐	☐	☐
1D.1. Does the agency have a written process to determine when a policy, practice or procedure modification request would cause a fundamental alteration or undue burden on the agency? (If "Yes," obtain a copy.)	☐	☐	☐	☐
1D.2. Does the agency have a complaint or appeal process to request a revision or exception to agency policies, procedures or practices to accommodate an individual's disability? (If "Yes," obtain a copy.)	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
1E. Are there criteria for accessing services that could potentially limit participation by people with disabilities (e.g., requiring a driver's license rather than other governmental issued I.D. as proof of identification)? (If "Yes," identify the criteria in the "Comments" section.)	☐	☐	☐	☐
1E.1. If "Yes," are any of these criteria necessary to the operation of the program or to the safety of the participants or staff? (Explain in the "Comments" section.)	☐	☐	☐	☐

Comments:

2. **Accommodations**

	Yes	No	Unk	N/A
2A. Do agency staff routinely ask if clients require any accommodations?	☐	☐	☐	☐
2A.1. If "No," are clients given the opportunity to ask about or make a request for accommodations?	☐	☐	☐	☐
2A.2. Are agency staff provided a list of available accommodation resources and options?	☐	☐	☐	☐
2A.3. Are agency staff trained on providing accommodations? (If "Yes," describe which staff are trained and how often in the "Comments" section.)	☐	☐	☐	☐
2A.4. Does the agency have a process to follow if requests for accommodations cannot be met? (If "Yes," describe in the "Comments" section.)	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
2B. Does the agency assure that service animals are allowed and that staff are trained on how to handle related questions and concerns?	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
2C. Is there an accommodation/alternate format line item in the agency's budget?	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
2D. Are the following resources available in an alternate format for sexual violence victims with disabilities to ensure fully integrated services (e.g., is such information on file)?				
• Information about counseling/support services for the client or family?	☐	☐	☐	☐
• Information about how to access legal services?	☐	☐	☐	☐
• Information about how to access interpreters or other special services (e.g., personal attendants) for clients with disabilities?	☐	☐	☐	☐
• Information about how to preserve evidence?	☐	☐	☐	☐
• Contact information for advocacy groups for clients with disabilities?	☐	☐	☐	☐
• Contact information for advocacy support services?	☐	☐	☐	☐
• Contact information for Adult Protective Services (APS)?	☐	☐	☐	☐
• Contact information for Child Protective Services (CPS)?	☐	☐	☐	☐
• Contact information for law enforcement?	☐	☐	☐	☐
• Information about paratransit and public transportation services?	☐	☐	☐	☐
• Contact information for personal assistant/nursing care agencies?	☐	☐	☐	☐
• Contact information for local disability service providers?	☐	☐	☐	☐
• Other? (If "Yes," list in the "Comments" section.)	☐	☐	☐	☐
2D.1. Are all materials readily accessible? (If "No," explain in the "Comments" section.)	☐	☐	☐	☐

Comments:

3. Outreach, Publications and Communication

	Yes	No	Unk	N/A
3A. Does the agency make the general public aware of program accommodations to ensure equal access for persons with disabilities? (If "Yes," describe how this is communicated in the "Comments" section.)	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
3B. Does the agency facilitate a welcoming environment by assuring that agency publications, outreach materials and services demonstrate that the agency's services are accessible to people with disabilities?	☐	☐	☐	☐
3B.1. If "Yes," which of the following specifically provide information regarding the availability and location of accessible communications, services and activities:				
• Signage and posters?	☐	☐	☐	☐
• Telephone directories?	☐	☐	☐	☐
• Message boards (on wall and/or electronic)?	☐	☐	☐	☐
• Website?	☐	☐	☐	☐
• Other media and advertisements?	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
3C. Are all agency public informational materials and forms (including handbooks, brochures, eligibility criteria for participation, rights statement, etc.) available in alternate formats?	☐	☐	☐	☐
3C.1. If "Yes," identify the formats used:				
• Computer/electronic format?	☐	☐	☐	☐
• Large print (e.g., 18 pt. and Arial or Times New Roman font)?	☐	☐	☐	☐
• Audio tape?	☐	☐	☐	☐
• Braille?	☐	☐	☐	☐
• Other? (If "Yes," list in the "Comments" section.)	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
3D. Do informational materials and agency literature:				
• Take into consideration the reading and comprehension levels of clients?	☐	☐	☐	☐
• Contain pictures of persons with disabilities?	☐	☐	☐	☐
• Display the International Symbol of Accessibility?	☐	☐	☐	☐
• Provide TTY, text telephone number or relay number (711) for people who are deaf or hard of hearing?	☐	☐	☐	☐

Comments:

4. Agency Website and Telecommunications Accessibility

	Yes	No	Unk	N/A
4A. Does the agency have its own website? (If "No," skip to question 4D.)	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
4B. Does the agency's website provide an e-mail contact link directly to the agency?	☐	☐	☐	☐
4B.1. If "Yes," is a warning noted on the website that such links provide no confidentiality for the client? (Describe in the "Comments" section.)	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
4C. Does the agency's website incorporate the following elements:	☐	☐	☐	☐
• Accessible for people who use a screen-reader (e.g., clear menus screens; free of flash graphics and pop-ups; contrasting color schemes accessible to people with color-blindness and people who have low vision; use of Alt Text for conversion of graphics/images to text, etc.)?	☐	☐	☐	☐
• Appropriate grade-level of written information?	☐	☐	☐	☐
• Pictures of people with disabilities?	☐	☐	☐	☐
• The International Symbol of Accessibility?	☐	☐	☐	☐
• TTY or text telephone number for persons who are deaf or hard of hearing?	☐	☐	☐	☐
• Information on how to access services and accommodations?	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
4D. Does the agency provide 24/7 services?	☐	☐	☐	☐
4D.1. If "Yes," describe in the "Comments" section how services are accessed after regular business hours.				

Comments:

	Yes	No	Unk	N/A
4E. Does the agency use an automated answering system or service?	☐	☐	☐	☐
4E.1. If "Yes," is the answering system message short, easy to understand and have few navigation options?	☐	☐	☐	☐
4E.2. If "Yes," does the automated answering system include an option to talk with a person immediately (e.g., press "0" option)?	☐	☐	☐	☐
4E.3. If "Yes," is there 24/7 access to on-call staff?	☐	☐	☐	☐
4E.4. If "Yes," is the automated answering system accessible using a TTY machine?	☐	☐	☐	☐

Comments:

5. Services for People Who Are Deaf or Hard of Hearing

	Yes	No	Unk	N/A
5A. Do agency staff offer callers alternative communication choices regarding which form of communication would be most effective for them (e.g., TTY or access to the relay system)?	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
5B. Does the agency offer qualified interpreters for participants who are deaf or hard of hearing? (If "No," skip to question #5C.)	☐	☐	☐	☐
5B.1. Is anyone on staff (staff or volunteer) trained in American Sign Language (ASL) for simple communication?	☐	☐	☐	☐
5B.2. Does the agency have a list of qualified sign language interpreters?	☐	☐	☐	☐
5B.3. Is there a clear and easy procedure for contacting qualified ASL interpreters?	☐	☐	☐	☐
5B.4. Is there a clear mechanism for paying for qualified ASL interpreter services?	☐	☐	☐	☐
5B.5. Is there a plan on how to provide ASL interpreter service during all hours of operation; including access to ASL interpreters outside of normal office hours for agencies providing 24-hour services?	☐	☐	☐	☐
5B.6. Does the agency have procedures to address confidentiality concerns regarding interpreters who are acquaintances of clients who are deaf or hard of hearing? (If "Yes," describe in the "Comments" section.)	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
5C. Does the agency have a TTY or text phone?	☐	☐	☐	☐
5C.1. If "Yes," is the TTY available after normal working hours?	☐	☐	☐	☐
5C.2. If "Yes," is the staff trained in using the TTY?	☐	☐	☐	☐
5C.3. If "Yes," is signage posted above public telephones to either indicate the presence or location of the TTY?	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
5D. Are all staff and volunteers (including answering services) trained on using West Virginia Relay?	☐	☐	☐	☐

Comments:

6. Staff Training and Competency Development

	Yes	No	Unk	N/A
6A. Does the agency's mandatory staff/volunteer training include a section on disability awareness/etiquette? (If "Yes," obtain a copy of the curricula.)	☐	☐	☐	☐
6A.1. If "Yes," disability awareness/etiquette training is provided in the following formats:				
• Formal face-to-face training environment?	☐	☐	☐	☐
• Self-paced/on-your-own reading material?	☐	☐	☐	☐
• DVD, video or audio cassette?	☐	☐	☐	☐
• Other? (If "Yes," describe in the "Comments" section.)	☐	☐	☐	☐
6A.2. If "Yes," which of the following staff receive disability awareness/etiquette training:				

	Yes	No	Unk	N/A
• New staff?	☐	☐	☐	☐
• Outreach staff?	☐	☐	☐	☐
• Reception staff?	☐	☐	☐	☐
• Volunteers?	☐	☐	☐	☐
• Other? (If "Yes," list in the "Comments" section.)	☐	☐	☐	☐
6A.3. If "Yes," do staff /volunteers receive disability awareness/etiquette training via:				
• New staff orientation?	☐	☐	☐	☐
• In-service training?	☐	☐	☐	☐
• Other? (If "Yes," describe in the "Comments" section.)	☐	☐	☐	☐

Comments:

6B. Mandatory staff training pertaining to clients with disabilities is provided (check one):

- ☐ Never
- ☐ Once
- ☐ Annually
- ☐ More than once per year
- ☐ Unknown
- ☐ Other (Describe in the "Comments" section.)

6B.1. If training is provided, describe in the "Comments" section who provides the training.

Comments:

	Yes	No	Unk	N/A
6C. Besides disability awareness and etiquette training, does the agency provide training for staff and volunteers to increase their skills and knowledge for working and communicating with a client with a specific disability?	☐	☐	☐	☐
6C.1. If "Yes," does the training address working and communicating with individuals with:				
• Cognitive disabilities?	☐	☐	☐	☐
• Mental illnesses?	☐	☐	☐	☐
• Sensory disabilities?	☐	☐	☐	☐
• Physical disabilities?	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
6D. Does the agency assure a welcoming environment through:				
• Annually evaluating staff service skills and performance?	☐	☐	☐	☐
• Soliciting and utilizing client feedback for quality of service improvement?	☐	☐	☐	☐
• Incorporating the concept of inclusive and welcoming client service within the agency's mission?	☐	☐	☐	☐
• Implementing regular client service training for staff and volunteers who interface with the public?	☐	☐	☐	☐
• Other? (If "Yes," describe in the "Comments" section.)	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
6E. Does the agency provide referral information and training for staff and volunteers on other community resources and supports available to clients with disabilities?	☐	☐	☐	☐
6E.1. If "Yes," are the referral resources/lists updated regularly? (Indicate how often and the date of the last update in the "Comments" section.)	☐	☐	☐	☐
6E.2. If "Yes," are those resources/lists available in alternate formats?	☐	☐	☐	☐
6E.3. If "Yes," does the agency regularly and actively communicate or collaborate with those referral agencies? (Describe in the "Comments" section.)	☐	☐	☐	☐

Comments:

7. Emergency Procedures

	Yes	No	Unk	N/A
7A. Does the facility have an emergency evacuation procedure that addresses the needs of individuals with disabilities?	☐	☐	☐	☐
7A.1. If "Yes," do staff members and volunteers receive training on emergency evacuation procedures?	☐	☐	☐	☐

Comments:

	Yes	No	Unk	N/A
7B. Does the facility have visual as well as auditory alarms?	☐	☐	☐	☐

Comments:

Thank you for your important work and your efforts to make your services more accessible for people with disabilities.

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the term "clients" is primarily used in this module to refer to those individuals who access the agency's services and programs.

[2]Resources drawn from to compile this tool: Adaptive Environments Center, Inc., *ADA Title II action guide for state and local governments* (Horsham, PA: LRP Publications, 1992), 71–120; S. Caprioli, *The women with disAbilities empowerment project: Family Services and Taconic Resources for Independence,* Incorporated (Poughkeepsie, NY: 2008); Hardesty, Gaffney, Rosenfeld & Mandel, *Accessing safety project: Promising practices in serving sexual violence survivors with disabilities* (Southern Arizona Center Against Sexual Assault, 2005); Institute on Disabilities at Temple University: Center for Excellence in Developmental Disabilities, Education, Research and Service, *Rape crisis/domestic violence comprehensive victim services, physical and programmatic accessibility survey* (Philadelphia, 2001), 4–16; Washington State's Collaboration to Improve Domestic and Sexual Violence Advocacy for People with disAbilities and Deaf Individuals, *Universal design/welcoming environments,* 29-50; Wisconsin Coalition for Advocacy, Wisconsin Coalition Against Domestic Violence, Wisconsin Coalition Against Sexual Assault and Independence First, *Accessibility guide for domestic violence and sexual assault service providers* (Violence Against Women with Disabilities Project, 2004), 73-85; and WV S.A.F.E., *Rape crisis center accessibility survey* (Unpublished, 2007), 12–21.

Physical Accessibility Checklist for Existing Facilities

This module offers a checklist that agencies can use to examine their facilities and identify *physical* barriers that may prevent persons with disabilities from having equal access to their services.

D2. Physical Accessibility Checklist for Existing Facilities

Purpose

Agencies can use the *Physical Accessibility Checklist* to examine their facilities and identify physical barriers that may prevent persons with disabilities from having equal access to their services. (To assess agency *programs and policies*, see *Tools to Increase Access. Programmatic and Policy Accessibility Checklist.*)

The Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973 set accessibility standards for state and local governments, public entities and organizations receiving government funds to prevent discrimination or exclusion of people due to their disability (See *Disabilities 101. Disability Laws.*) The checklist *does not* cover all of the requirements of the standards, nor does it provide every possible solution. Rather, it is designed to be used as an assessment tool for individual organizations, targeting specific areas of physical access and providing possible solutions for addressing areas of concern. The information gathered from this assessment can be useful when agencies develop their transition plans for increasing the accessibility of their services. (See *Tools to Increase Access. Developing a Transition Plan.* Note, however, that the module focuses on planning for programmatic and policy changes rather than physical changes.)

Accessibility standards change. This tool was developed in 2010 utilizing the 1991 Americans with Disabilities Act Accessibility Guidelines (ADAAG) that were adopted by the Department of Justice as the Standards for Accessible Design in 1994. New accessibility regulations were released in 2010 and will be published in 2012. (See www.access-board.gov/ada-aba/comparison/comparison.pdf.)

If an agency wishes to conduct an accessibility survey to assess for full compliance with relevant laws, building codes and standards, please contact the Mid Atlantic ADA Information Center at 800-949-4232 or www.adainfo.org for recommendations of individuals who are qualified to provide the expertise needed for a comprehensive compliance review.

In compiling this checklist, the West Virginia Sexual Assault Free Environment (WV S.A.F.E.) project drew from multiple resources, as cited in the endnote section.[1]

Preparation

- **Select an assessment team.** To get started, it is recommended that a two to three member assessment team be created. The composition of the team should be based on the size of the facility and the nature of the services provided. Team members should include the agency's designated ADA coordinator and a representative from management. Larger organizations may want to include members of the maintenance staff or building managers to facilitate access to all service areas of the agency, provide building floor plans and assist with taking

measurements. If the agency has a designated ADA coordinator, this person should lead this activity. If no ADA coordinator exists, it is best to have the management of the organization designate someone to serve as the team leader. Before beginning the assessment, it is important to determine who will receive the completed checklist and summary of findings. This assessment process must be supported by management so the team can freely access all areas of the facility.

- **Follow the outline.** Completing the checklist as designed will ensure a complete and organized assessment of the facility. The team should review the entire tool prior to beginning the process to ensure they fully understand what is being assessed. You may decide to make additional copies of certain sections of the tool to account for and assess all areas of the facility. For example, if there are two or more restrooms within the facility, you may need to complete a separate accessibility assessment on each of the restrooms. In these cases, be sure to clearly note the location of each of these areas on the assessment sheets. It may be helpful to have the building floor plans with you while you survey. If the plans are not available, you can use graph paper to sketch the layout of all interior and exterior spaces used by your organization. Make notes on the sketch or plan while you are surveying. Reviewing the checklist prior to starting the process will also help identify the expertise needed. If desired, the Mid Atlantic ADA Information Center can recommend a qualified individual to provide training on accessibility surveys and answer questions related to the standards addressed in the tool.

- **Identify equipment needed.** Each team member should have a copy of the checklist. A clip board for each team member is helpful in providing a surface when documenting measurements and comments. A flexible steel tape measure will be needed. Document exact measurements; do not round up or down (if the measurement is 32.5 inches, record it as such rather than estimating it to be 32 or 33.) Please note that, if you answer "No" to any question in the checklist that requires a measurement, you should write the actual measurement (within 1/4 inch) in the box provided. One team member should take the measurements while another records the findings. If there are three team members, the third person can clear the area of consumers, answer questions about the assessment, and direct the team to the next area to be surveyed. Taking photographs can be helpful to document findings.

  NOTE: ***Measuring for slope.*** For measuring the slope of a walkway, ramp or parking area, you will need a tape measure and a level. Typical slope measurements include the *running slope*, which is the slope that runs in the direction of travel, and the cross slope, which is the slope running perpendicular (left to right) of the route of travel. The slope reference measurements below are calculated using a 24-inch (2 foot) level, measuring the gap distance from the surface to the tip of the level (back of the level against surface; front held "at level"):

  1:50 (or 2%) slope = 1/2 inch gap

  1:20 (or 5%) slope = 1 1/4 inch gap

  1:12 (or 8.3%) slope = 2 inch gap

  Some general measurement information and guidelines on slope requirements for various surface areas commonly found at worksites and within this checklist are listed below for reference. For more information or clarification, please contact either your local, state or national resource centers as listed at the end of this document.

  o Walkways and sidewalks (or other accessible routes of travel):

    Running slope of no more than 1:20 or 5%

    Cross slope of no more than 1:50 or 2%

- Accessible parking and access aisles:

  Running and cross slope of no more than 1:50 or 2%

- Ramps and curb ramps

  Running slope of no more than 1:12 or 8.3%

  Crossing slope of no more than 1:50 or 2%

- **Determine how the assessment results will be used.** Once the checklist is completed, summarize any identified barriers. Many older buildings have barriers to access. Most agencies do not have the resources to remove all barriers at one time and will need to develop a plan to set priorities. Some barriers can be easily addressed with simple fixes (e.g., moving a display case that is narrowing a hallway). Other barriers may require qualified individuals and appropriated funds to address them. Again, this assessment is NOT designed to determine full compliance with standards and building codes, but rather to help identify barriers that may be preventing physical access for persons with disabilities. Creating solutions to barriers may require a plan to transition to more accessible services. For agencies interested in making substantial building modifications, it is highly recommended that they obtain the assistance of qualified individuals to ensure that the changes made are compliant with state and federal codes and standards. A strategy for implementing changes should be a component of all transition plans.

Definitions

It is helpful for those using this checklist to know the meanings of the terms listed below. Consult with the ***ADA Accessibility Guidelines for Building and Facilities*** *(ADAAG)* at http://access-board.gov/ada-aba/final.cfm for additional term definitions.

Circulation path: An exterior or interior way of passage from one place to another for pedestrians, including, but not limited to: walks, hallways, courtyards, stairways and stair landings.

Curb ramp: A short ramp cutting through a curb or built up to it.

Conical: An example is there might be cone-shaped curb ramps where the corner of an intersection is rounded and the sidewalk edge drops down to the street. The other side remains high, giving the curb ramp a conical shape that can make a wheelchair unstable.

Switchbacks: A landing connecting two ramps where the ramps change or reverse direction. The minimum landing size should be 60 inches by 60 inches.

Pull side of the door: The side of the door that swings toward the person pulling the door to an open position. The push side of the door is the side which a person would push the door to an open position.

Tactile signage: Signs from which the user or reader receives the message by the sense of touch. Raised characters on a room sign are felt to determine the user's location. Tactile can be used to describe any object that can be perceived through touch.

Lavatory apron: The front lower edge of a bathroom sink; related to knee clearance. Lavatory is defined as "a room equipped with washing and toilet facilities," which has come to refer to the sink within a toilet room. There are different requirements for "lavatories" (sinks within toilet rooms) and "sinks" (as in kitchens or break rooms).

PHYSICAL ACCESSIBILITY CHECKLIST FOR EXISTING FACILITIES

QUESTIONS AND SOLUTIONS

Priority 1: Accessible Approach/Entrance

People with disabilities should be able to arrive on the site, approach the building and enter as freely as everyone else. At least one route of travel (e.g., from a parking lot in front of the building to the entrance of an office within the building) should be safe and accessible for everyone, including people with disabilities.

Route of Travel (ADAAG 1994: 4.3, 4.4, 4.7; 2010: 402, 307, 406) **YES** **NO**

Question 1A. *Is there a route of travel that does not require the use of stairs?* ☐ ☐

Possible solutions.

- ☐ Add a ramp if the route of travel is interrupted by stairs.
- ☐ Add an alternative route on level ground.

Question 1B. *Is the route of travel stable, firm and slip-resistant?* ☐ ☐

Possible solutions:

- ☐ Repair uneven paving.
- ☐ Fill small bumps and breaks with beveled patches.
- ☐ Replace gravel with hard top.

Question 1C. *Is the route at least 36 inches wide?* ☐ ☐

Possible solutions:

- ☐ Change or move landscaping, furnishings or other features that narrow the route.
- ☐ Widen the route.

Width

Question 1D. *Can all objects protruding into the circulation paths be detected by a person with a visual disability using a cane?* ☐ ☐

NOTE: In order to be detected using a cane, an object must be within 27 inches of the ground. Objects hanging or mounted overhead must be higher than 80 inches to provide clear head room. Any objects mounted to the wall should not protrude more than 4 inches from the face of the wall. It is not necessary to remove objects that protrude less than 4 inches from the wall.

Distance from Wall/ Height

Possible solutions:

- ☐ Move or remove protruding objects.
- ☐ Add a cane-detectable base that extends to the ground.
- ☐ Place a cane-detectable object on the ground underneath as a warning barrier.

Question 1E. *Do curbs have curb ramps at drives, parking and drop-offs that are at least 36 inches wide (not conical in shape) and flush with other surfaces?* ☐ ☐

Possible solutions:

- ☐ Install a curb cut.
- ☐ Add a small ramp up to the curb.

Width

Ramps (ADAAG 1994: 4.8; 2010: 405)

YES NO

Question 2A. *Are the slopes of ramps no greater than 1:12?* ☐ ☐

NOTE: Slope is given as a ratio of the height to the length. 1:12 means for every 12 inches along the base of the ramp, the height increases one inch. For a 1:12 maximum slope, at least a one foot of ramp length is needed for each inch of height. (See *Measuring for slope* on page D2.2 of this checklist.)

Slope

Possible solutions:

- ☐ Lengthen the ramp to decrease slope.
- ☐ Relocate the ramp.
- ☐ If available space is limited, reconfigure the ramp to include switchbacks.

Question 2B. *Do all ramps longer than 6 feet have railings on both sides that are are sturdy and between 34 and 38 inches high?* ☐ ☐

Height

Possible solution:

- ☐ Add railings.

Question 2C. *Is the width between railings or curbs at least 36 inches?* ☐ ☐

Width

Possible solutions:

- ☐ Relocate the railings.
- ☐ Widen the ramp.

Question 2D. *Are ramps non-slip?* ☐ ☐

Possible solution:

- ☐ Add non-slip surface material.

Question 2E. *Is there a 5-foot-long level landing at every 30-foot horizontal length of ramp, at the top and bottom of ramps and at switchbacks?* ☐ ☐

Length

Possible solution:

- ☐ Remodel or relocate the ramp.

Question 2F. *Does the ramp rise no more than 30 inches between landings?* ☐ ☐

Rise

Possible solution:

- ☐ Remodel or relocate the ramp.

Parking and Drop-Off Areas (ADAAG 1994: 4.5; 2010: 502)

Question 3A. *Are an adequate number of accessible parking spaces available (8 feet wide for car plus 5-foot access aisle)?* ☐ ☐

#Accessible Spaces

NOTE: For guidance in determining the appropriate number of spaces to designate, the table below gives the ADAAG requirements for new construction and alterations (for lots with more than 100 spaces, refer to ADAAG):

Total Spaces	Accessible
1 to 25	1 space
26 to 50	2 spaces
51 to 75	3 spaces
76 to 100	4 spaces

Possible solution:

☐ Reconfigure a reasonable number of spaces by repainting stripes.

YES **NO**

Question 3B. *Are 8-foot-wide spaces, with minimum 8-foot-wide access aisles and 98 inches of vertical clearance, available for lift-equipped vans?* ☐ ☐

Width/Vert. Clearance

NOTE: At least one of every 8 accessible spaces must be van-accessible (at least one van-accessible space in all cases) and measurement should be from the center of one painted line to the center of the next painted line.

Possible solution:

☐ Reconfigure to provide van-accessible space(s).

Question 3C. *Are access aisles part of the accessible route to the accessible entrance?* ☐ ☐

Possible solutions:

☐ Add curb ramps.

☐ Reconstruct the sidewalk.

Question 3D. *Are the accessible spaces closest to the accessible entrance?* ☐ ☐

Possible solution:

☐ Reconfigure spaces.

Question 3E. *Do all accessible parking spaces and access aisles have a slope of no more than 1:50 or 2%? (See Measuring for slope on page D2.2 of this checklist.)* ☐ ☐

Slope

NOTE: For better accuracy when measuring parking spaces and access aisles,take a measurement in three different locations within the space (avoiding pronounced dips and depressions) and record the average of the three measurements.

Possible solutions:

☐ Reconfigure or relocate accessible spaces to level areas.

☐ Modify/re-grade the accessible parking area.

Question 3F. *Are accessible spaces marked with the International Symbol of Accessibility? Are there signs reading "Van Accessible" at van spaces?* ☐ ☐

Possible solution:

☐ Add signs, placed so that they are not obstructed by cars.

Question 3G. *Are accessible parking signs permanently mounted and at least 60 inches from the ground (from the surface to the bottom of the sign)?* ☐ ☐

Height

Possible solutions:

☐ Permanently mount signage to the ground or the wall surface.

☐ Adjust sign height so that they are not obstructed by cars.

	YES	NO
Question 3H. *Is there an enforcement procedure to ensure that accessible parking is used only by those who need it?*	☐	☐

Possible solution:

- ☐ Implement a policy to check periodically for violators and report them to the proper authorities.

Entrance (ADAAG 1994: 4.13, 4.14, 4.5; 2010: 404, 206,302)

Question 4A. *If there are stairs at the main entrance, is there also a ramp or a lift, or is there an alternative accessible entrance?*	☐	☐

NOTE: Do not use a service entrance as the accessible entrance unless there is no other option.

Possible solutions:

- ☐ If it is not possible to make the main entrance accessible, create a dignified alternate accessible entrance.
- ☐ If parking is provided, make sure there is accessible parking near all accessible entrances.

Question 4B. *Do all inaccessible entrances have signs indicating the location of the nearest accessible entrance?*	☐	☐

Possible solution:

- ☐ Install signs before inaccessible entrances so that people do not have to retrace their approach.

Question 4C. *Can the alternate accessible entrance be used independently?*	☐	☐

Possible solution:

- ☐ Eliminate as much as possible the need for assistance-to answer a doorbell, to operate a lift or to put down a temporary ramp, for example.

Question 4D. *Does the entrance door have at least 32 inches clear opening (for a double door, at least one 32-inch opening)?*	☐	☐

☐ Clear Opening

Possible solutions:

- ☐ Widen the door to 32 inches clear.
- ☐ If technically infeasible, widen to 31 and 3/8 inches minimum.
- ☐ Install offset (swing-clear) hinges.

Question 4E. *Is there at least 18 inches of clear wall space on the pull side of the door, next to the handle?*	☐	☐

☐ Clear Space

NOTE: A person using a wheelchair or crutches needs this space to get close enough to open the door.

Possible solutions:

- ☐ Remove or relocate furnishings, partitions or other obstructions.
- ☐ Move the door.
- ☐ Add a power-assisted or automatic door opener.

YES **NO**

Question 4F. *Is the threshold edge 1/4-inch high or less, or if beveled edge, no more than 3/4-inch high?* ☐ ☐

Height

Possible solutions:

- ☐ If there is a single step with a rise of 6 inches or less, add a short ramp.
- ☐ If there is a threshold greater than 3/4-inch high, remove it or modify it to be a ramp.

Question 4G. *If provided, are mats or carpeting a maximum of 1/2-inch high?* ☐ ☐

Height

Possible solution:

- ☐ Replace or remove mats or carpeting.

Question 4H. *Are edges securely installed to minimize tripping hazards?* ☐ ☐

Possible solution:

- ☐ Secure carpeting or mats at the edges.

Question 4I. *Is the door handle no higher than 48 inches and operable with a closed fist?* ☐ ☐

Height

NOTE: The "closed fist" test for handles and controls is as follows—try opening the door or operating the control using only one hand, held in a fist. If you can do it, so can a person who has limited use of his or her hands.

Possible solutions:

- ☐ Lower the handle.
- ☐ Replace an inaccessible knob with a lever or loop handle.
- ☐ Retrofit with an add-on lever extension.

Question 4J. *Can doors be opened without too much force (maximum is 5 lb for interior doors)?* ☐ ☐

Force (lbs)

NOTE: You can use an inexpensive force meter or a fish scale to measure the force required to open a door. Attach the hook end to the doorknob or handle. Pull on the ring end until the door opens, and read off the amount of force required. If you do not have a force meter or a fish scale, you will need to judge subjectively whether the door is easy enough to open.

Possible solutions:

- ☐ Adjust the door closers and oil the hinges.
- ☐ Install power-assisted or automatic door openers.
- ☐ Install lighter doors.

Question 4K. *If the door has a closer, does it take at least 3 seconds to close?* ☐ ☐

Seconds

Possible solution:

- ☐ Adjust the door closer.

Other Considerations (Priority 1: Accessible Approach and Entrance)

The following elements are intended as supplemental to the above checklist and are not legally required under the ADA.

	YES	NO
Question 5A. *If the agency has a security system which requires ringing a bell or pushing an intercom button, is it clearly marked (5/8 to 2 inch letters with high contrast)?*	☐	☐
• Braille text of the same information?	☐	☐
• Is the system accessible for someone who is deaf?	☐	☐
• Is the button within reach of someone in a wheelchair?	☐	☐

NOTE: **Reach ranges:** ADAAG, 1994, stipulates the maximum height for a side reach is 54 inches; for a forward reach, 48 inches. The minimum reachable height is 15 inches for a front approach and 9 inches for a side approach. ADAAG, 2010, stipulates the maximum height for a side reach is 48 inches (exception: 54 inches for existing structures); for a forward reach, 48 inches. The minimum reachable height is 15 inches for a front approach and 15 inches for a side approach.

Possible solutions:

- ☐ Replace existing signs.
- ☐ Install an intercom for verbal communication.
- ☐ Move push buttons within an accessible reach range.

Question 5B. *Is there accessible informational signage (with good visual contrast and large enough letters) at the entrance that provides directional information for persons with disabilities?*	☐	☐

Possible solution:

- ☐ Install accessible informational signage denoting accessible routes.

Question 5C. *Is there signage at the entrance that lets people know that service animals are welcome?*	☐	☐

Possible solution:

- ☐ Install accessible signage denoting service animals are welcome.

Question 5D. *If there is a sign at the entrance asking "If you need assistance…" does it include the International Symbol of Accessibility and have good visual contrast?*	☐	☐

Possible solution:

- ☐ Install accessible signage that includes the International Symbol of Accessibility and has good visual contrast.

Question 5E. *Is confidentiality possible at the counter, in the waiting room or while filling out forms?*	☐	☐

Possible solution:

- ☐ Move intake activities to a private area.

Priority 2: Access to Goods and Services

Ideally, the layout of the building should allow people with disabilities to obtain materials or services without assistance.

Horizontal Circulation (ADAAG 1994: 4.3; 2010: 402)

YES **NO**

Question 6A. *Does the accessible entrance provide direct access to the main floor, lobby or elevator?* ☐ ☐

Possible solutions:

- ☐ Add ramps or lifts.
- ☐ Make another entrance accessible.

Question 6B. *Are all public spaces on an accessible route of travel?* ☐ ☐

Possible solution:

- ☐ Provide access to all public spaces along an accessible route of travel.

Question 6C. *Is the accessible route to all public spaces at least 36 inches wide and 80 inches in height clearance?* ☐ ☐ _____ Width/Height

Possible solution:

- ☐ Move furnishings such as tables, chairs, display racks, vending machines and counters to make more room.

Question 6D. *Is there a 5-foot circle or a T-shaped space for a person using a wheelchair to reverse direction?* ☐ ☐ _____ Width

Possible solution:

- ☐ Rearrange furnishings, displays and equipment.

Doors (ADAAG 1994: 4.13; 2010: 404)

Question 7A. *Do doors into public spaces have at least a 32-inch clear opening?* ☐ ☐ _____ Clearance

Possible solutions:

- ☐ Install offset (swing-clear) hinges.
- ☐ Widen doors.

Question 7B. *On the pull side of doors, next to the handle, is there at least 18 inches of clear wall space so that a person using a wheelchair or crutches can get near to open the door?* ☐ ☐ _____ Clearance

Possible solutions:

- ☐ Reverse the door swing if it is safe to do so.
- ☐ Move or remove obstructing partitions.

YES NO

Question 7C. *Can doors be opened without too much force (5 pounds maximum for interior doors)?* ☐ ☐

Force (lbs)

Possible solutions:

- ☐ Adjust or replace closers.
- ☐ Install lighter doors.
- ☐ Install power-assisted or automatic door openers.

Question 7D. *Are door handles 48 inches high or less and operable with a closed fist?* ☐ ☐

Height

Possible solutions:

- ☐ Lower handles.
- ☐ Replace inaccessible knobs or latches with lever or loop handles.
- ☐ Retrofit with add-on levers.
- ☐ Install power-assisted or automatic door openers.

Question 7E. *Is the threshold edge 1/4-inch high or less, or if beveled edge, no more than 3/4-inch high?* ☐ ☐

Height

Possible solutions:

- ☐ If there is a threshold greater than 3/4-inch high, remove it or modify it to be a ramp.
- ☐ If between 1/4- and 3/4-inch high, add bevels to both sides.

Emergency Alarms (ADAAG 1994: 4.38; 2010: 702)

Question 8A. *If emergency systems are provided, do they have both flashing lights and audible signals?* ☐ ☐

Possible solutions:

- ☐ Install visible and audible alarms.
- ☐ Provide portable devices.

Rooms and Spaces (ADAAG 1994: 4.2, 4.4 4.5; 2010: 304, 307)

Question 9A. *Are all aisles and pathways to materials and services at least 36 inches wide?* ☐ ☐

Width

Possible solution:

- ☐ Rearrange furnishings and fixtures to clear aisles.

Question 9B. *Is there a 5-foot circle or T-shaped space for turning a wheelchair completely?* ☐ ☐

Width

Possible solution:

- ☐ Rearrange furnishings to clear more room.

YES NO

Question 9C. *Is carpeting low-pile, tightly woven, and securely attached along the edges?* ☐ ☐

Possible solutions:

- ☐ Secure edges on all sides.
- ☐ Replace carpeting.

Question 9D. *In the circulation paths through public areas, are all obstacles cane-detectable (located within 27 inches of the floor or higher than 80 inches, or protruding less than 4 inches from the wall)?* ☐ ☐

Height/ Protrusion

Possible solutions:

- ☐ Remove obstacles.
- ☐ Install furnishings, planters or other cane-detectable barriers underneath.

Signage for Goods and Services (ADAAG 1994: 4.30; 2010: 703)

Different requirements apply to different types of signs.

Question 10A. *If provided, do signs designating permanent rooms and spaces where goods and services are provided comply with the appropriate requirements for such signage? (See specifications below.)* ☐ ☐

	YES	NO	
• Signs mounted with centerline 60 inches from floor.	☐	☐	Height
• Signs mounted on wall adjacent to latch side of door or as close as possible.	☐	☐	
• Signs with raised characters, sized between 5/8 and 2 inches high, with high contrast.	☐	☐	Size (Height)
• Signs with raised Brailed text of the same information.	☐	☐	
• If pictogram is used in the sign, it must be accompanied by raised characters and Braille.	☐	☐	

Possible solution:

- ☐ Provide signs that have raised letters, Braille and that meet all other requirements for permanent room or space signage.

Directional and Informational Signage

The following questions apply to directional and informational signs that fall under Priority 2.

Question 11A. *If mounted above 80 inches, do signs have letters at least 3 inches high, with high contrast and non-glare finish?* ☐ ☐

Letter Height

Possible solution:

- ☐ Review requirements and replace signs as needed, meeting the requirements for character size, contrast and finish.

YES NO

Question 11B. *Do directional and informational signs comply with legibility requirements? (Building directories or temporary signs need not comply.)* ☐ ☐

Possible solution:

☐ Review requirements and replace signs as needed, meeting the requirements for character size, contrast and finish.

Controls (ADAAG 1994: 4.27; 2010: 407.2, 308, 309.4)

Question 12A. *Are all controls that are available for use by the public (including electrical, mechanical, cabinet, game and self-service controls) located at an accessible height?* ☐ ☐ _____ Height

NOTE: For additional reach range information, see "NOTE" on page D2.9, item 5A.

Possible solution:

☐ Relocate controls.

Question 12B. *Are controls operable with a closed fist?* ☐ ☐

Possible solution:

☐ Replace controls.

Seats, Tables, and Counters (ADAAG 1994: 4.3, 4.32, 7.2; 2010: 306, 902)

Question 13A. *Are the aisles between fixed seating (other than assembly area seating) at least 36 inches wide?* ☐ ☐ _____ Width

Possible solution:

☐ Rearrange chairs or tables to provide 36-inch aisles.

Question 13B. *Are the spaces for wheelchair seating distributed throughout?* ☐ ☐

Possible solutions:

☐ Rearrange tables to allow room for wheelchairs in seating areas throughout the area.

☐ Remove some fixed seating.

Question 13C. *Are the tops of tables or counters between 28 and 34 inches high?* ☐ ☐ _____ Height

Possible solutions:

☐ Lower part or all of the high surface.

☐ Provide an auxiliary table or counter.

YES NO

Question 13D. *Are knee spaces at accessible tables at least 27 inches high, 30 inches wide and 19 inches deep?* ☐ ☐

Height/ Width/Depth

Possible solution:

☐ Replace or raise tables.

Question 13E. *At each type of cashier counter, is there a portion of the main counter that is no more than 36 inches high?* ☐ ☐

Height

Possible solutions:

☐ Provide a lower auxiliary counter or folding shelf.

☐ Arrange the counter and surrounding furnishings to create a space to hand items back and forth.

Question 13F. *Is there a portion of food-ordering counters that is no more than 36 inches high or is there space at the side for passing items to customers who have difficulty reaching over a high counter?* ☐ ☐

Height

Possible solutions:

☐ Lower the section of the counter.

☐ Arrange the counter and surrounding furnishings to create a space to pass items.

Vertical Circulation (ADAAG 1994: 4.1.3(5), 4.3; 2010: 203, 206)

Question 14A. *Are there ramps, lifts or elevators to all levels?* ☐ ☐

Possible solutions:

☐ Install ramps or lifts.

☐ Modify a service elevator.

☐ Relocate goods or services to an accessible area.

Question 14B. *On each level, if there are stairs between the entrance and/or elevator and essential public areas, is there an accessible alternate route?* ☐ ☐

Possible solution:

☐ Clearly post signs directing people along an accessible route to ramps, lifts or elevators.

Stairs (ADDAG 1994: 4.9; 2010: 504, 505)

The following questions apply to stairs connecting levels not serviced by an elevator, ramp or lift.

Question 15A. *Do treads have a non-slip surface?* ☐ ☐

Possible solution:

☐ Add a non-slip surface to treads.

	YES	NO
Question 15B. *Do stairs have continuous rails on both sides, with extensions beyond the top and bottom stairs?*	☐	☐

Possible solution:

☐ Add or replace handrails if possible within the existing floor plan.

Elevators (ADDAG 1994: 4.10; 2010: 407)

Question 16A. *Are there both visible and verbal or audible door opening/closing and floor indicators (e.g., one tone = up, two tones = down)?*	☐	☐

Possible solution:

☐ Install visible and verbal or audible signals.

Question 16B. *Are the call buttons in the hallway no higher than 42 inches?*	☐	☐

Possible solutions:

☐ Lower the call buttons. ☐ Provide a permanently attached reach stick.

Height

Question 16C. *Do the controls inside the cab have raised and Braille lettering?*	☐	☐

Possible solution:

☐ Install raised lettering and Braille next to the buttons.

Question 16D. *Is there a sign on both door jambs at each floor identifying the floor in raised and Braille letters?*	☐	☐

Possible solution:

☐ Install tactile signs to identify floor numbers, at a height of 60 inches from the floor.

Question 16E. *If an emergency intercom is provided, is it usable without voice communication?*	☐	☐

Possible solution:

☐ Modify the communication system.

Question 16F. *Is the emergency intercom identified by Braille and raised letters?*	☐	☐

Possible solution:

☐ Add tactile identification.

Lifts (ADDAG 1994: 4.3, 4.11; 2010: 305.3, 410)

Question 17A. *Can the lift be used without assistance? If not, is a call button provided?*	☐	☐

Possible solutions:

☐ At each stopping level, post clear instructions for use of the lift.

☐ Provide a call button.

Question 17B. *Is there at least 30 by 48 inches of clear space for a person in a wheelchair to approach to reach the controls and use the lift?* YES ☐ NO ☐

Clearance ☐

Possible solution:

☐ Rearrange furnishings and equipment to clear more space.

Question 17C. *Are controls between 15 and 48 inches high (up to 54 inches if a side approach is possible)? For reach range information, see NOTE on page D2.9, item 5A.* ☐ ☐

Height ☐

Possible solution:

☐ Move the controls.

Other Considerations (Priority 2: Access to Goods and Services)

The following elements are intended as supplemental to the above check list and may not be legally required under the ADA.

Question 18A. *Is the reception or waiting area noisy and/or busy?* ☐ ☐

NOTE: Excessive noise may create difficulties for persons with hearing loss or those with cognitive disabilities.

	YES	NO
• Are there a lot of people talking at once?	☐	☐
• Is there a TV or music playing in the background?	☐	☐
• Are announcements made over a loudspeaker?	☐	☐

Possible solutions:

☐ Divide waiting areas into smaller spaces to decrease the number of people in the room.

☐ Decrease TV or music volumes or eliminate them altogether.

☐ Decrease loudspeaker volume or implement an alternative communication system.

Question 18B. *Are the chairs in the facility available in a variety of styles and sizes?* ☐ ☐

NOTE: Seating areas should contain chairs that are accessible to people with limited mobility and people who use wheelchairs, including chairs without arm rests, chairs in larger sizes and chairs that do not roll.

Possible solution:

☐ Install chairs of various sizes and chairs without arms and rollers.

Question 18C. *Is there room to transfer from a wheelchair to a standard chair?* ☐ ☐

Possible solutions:

☐ Reconfigure the space to allow for ample transfer room to accessible chairs.

☐ Install chairs of various sizes and chairs without arms at the end of rows.

Question 18D. *Are there footrests available with any of the chairs?* ☐ ☐

Possible solution:

☐ Make footrests available.

YES NO

Question 18E. *Are the offices adequately lighted so that someone with low vision would be able to see written materials or other people; but not too bright, flickering or noisy, which may affect someone with light sensitivity, who has difficulty paying attention, or who has seizures?* ☐ ☐

Possible solutions:

- ☐ Replace or relocate lighting fixtures.
- ☐ Add indirect lighting.

Question 18F. *Is there enough room and is the layout conducive for an interpreter to also be in the office, waiting or intake area?* ☐ ☐

NOTE: The layout should allow for an interpreter to sit across from the individual and to not have to be in front of a window.

Possible solution:

- ☐ Reconfigure the space.

Priority 3: Usability of Restrooms

When restrooms are open to the public, they should be accessible to people with disabilities.

Getting to the Restrooms (ADAAG 1994: 4.1; 2010: 201)

Question 19A. *If restrooms are available to the public, is at least one restroom (either one for each sex, or unisex) fully accessible?* ☐ ☐

Possible solutions:

- ☐ Reconfigure the restroom.
- ☐ Combine the restrooms to create one unisex accessible restroom.

Question 19B. *Are there signs at inaccessible restrooms that give directions to accessible restroom facilities?* ☐ ☐

Possible solution:

- ☐ Install accessible signs.

Doorways and Passages (ADAAG 1994: 4.2, 4.13, 4.30; 2010: 404, 304, 703)

Question 20A. *Is there tactile signage identifying restrooms?* ☐ ☐

NOTE: **Mount signs on the wall**, on the latch side of the door, complying with the requirements for permanent signage.

Possible solutions:

- ☐ Add accessible signage, placed to the side of the door, 60 inches to the centerline (but not on the door itself).
- ☐ If symbols are used, add supplementary verbal signage.

YES NO

Question 20B. *Are pictograms or symbols used to identify rest rooms, and if used, are raised characters and Braille included below?* ☐ ☐

Possible solution:

- ☐ If symbols are used, add supplementary verbal signage with raised characters and Braille below the pictogram symbol.

Question 20C. *Is the doorway at least 32 inches clear?* ☐ ☐

Possible solutions: _____ Width

- ☐ Install offset (swing-clear) hinges.
- ☐ Widen the doorway.

Question 20D. *Are doors equipped with accessible handles (operable with a closed fist), 48 inches high or less?* ☐ ☐

Possible solutions: _____ Height

- ☐ Lower handles.
- ☐ Replace knobs or latches with lever or loop handles.
- ☐ Add lever extensions.
- ☐ Install power-assisted or automatic door openers.

Question 20E. *Can doors be opened easily (5 pounds maximum force)?* ☐ ☐

Possible solutions: _____ Force (lbs)

- ☐ Adjust or replace closers.
- ☐ Install lighter doors.
- ☐ Install power-assisted or automatic door openers.

Question 20F. *Does the entry configuration provide adequate maneuvering space for a person using a wheelchair?* ☐ ☐

_____ Clearance

NOTE: A person using a wheelchair needs 36 inches of clear width for forward movement and a 5-foot diameter clear space or a T-shaped space to make turns. A minimum distance of 48 inches clear of the door swing is needed between the two doors of an entry vestibule.

Possible solutions:

- ☐ Rearrange furnishings such as chairs and trash cans.
- ☐ Remove inner door if there is a vestibule with two doors.
- ☐ Move or remove obstructing partitions.

Question 20G. *Is there a 36-inch-wide path to all fixtures?* ☐ ☐

Possible solution: _____ Width

- ☐ Remove obstructions.

Stalls (ADAAG 1994: 4.17; 2010: 604)

YES NO

Question 21A. *Is the stall door operable with a closed fist, inside and out?* ☐ ☐

Possible solutions:

- ☐ Replace inaccessible knobs with lever or loop handles.
- ☐ Add lever extensions.

Question 21B. *Is there a wheelchair-accessible stall that has an area of at least 5 feet by 5 feet, clear of the door swing?* ☐ ☐

Width

Possible solutions:

- ☐ Move or remove partitions.
- ☐ Reverse the door swing if it is safe to do so.

Question 21C. *In the accessible stall, are there grab bars behind and on the side wall nearest to the toilet with a 1 1/2 inch grab clearance?* ☐ ☐

Clearance

Possible solution:

- ☐ Add grab bars.

Question 21D. Is the toilet seat 17 to 19 inches high? ☐ ☐

Height

Possible solution:

- ☐ Add a raised seat.

Lavatories (ADAAG 1994: 4.19, 4.24; 2010: 606, 308)

Question 22A. *Does one lavatory have a 30-inch-wide by 48-inch-deep clear space in the front?* ☐ ☐

Clearance

NOTE: A maximum of 19 inches of the required depth may be under the lavatory.

Possible solutions:

- ☐ Rearrange furnishings.
- ☐ Replace the lavatory.
- ☐ Remove or alter cabinetry to provide space underneath.
  Make sure hot pipes are covered.
- ☐ Move a partition or wall.

Question 22B. *Is the lavatory rim no higher than 34 inches?* ☐ ☐

Height

Possible solution:

- ☐ Adjust or replace the lavatory.

YES NO

Question 22C. *Are there at least 29 inches from the floor to the bottom of the lavatory apron (excluding pipes)?* ☐ ☐

Height

Possible solution:

☐ Adjust or replace the lavatory.

Question 22D. *Are any drain pipes or water lines under the lavatory exposed and uncovered?* ☐ ☐

NOTE: Exposed pipes or hot water lines can potentially cause burn injuries to people who use wheelchairs and must pull their chair under the lavatory apron to reach the faucet handles or soap dispensers.

Possible solution:

☐ Cover exposed pipes with pipe cover kit.

Question 22E. *Can the faucet be operated with one closed fist?* ☐ ☐

Possible solution:

☐ Replace faucet handles with paddle type.

Question 22F. *Are soap and other dispensers and hand dryers within reach ranges and usable with one closed fist?* ☐ ☐

Reach

NOTE: For reach range information, see "NOTE" on page D2.9, item 5A.

Possible solutions:

☐ Lower dispensers.

☐ Replace with or provide additional accessible dispensers.

Question 22G. *Is the mirror mounted with the bottom edge of the reflecting surface 40 inches high or lower?* ☐ ☐

Height

Possible solutions:

☐ Lower or tilt down the mirror.

☐ Add a larger mirror anywhere in the room.

Priority 4: Additional Access

Note that this priority is for items not required for basic access in the first three priorities. When amenities such as drinking fountains and public telephones are provided, they should also be accessible to people with disabilities.

Drinking Fountains (ADAAG 1994: 4.15; 2010: 305.3, 602)

Question 23A. *Is there at least one fountain with clear floor space of at least 30 by 48 inches in front?* ☐ ☐

Clearance

Possible solution:

☐ Clear more room by rearranging or removing furnishings.

YES NO

Question 23B. *Is there one fountain with its spout no higher than 36 inches from the ground, and another with a standard height spout (or a single "hi-lo" fountain)?* ☐ ☐

Height

Possible solutions:

☐ Provide cup dispensers for fountains with spouts that are too high.

☐ Provide an accessible water cooler.

Question 23C. *Are fountain controls mounted on the front or on the side near the front edge and operable with one closed fist?* ☐ ☐

Possible solution:

☐ Replace the controls.

Question 23D. *Is each water fountain cane-detectable (located within 27 inches off the floor or protruding less than 4 inches from the wall into the circulation path)?* ☐ ☐

Height/ Protrusion

Possible solution:

☐ Place a planter or other cane-detectable barrier on each side at floor level.

Telephones (ADAAG 1994: 4.31; 2010: 704)

Question 24A. *If pay or public use phones are provided, is there clear floor space of at least 30 by 48 inches in front of at least one?* ☐ ☐

Clearance

Possible solutions:

☐ Move furnishings.

☐ Replace the booth with open station.

Question 24B. *Is the highest operable part of the phone no higher than 48 inches (up to 54 inches if a side approach is possible)?* ☐ ☐

Height

Possible solution:

☐ Lower the telephone.

Question 24C. *Does the phone protrude no more than 4 inches into the circulation space?* ☐ ☐

Possible solution:

☐ Place a cane-detectable barrier on each side at floor level.

Protrusion

Question 24D. *Does the phone have push-button controls?* ☐ ☐

Possible solution:

☐ Contact the phone company to install push-buttons.

Question 24E. *Is the phone hearing-aid compatible?* ☐ ☐

Possible solution:

☐ Contact the phone company to replace the current phone with a hearing-aid compatible phone.

YES NO

Question 24F. *Is the phone adapted with volume control?* ☐ ☐

Possible solution:

☐ Contact the phone company to add volume control.

Question 24G. *Is the phone with volume control identified with appropriate signage?* ☐ ☐

Possible solution:

☐ Add signage.

Question 24H. *If there are four or more public phones in the building, is one of the phones equipped with a text telephone (TTY or TDD)?* ☐ ☐

Possible solutions:

☐ Install a text telephone.

☐ Have a portable text telephone available.

☐ Provide a shelf and outlet next to phone.

Question 24I. *Is the location of the text telephone identified by accessible signage bearing the International TDD Symbol?* ☐ ☐

Possible solution:

☐ Add signage.

Other Considerations (Priority 4: Additional Access)

The following elements are intended as supplemental to the above checklist and may not be legally required under the ADA.

Question 25A. *Are there policies in place regarding flash photography at meetings?* ☐ ☐

NOTE: Flash photography may trigger seizures and/or migraine headaches for those with photo-sensitivity. Policies should require the announcement of the intent to use a flash, providing an opportunity for the person who may be sensitive to leave the area.

Possible solution:

☐ Implement or modify policy.

Question 25B. *Are there policies in place about the use of non-scented products?* ☐ ☐

NOTE: Scented products such as candles, flowers or perfumes may cause reactions for those with chemical sensitivity.

Possible solution:

☐ Implement or modify policy.

Question 25C. *If the agency provides residential housing (temporary or permanent), are there an adequate number of accessible beds?* ☐ ☐

☐ # of Beds

NOTE: Bedrooms should be accessible to people with various types of disabilities, including individuals who are deaf. Use the following as a guide in determining the appropriate number of accessible bedrooms:

Total Number of Beds	Number of Accessible Beds
1 to 25	1
26 to 50	2
51 to 75	3
76 to 100	4
101 to 150	5
151 to 200	6

Possible solution:

☐ Reconfigure or modify beds and/or bedrooms.

	YES	NO
Question 25D. *If the agency provides residential housing (temporary or permanent), is at least one type of amenity (washer, dryer, etc.) in common areas accessible and located on an accessible route to any accessible sleeping room?*	☐	☐

Possible solutions:

☐ Reconfigure or modify existing amenities to meet ADA guidelines (appropriate reach ranges, path clearance, etc., as detailed throughout this survey.)

☐ Provide appropriate signage directing individuals to the accessible amenities.

Thank you for your efforts to increase the accessibility of your facility and your important work in serving people with disabilities.

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[1]Resources drawn from to compile this checklist include: (1) Adaptive Environments Center, Inc. and Barrier Free Environments, Inc., A checklist for existing facilities (for National Institute on Disability and Rehabilitation Research, revised 1995); (2) Metro-Milwaukee DART Initiative, Safe, accessible and welcoming environment survey; (3) Americans with Disabilities Act accessibility guidelines (ADAAG, 1991) and (4) WV S.A.F.E., Rape crisis center accessibility survey (Unpublished, 2007).

Readiness to Serve Victims with Disabilities: A Review of Intake Practices

Through the use of this review tool, service providers can (1) raise their understanding of the intake practices of both their own agency and partnering agencies that serve victims of sexual violence with disabilities; (2) consider the effectiveness of these practices in helping victims with disabilities to access the services that meet their needs; and (3) identify if/where barriers to responsive and accessible services exist and ways to eliminate any barriers.[1]

Key Points

- It is critical to assess whether your agency's intake policies make services available and welcoming to sexual violence victims with disabilities. Consider:
  - Does your agency have policies and standardized practices related to intake?
  - Are your agency's intake policies and practices "user friendly" for individuals with disabilities who have been sexually victimized?
  - Are your agency's intake policies and practices designed to identify and address the varied accessibility needs of sexual violence victims with disabilities?
- Intake practices can potentially create barriers in the accessibility of services. For example, barriers may emerge from agency intake policies and forms, eligibility requirements for services, or intake practices related to confidentiality. They may also be created by the physical inaccessibility of your facility to persons with disabilities.
- Agencies may be able to partner during their intake processes–particularly through utilizing one another's services–to better meet the needs of sexual violence victims with disabilities who are seeking their services.

D3. Readiness to Serve Victims with Disabilities: A Review of Intake Practices

Purpose

Agencies typically conduct intake interviews as part of their initial communications with individuals seeking their services. The intake process is an opportunity for these individuals to learn more about an agency's services, as well as to provide information to the agency about their circumstances and needs. Through this information, the individuals seeking services can guide the agency in determining how it can best assist them. Agencies striving to enhance services to sexual violence victims with disabilities must consider whether their intake practices make their services available and welcoming to this population.[2]

This review tool seeks to help service providers: (1) raise their understanding of the intake practices of both their own agency and partnering agencies that serve sexual violence victims with disabilities; (2) consider the effectiveness of these practices in helping victims with disabilities access the services that meet their needs; and (3) identify if/where barriers to responsive and accessible services exist and ways to eliminate any barriers. *Part 1: Core Knowledge* uses a worksheet format to allow participants to individually examine their agency's intake practices, identify potential barriers posed to victims with disabilities, and consider ways to overcome those barriers. *Part 2: Discussion* can be used to facilitate a discussion on this topic among providers within an agency and/or across agencies.

Objectives

Those completing this module will be able to:

- Discuss their agency's intake practices in the context of the level of inclusiveness for sexual violence victims with disabilities;
- Discuss how their agency's intake practices may potentially create service barriers for victims with disabilities;
- Discuss major similarities and differences among partnering agencies' intake practices and identify barriers that are common across agencies (*Part 2: Discussion* only); and
- Discuss what agencies can do, both separately and in partnership with one another, to enhance their intake practices to better meet the needs of sexual violence victims with disabilities seeking services.

Preparation

- Each participant should review their agency's (1) written policies related to intake practices; and (2) eligibility and program requirements to determine what barriers and/or limitations exist that could make a victim ineligible for services based on a disability.

Part 1: CORE KNOWLEDGE

What is the key issue related to agency intake practices with sexual violence victims with disabilities?[3]

The key issue is whether an agency's intake policies and practices make its services available and welcoming to victims of sexual violence with disabilities. The questions below can be used to assess whether the intake policies and practices of your agency are inclusive of this population. Answer "Yes" or "No" to each question and provide written comments. (Note that issues of accessibility and accommodations are covered in greater depth in the *Disabilities 101* modules, as well as the other *Tools to Increase Access* modules.)

FYI While an effort was made to reduce repetition in the *Agency Intake Practices Worksheet* below, some questions are adapted to ensure the inclusion of the different types of service providers and related issues.

AGENCY INTAKE PRACTICES WORKSHEET

1. **Does your agency have policies/standardized practices for client intake?**

__Y __N 1a. Does your agency have a written policy addressing intake practices that guide staff and volunteers in their initial communications with individuals seeking services?

__Y __N 1b. Does your agency have related written procedures or informal practices (that differ from or expand upon the above policies)?

It is useful for agencies to have standardized policies and practices related to the initial communications with individuals seeking their services. Agencies develop written procedures to help ensure the policies are implemented. Such standardization helps clarify for staff and volunteers what is expected of them in these interactions, guides their efforts to gather information from individuals, and allows them to determine what services are appropriate given an individual's self-defined needs.

2. **Are your agency's intake policies and procedures "user friendly" for individuals with disabilities who have been sexually victimized?** (See *Disabilities 101. Accommodating Persons with Disabilities.*) Consider, for example:[4]

__Y __ N 2a. Are the facilities where intake interviews are conducted and services are provided accessible to people with disabilities?

__Y __ N 2b. Are the furniture, lighting and noise levels in the facilities able to be adapted to accommodate people with sensory and/or physical disabilities?

__Y __ N 2c. Are off-site intake interviews feasible (e.g., when an individual has difficulty with mobility or is living in a residential facility)?

__Y __ N 2d. Are service animals permitted in the facilities to enable an individual with a disability to participate more fully in the services?

__Y __ N 2e. Is there flexibility in the interviewing format (e.g., interviews could be conducted by telephone if it is difficult for an individual to physically come into the facility; appointment times could be scheduled to accommodate a victim's needs—some may function better at certain times of the day or with shorter or longer meeting times)?

__Y __ N 2f. Are adaptive devices (e.g., TTYs for persons who are deaf) and materials in alternate formats (e.g., materials written in large print or Braille) available?

__Y __ N 2g. Are intake forms kept simple, making it easier for those with cognitive disabilities to understand and those with physical disabilities to complete?

__Y __ N 2h. Are all individuals seeking services offered a standardized list of accessible services and resources?

__Y __ N 2i. In addition to the above list, do individuals seeking services receive additional referrals as needs are identified?
NOTE: Don't assume, however, that individuals need a referral for a particular service based solely on their disability (e.g., a person with a mental illness does not automatically need a referral to a mental health counselor).

__Y __ N 2j. Are interpreter services readily accessible (e.g., a victim who is deaf may require an American Sign Language (ASL) interpreter)?

__Y __ N 2k. Do you tell individuals seeking services that you are a mandated reporter of suspected abuse or neglect against adults considered by the state to be incapacitated,[5] or of emergency situations where adults who are incapacitated are at imminent risk of serious harm (if you are)? This information should be provided early in your initial contact, so that individuals seeking services can make an informed decision about if and what they disclose. They should understand what/when you are required to report and that their disclosure could lead to an investigation by law enforcement and/or protective services. (See *Sexual Violence 101. Mandatory Reporting.*)

__Y __ N 2l. Do intake procedures include safety planning that is inclusive of the individual seeking services, regardless of ability/disability? (See *Sexual Violence 101. Safety Planning.*)

3. **Are your agency's intake practices designed to identify and address the varied accessibility needs of sexual violence victims with disabilities?**

__Y __N 3a. *For non-disability service providers:*[6] **Do your agency's intake policies and procedures include screening victims to see if they require an accommodation?** Consider:

__Y __N 3a.1. During intake, do you ask victims seeking services if they have a disability? If yes, when and how?

_____

_____

3a.2. If victims disclose that they have a disability, when/how do you ask about their need for accommodations? (In this context, an accommodation is a change, adaptation or modification to a policy, program or service that allows a person with a disability to participate fully in a program or take advantage of a service.[7]) (See *Disabilities 101. Accommodating Persons with Disabilities.*)

_____

_____

3a.3. Provide examples of procedures your agency has in place for meeting potential accommodation needs. (Examples should be in addition to those noted in Question #2 in this worksheet.)

_____

_____

3a.4. How are accommodations documented so that if other staff later work with the same victim, they know what accommodations are needed?

_____

_____

3a.5. Describe how agency staff and volunteers are trained in providing and accessing accommodations for persons with disabilities. Is the training adequate? What additional training, if any, would be useful?

_____

_____

__Y __N 3b. *For disability service providers:*[8] **Do your agency's intake practices include screening individuals for sexual victimization?** (See *Sexual Violence 101. Indicators of Sexual Violence.*)

__Y __N 3b.1. Do you ask individuals if they have experienced sexual violence? If yes, when and how.

_____

_____

__Y __ N 3b.2. Does your agency have a written procedure on what to do if someone discloses that they are or have been a victim of sexual violence? If yes, describe.

_____

_____

3b.3. Describe how your agency's staff is trained in conducting trauma-informed interviews and crisis intervention with sexual violence victims. What additional training, if any, would be useful? (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma* and *Sexual Violence 101. Crisis Intervention.*)

_____

_____

__Y __ N 3c. **During the intake process, do you refer victims with disabilities to resources in the community if and when your agency's services are not accessible or when the needs of a victim go beyond what your agency provides?** (See *Collaboration 101. Creating a Community Resource List.*)

__Y __ N 3c.1. Are you aware of the services available in your community for sexual violence victims with disabilities? If yes, identify.

_____

_____

__Y __ N 3c.2. Are there situations when you have to coordinate with an outside agency (rather than just make a referral) to ensure accessible/appropriate services for sexual violence victims with disabilities? If yes, describe.

_____

_____

__Y __ N 3c.3. Are there resources for sexual violence victims with disabilities that are needed but not available in the community (e.g., shelter accessible to persons with disabilities)? If yes, describe.

_____

_____

Identifying Barriers: In the process of answering the above questions, did you identify any intake practices that create potential barriers to effectively serving victims with disabilities?

_____

_____

_____

4. **Does your agency have barriers to services created by any policies, practices and forms?**

4a. **Policies,pactices and forms:**

4a.1. *For <u>non-disability</u> service providers:* What, if any, agency intake or accommodation practices might make a victim with a disability reluctant to seek your services?

_____

_____

4a.2. *For <u>disability</u> service providers:* What practices, if any, might make a sexual violence victim reluctant to seek your services or to disclose sexual victimization?

_____

_____

4b. **Eligibility for services:** Does your agency have any policies or procedures that define who is eligible for services that may inadvertently make someone ineligible for services based on a disability? Think about what program participant "requirements" (written or unwritten) are in place that may disqualify a person with a disability because they cannot fulfill a requirement due to their disability. (For example, requiring that all residents in a group-living facility rotate all chores may exclude someone with a physical disability from staying there. Or requiring a driver's license, rather than a government-issued identification, to verify identity would make a person who is blind ineligible for services.)

_____

_____

4c. **If your facilities are not physically accessible to persons with disabilities,** what does your agency already do or what can it do to ensure equal access to services? For example, can staff go to another location to conduct the intake if the person cannot come to you? Do your intake forms require signatures? If so, what do you do if the person does not have the ability to write? Are there parts of your intake procedures that require the person seeking your assistance to read? If so, what do you do if the person is not able to read the required forms or resource materials due to a cognitive or visual disability?

_____

_____

__Y __N 4d. **Confidentiality:** Do your intake practices maintain a victim's privacy, keeping confidentiality a priority? If no, explain.

_____

_____

4e. Unintended consequences:

4e.1. *For <u>non-disability</u> service providers:* What are potential unintended consequences for a sexual violence victim who seeks your services, but services are not accessible?

_____

_____

4e.2. For *disability* service providers: What are potential unintended consequences if someone discloses during intake that they are a victim of sexual violence, but your staff is not trained to respond?

_____

_____

5. **In what ways can your agency address the barriers identified above, both on its own as well as in collaboration with partnering agencies?**

_____

_____

_____

_____

_____

_____

_____

_____

Part 2: DISCUSSION

Projected Time for Discussion
1.75 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their collaborative work. The discussion could be incorporated into forums such as agency staff meetings, orientations and continuing education programs, as well as multi-agency meetings or trainings. Anticipated discussion outcomes include an increased understanding of barriers and challenges experienced at intake by victims with disabilities; the identification of ways to enhance accessible and victim-centered services through responsive agency policies, procedures and resources; and an increased knowledge of partnering agencies' intake guidelines and practices.

Refer to the learning objectives at the beginning of this module for specific outcomes.

Preparation

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator.
- Decide who will be involved in the discussion—participants from one agency, with the focus on agency intake practices, or from multiple agencies, with the focus on building awareness of other agencies' intake practices and assisting one another in overcoming barriers to service accessibility for sexual violence victims with disabilities.

- Assign a note taker for the meeting. If participants break into small groups, a note taker for each of those conversations should also be identified.
- Participants should individually review and complete *Part 1: Core Knowledge* in this module before the discussion. They should bring enough copies of their agencies' written policies on intake practices to share with their partners.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, blank attendance sheet, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify/review the discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2. **Ask a representative from each agency to briefly share their agency's intake materials.** They may also briefly describe their agency's activities that relate to responding to sexual violence victims with disabilities. *(10 minutes)*
3. **Ask the participants to collectively review their answers and comments about intake practices from the *Agency Intake Practices Worksheet*** (Questions #1 through #3) from *Part 1: Core Knowledge* of this module, either as a large group or in small groups. The broad issue is whether each agency's intake policies and practices are inclusive of the needs of sexual violence victims with disabilities. To help organize the conversation, for each question area below, **first discuss the strengths of each agency's intake policies and practices and then identify any areas of concern or potential barriers.** *(30 minutes)*

   a. Does your agency have policies/standardized practices related to intake?

   b. Are your agency's intake policies and practices "user friendly" for individuals with disabilities who have been sexually victimized?

   c. Are your agency's intake policies and practices designed to identify and address the varied accessibility needs of victims with disabilities?

4. In addition to any concerns/barriers identified above that need to be addressed in order to effectively serve victims with disabilities, **ask participants to consider any potential barriers to accessibility in the following areas** (See Question #4 on the *Agency Intake Practices Worksheet*): *(20 minutes)*

- Agency intake policies, practices and forms;
- Eligibility for agency services/programs or funding requirements;

- Physical accessibility of your facility for persons with disabilities; and
- Intake practices related to confidentiality.

Discuss possible unintended consequences for victims faced with barriers to accessibility.

5. **Facilitate a large group discussion on how partnering agencies can help each other address accessibility issues during their intake processes.** (See Question #5 on the *Agency Intake Practices Worksheet.)* (*25 minutes*)

   a. What are major similarities and differences in agencies' intake practices? Why are they different?

   b. What inclusive practices and/or barriers to accessible services stand out or are consistent across agencies? Are there sections of each others' policies, practices and forms that should be incorporated into other agencies' policies, practices and forms to ensure equal access?

   c. In what ways can agencies partner to overcome barriers during intake to better meet the needs of victims with disabilities seeking services? In particular, consider how to utilize one another's resources. For example, a disability organization may be able to assist a sexual assault provider in determining how to help victims in finding resources to obtain accessible transportation to an appointment. A sexual assault provider may be able to assist a disability provider in identifying support groups for victims of sexual assault. Each partnering agency has resources they can contribute.

   d. Discuss those resources and eligibility requirements, where applicable, including any limitations of each.

6. **Closing:** Ask each participant to write down how the information gained from this module discussion will:

- Change the way they interact with individual clients;
- Change the way they partner with other agencies to assist clients; and
- Promote change in the policies, practices or training programs of their agency.

Then facilitate a large group discussion on this topic. (*10 minutes*)

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]Day One: The Sexual Assault and Trauma Resource Center, Rhode Island Coalition Against Domestic Violence and PAL: An Advocacy Organization for Families and People with Disabilities, Is your agency prepared to ACT? *Conversation modules to explore the intersection of violence and disability* (Advocacy Collaboration Training Initiative, 2004), 19.

[3]Information in Part 1. Core Knowledge was drawn in part from Wisconsin Coalition Against Sexual Assault, *Widening the circle: Sexual assault/abuse and people with disabilities and the elderly* (Madison, WI: 1998), 98-111.

[4]Drawn partially from *Day One* et al., 19. Originally adapted from D. Akers, *Balancing Power: Creating a Crisis Center Accessible to People with Disabilities* (Austin, TX: Morgan Printing, 2005).

[5]An adult who is considered "incapacitated," according to West Virginia law (WVC§9-6-9), is someone who cannot independently conduct daily life sustaining activities due to a physical, mental or other infirmity.

[6]Those service providers who do not serve persons with disabilities as their primary mission. For example, most advocates at rape crisis centers serve victims and their significant others, whether or not they have a disability.

[7]Adapted from *Day One* et al., 13. Originally drawn from www.hud.gov/offices/fheo/disabilities. For more information on public accommodations, also see *The ADA: Questions and answers, public accommodations* (U.S. Equal Employment Opportunity Commission), http://www.eeoc.gov/facts/adaqa2.html. The online documents referenced in this module were available at the links provided at the time the module was written. It is suggested that you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[8]Those service providers whose agency's primary mission is serving persons with disabilities.

Developing a Transition Plan

This module can aid service providers in developing an agency transition plan for increasing access to services for sexual violence victims with disabilities.[1] It focuses on transition planning for *programmatic and policy* accessibility changes rather than physical/structural changes. If deemed necessary, structural changes can be added to the plan later in the process.

Key Points

- An agency's plan to move from inaccessible services to accessible services for victims with disabilities is considered, for the purposes of this module, a transition plan. Such a plan acknowledges barriers to accessing services and identifies how accessibility can be increased within a specified time period. It establishes priorities among needed actions.
- A transition planning team should include representation from the major divisions and programs of the organization and personnel who have the skills and experience necessary to carry out the planning and implement tasks. Also consider adding community partners to the team, as they can add a broader perspective on the accessibility of an agency's services. They can sometimes be helpful in providing technical assistance, identifying community resources and providing cross-training.
- Your transition plan should identify the following:[2] barriers your agency is addressing; action steps necessary to eliminate those barriers; who is responsible for making or coordinating the changes; what resources are needed to make the changes; what administrative approval is needed to make the changes; established timelines for implementation of the changes; how the plan will be regularly monitored to measure the progress and the implementation of the action steps; and an evaluation process to determine if the implemented changes have improved access for persons with disabilities. The attached *Transition Planning Worksheet* can assist agencies in considering each of these factors.

D4. Developing a Transition Plan

Purpose

Once an agency identifies barriers that prevent sexual violence victims with disabilities from accessing its services, it can develop a plan to create equal access for these individuals. This plan to move from inaccessible services to accessible services over a period of time is considered, for our purposes, a transition plan. This module can aid service providers in developing an agency transition plan for increasing access to services for sexual violence victims with disabilities.

Note that this module focuses on transition planning for *programmatic and policy* accessibility changes. It does not address planning for physical accessibility. If deemed necessary, structural changes can be added to the plan later in the process.[3] (See *Tools to Increase Access. Physical Accessibility Checklist for Existing Facilities.*)

Objectives

Those who complete this module will be able to:

- Establish a transition planning team;
- Participate in creating a transition plan to increase service accessibility for sexual violence victims with disabilities; and
- Assist in implementing a transition plan.

Preparation

- As a prerequisite to this module, community agencies that serve sexual violence victims and persons with disabilities should individually conduct a self-assessment of their general programmatic policies and procedures. (See *Tools to Increase Access. Programmatic and Policy Accessibility Checklist.*) The purpose of this assessment is to determine the extent of programmatic accessibility of an agency's services for persons with disabilities.
- Review the findings of the above self-assessment of your agency—most likely the results will highlight policy and programmatic barriers for victims with disabilities. The agency will want to address these barriers in its transition plan.

Part 1: CORE KNOWLEDGE

What is a transition plan?[4]

A transition plan acknowledges barriers to accessing services and identifies how accessibility can be increased within a specified time period. It establishes priorities among needed actions. When a transition plan for improved access to services is developed through a collaborative effort within an agency and with input from outside agencies and consumers, it can lead to the sharing of information and resources, creative problem solving and increased accountability to carry out the plan.

Planning sometimes can seem more like talking than taking action, but careful consideration and agreement among staff and advisors on a course of action is a key to successful collaboration. (See *Collaboration 101. Examining Your Collaboration.*) A solid plan for achieving desired outcomes helps ensure the efficiency and effectiveness of the effort. Common questions about the process that are helpful to discuss with those involved in planning include:[5]

- How does transition planning address our ongoing needs?
- Who in the organization should create the plan?
- Who outside of the organization should be involved in the planning process?
- How comprehensive should the plan be and what length of time should it cover?
- Can the plan be modified or changed if new issues arise?
- What if the plan doesn't work?

How does a transition plan address your ongoing needs?

If an agency has made a commitment to serving sexual violence victims with disabilities, that commitment should be reflected in its vision and mission statements and strategic plan. A transition plan is only necessary if there are policies or barriers that are impeding access to services. It provides the roadmap to help an agency address those barriers.

Who should be on a transition planning team?

Seek representation from the major divisions and programs within the organization. Include personnel who have the skills and experience necessary to carry out planning and implement tasks. The leadership of the organization must demonstrate a commitment to this process in order for the plan to be successful in creating sustainable organizational change. One of the first steps in demonstrating this commitment is the appointment of a coordinator to lead and coordinate the planning and implementation process. The coordinator's role is to facilitate the teamwork necessary to achieve the tasks outlined in the plan. When choosing this person, designate someone who has authority within the organization. In addition to authority, this person should have knowledge of the agency, the programs provided and the community. A new employee or one with little authority may reduce the potential for success because they may not have the knowledge to effectively manage the process or to obtain the information necessary to develop creative solutions.

FYI An agency's designated accessibility coordinator would be a key team member. Two online resources that provide helpful information for this position include:

- http://askjan.org/naadac/, the National Association of ADA coordinators, providing resources and support to accessibility coordinators; and
- http://arts.endow.gov/resources/accessibility/Planning/Step3.pdf, which offers resources and job descriptions for accessibility coordinators.

Note that for disability service agencies, their coordinator will need to focus on making service delivery more inclusive of clients with disabilities who have experienced sexual violence.

Other staff to consider for team membership can include:

- Program managers/developers;
- Financial manager;
- Outreach or public relations staff;
- Human resource personnel;
- Facility managers; and
- Direct care staff.

When selecting team members, also look for what could be called "opinion leaders." These staff members influence decisions, not because of their positions or titles, but more from the esteem in which they are held by their co-workers.[6] Keep in mind that direct care staff, rather than agency administrators/managers, may be more knowledgeable about how policies and procedures are implemented on a day-to-day basis. It is essential that staff members support the purpose and values behind the changes that are planned and have confidence that the new policies and procedures are workable and effective in achieving the desired results. Having front line staff involved from the beginning of the process helps to create buy-in.

Support from agency leadership is necessary if policies and practices will need to be changed. The involvement of the agency director or her/his designee, as well as representation from the board of directors, can lend leadership and ensure the agency's commitment to providing accessible services to victims.

TOOLS to INCREASE ACCESS

Community partners are key to successful transition planning. Adding community partners to the team will add a broader perspective on the accessibility of your agency's services. Partners that influence the services your agency provides can be helpful in providing technical assistance, identifying community resources and providing cross-training. Some suggested partners include:

- Sexual assault service providers;
- Disability service providers;
- Mental health service providers;
- Law enforcement agencies; and
- Adult Protective Services (APS).

Include the perspectives of persons with disabilities. Engage them during the transition planning process to add their insight regarding accessibility needs. Persons with disabilities could be invited to share their input during a transition team meeting or to participate in a separate focus group discussion on this topic. Or their input could be sought through surveying (written surveys, telephone surveys, face-to-face interviews, etc.). Subsequently, results of the focus group discussion, surveys and/or interviews could be compiled and shared with the transition team. Incorporating the voices of persons with disabilities into the transition plan can add credibility and accountability to the process.[7]

Who can provide technical support to help with planning?

To ensure that your transition plan includes the appropriate steps to increase the accessibility of your services to persons with disabilities, it is recommended that your agency seek qualified technical support and guidance. Find out if a local disability agency has the capacity to provide this support to other agencies. You can also contact the regional Disability and Business Technical Assistance Center (DBTAC)-Mid Atlantic ADA Center at 301-217-0124 (voice/TTY) or adainfo@transcen.org or go to www.adainfo.org for recommendations of resources to provide this support. DBTAC-Mid Atlantic also sponsors the West Virginia ADA Coalition, which has members who may be available to offer this type of assistance. Contact the West Virginia ADA Coalition at 800-946-9471 (voice/TTY), WVADACoalition@msn.com or go to www.wvadacoalition.org/.

What should be in your transition plan?

It is important that your plan addresses the barriers to services that your self-assessment identified. Your overall goal is to ensure that persons with disabilities feel welcome at your agency and that you have the resources and support needed to provide equivalent services to all who need them. "Success in the implementation of permanent changes depends, to a great extent, on the quality of the planning process itself and on the degree to which compliance becomes integrated into ongoing operations."[8] It is also important that the plan is flexible so it can be modified as other issues and priorities are identified. It is suggested that you keep records of your planning process.

All plans should include the following:[9]

- What specific barriers you are addressing;
- Action steps necessary to eliminate the barriers;
- Who is responsible for making or coordinating the changes;
- What resources are needed to make the changes;

- What administrative approval is needed to make the changes;
- Established timelines for the implementation of the changes;
- How the plan will be regularly monitored to measure the progress and the implementation of the action steps; and
- An evaluation process to determine if the changes implemented have improved access for persons with disabilities.

A *Transition Planning Worksheet* and *Example Transition Plans* (for both a disability service agency and rape crisis center) can be found at the end of this module.

It is helpful for agencies to identify priorities among issues to be addressed and actions to be taken so that achieving the plan does not become too overwhelming, unmanageable or unfocused. Rather than doing everything at once, planning can incrementally eliminate barriers. To plan for incremental change, take into consideration which issues would be easy to address, which would be more difficult to address and which would have the greatest impact on improving access for people with disabilities. Also recognize to what extent staff members are available to coordinate specific actions and in what time frame they can complete the tasks.

You've got a plan, now what?

The development of an accessibility transition plan is as much a process as it is a final destination. In many instances, the process will become just as significant as the final product. Circulate and present the plan at all levels of the agency and among all programs, detailing the immediate and long range accessibility goals. Once the plan has been reviewed, the planning committee should analyze any feedback and incorporate appropriate suggestions into the plan.

Prior to implementing the plan, determine if any additional staff training is needed or if new resources need to be developed. Critically consider any unintended consequences of implementing new policies or practices. For example, if a disability service provider adds an intake screening question regarding sexual victimization, the agency needs to have the intake workers prepared for victimization disclosures. The planning committee for that agency would need to ensure that an appropriate training program is in place and referral lists created prior to changing the intake form.

Once implemented, the process should be periodically evaluated for effectiveness and efficiency: Is the plan working? Are we achieving or exceeding our stated goals? Are all of the key stakeholders involved and moving toward common goals? What is missing? How can we make this work better? An evaluation process is necessary to determine if the changes are making an impact, both externally for consumers and internally for staff.[10]

All plans should include a process for modification as well as a specified period for assessing the impact of new policies and practices. If a 10 (or 30 or 60) day assessment indicates that a new practice is having a detrimental impact on accessibility or services, it should immediately be stopped.

Part 2: DISCUSSION

Projected Time for Discussion
Allow 2.25 hours for the initial meeting.

Developing a transition plan is a process and will involve a series of meetings. This module is designed to provide the framework for initiating the discussion and planning process.

Purpose and Outcomes

This discussion is designed to help participants from a specific agency apply the information presented in *Part 1: Core Knowledge* of this module to improve access to services for sexual violence victims with disabilities. It could be incorporated into forums such as agency staff meetings and meetings of an agency's board of directors. (NOTE: If the meeting is part of a multi-agency gathering, break into agency-specific small groups for the *Suggested Activities and Questions* below.) Anticipated discussion outcomes include increased understanding of the barriers and challenges experienced by victims with disabilities in accessing the current services; identification of ways to increase accessibility through responsive agency policies, procedures and resources; identification of ways to ensure that the safety needs of sexual violence victims are adequately addressed throughout the service delivery system; and the development of a plan to create changes in the current service delivery system.

Specific desired outcomes for this module are identified in the learning objectives on page D4.2.

Planning

- Select a facilitator. The facilitator should be experienced in transition/strategic planning for agencies. Determine whether the facilitator is strictly facilitating the discussion at the meeting or serving as chairperson of a transition planning committee.
- Select a note taker.
- Before the discussion, participants and the facilitator should review *Part 1: Core Knowledge*, the attached worksheet and example transition plans, as well as the summarized findings from their agency's self-assessment of general programmatic policies and procedures. (See *Tools to Increase Access. Programmatic and Policy Accessibility Checklist.*) A copy of the findings should be available during the meeting, as well as a blank copy of the assessment tool.
- Provide a flip chart and three colors of markers (e.g., blue, red and green). Identify and secure any other needed meeting supplies and materials—for example, name badges, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time.

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality.

2. **Ask one or more agency representatives to summarize the self-assessment findings.** *(10 minutes)*
3. As a large group, **ask the participants to discuss the following questions and complete the tasks:** *(1.5 hours)*

a. Describe the accessibility challenges and their experiences in trying to serve sexual violence victims with disabilities within the agency. Are there specific policies or practices (or an absence of policies, practices and/or resources) that are creating those challenges? **List the challenges on a flipchart.**

b. Collectively review the findings from the agency's self assessment. **List the identified barriers on a flipchart.** How does this list mirror the previous list?

c. **Prioritize a list of needed changes.** Then, using different colored markers, indicate which items would be easy to change (underline with blue marker); which would be more difficult to change (red marker); and which would have the greatest impact on improving access for people with disabilities (green marker).

4. **Review the list and consider what would be needed to make the changes. Determine if anyone else needs to be involved in the process.**

5. Once the representative planning team is brought together (as described in *Part 1: Core Knowledge* and based on who was identified above as essential to the process), which may take at least one additional meeting, use the template at the end of this module to **chart the challenges identified above and develop a transition plan for your agency**.

6. **Closing.** Ask participants to write down how the information gained from this module discussion will potentially impact the way services are provided in the agency and to identify their own next step in the process of initiating that change. Then facilitate a large group discussion on this topic. *(15 minutes)*

Transition Planning Worksheet

Goal: To increase access to services for sexual violence victims with disabilities.

Agency: _____

Barriers and Action Steps to Address the Problem	Time Frame for Completion	Responsible Party & Resources Needed	Desired Outcomes (O) & Evaluation Method to Measure Progress (EM)

Example Transition Plan: Serving Sexual Violence Victims

Goal: To increase the accessibility and responsiveness of services for sexual violence victims with disabilities.

Agency: *A disability service agency*

Barriers and Action Steps to Address the Problem	Time Frame for Completion	Responsible Party & Resources Needed	Desired Outcomes (O) & Evaluation Method to Measure Progress (EM)
Barrier 1: Staff does not have an adequate resource list of services for sexual violence victims with disabilities. **Action 1:** Partner with the local rape crisis center (rcc)/state sexual assault victim advocacy coalition to identify resources for sexual violence victims and learn how persons with disabilities can access these services. With their input, create a more comprehensive resource list. Also, establish methods of referral to these and other providers to facilitate timely client assistance in accessing services for sexual violence victims.	Month 3	Executive director (ED) makes initial contact with relevant local/state agencies. _____ follows up to obtain input and develop list and referral procedures.	O: Established relationships to facilitate timely client assistance. Resource list developed and implemented. EM: Informal feedback from staff, clients and other agencies after 3 months on the usefulness of the resource list and the number of referrals.
Barrier 2: Staff is not trained on general responses to sexual violence victims or how to assist clients who have been sexually victimized in determining what services could be helpful and how to access these services. **Action 2:** Seek the help of the rcc/coalition to train staff on: general responses to sexual violence victims; assisting clients in determining what services could be helpful and how to access these services; using the resource list; and coordinating referrals to appropriate services.	Month 3	ED/_____ seeks the help of other relevant agency representatives to plan and conduct the training.	O: Training delivered. EM: Feedback from staff (class evaluation and 6 month follow-up) on the usefulness of the training.
Barrier 3: Materials are not available in alternate formats for clients who have been sexually victimized (on rcc services, information about applicable laws, what to do if you are sexually victimized, reporting to law enforcement and other agencies, forensic evidence collection, counseling and support groups, legal assistance, victim compensation, etc.). **Action 3:** Convert resource list (above) into alternate formats that can be offered to clients. Also, reach out to agencies that provide the above services to consider how to collaborate to convert their materials into alternate formats. Offer technical assistance as possible.	Months 3-6 for resource list conversion. Years 1–2 for outreach.	ED/_____ coordinate conversion of resource list into alternate formats. Ongoing collaboration with relevant local/state agencies to promote conversion of their materials into alternative formats.	O: Resource list/array of other agencies' materials in alternate formats. EM: Staff/client feedback (through staff meetings) on usefulness within 6 months of implementation.

Example Transition Plan: Service Accommodations

Goal: To increase access to services for sexual violence victims with disabilities.
Agency: A sexual assault crisis center

Barriers and Action Steps to Address the Problem	Time Frame for Completion	Responsible Party & Resources Needed	Desired Outcomes (O) & Evaluation Method to Measure Progress (EM)
Barrier 1: RCC staff does not have an adequate resource list of available accommodation options. **Action 1:** Partner with local/state disability service providers to identify resources for accommodations for persons with disabilities and learn how to access the accommodations. With their input, create a more comprehensive resource list. Also, establish methods of referral to these and other providers to facilitate timely victim assistance in accessing accommodations.	Month 2	Executive director (ED) makes initial contact with local/state disability service providers. _____ follows up to obtain input and develop the list and referral procedures.	*O:* Established relationships to facilitate timely victim assistance. Resource list is developed and implemented. *EM:* Informal feedback from staff, clients and other agencies after 1 and 3 months on the usefulness of the resource list and the number of referrals.
Barrier 2: Currently do not ask victims during initial agency contact/intake whether they require accommodations to access agency services. However, do close intake by asking clients if they have any other concerns that need to be addressed. **Action 2:** With the input of local/state disability service providers, adjust intake procedures and forms so they more directly ask clients about their needs for accommodations.	Month 4	_____ makes adjustments to written procedures and forms. ED informs staff of changes in conjunction with the training activity below. ED plans a follow-up consumer satisfaction survey to implement in months 5 and 7.	*O:* Procedures adjusted and forms implemented. *EM:* Feedback (survey) from staff/clients after 1 month on usefulness of changes.
Barrier 3: RCC staff is not trained to assist clients in determining what accommodations they need and how to access accommodations. **Action 3:** Seek the help of local/state disability service agencies to train rcc staff on: assisting clients in determining what accommodations they need and how to access accommodations; using the resource list; and coordinating referrals to appropriate services.	Month 4	ED/_____ seeks the help of other agency representatives to plan and conduct a training.	*O:* Training delivered. *EM:* Feedback (class evaluation and 3 month follow-up) from staff and victims on usefulness.
Barrier 4: Intake forms/agency materials are generally not available in alternate formats. **Action 4:** With help of local/state disability service agencies, create a prioritized list of needs for alternate formats for agency's printed materials (e.g., if there is a nearby school for the blind, accommodations for blind/vision loss should be a priority), and craft a plan to incrementally develop materials in alternate formats over a 2-year period.	Month 6 (or next agency board of directors mtg.)	ED and board of directors. Local/state disability service agencies sought to provide technical assistance to convert material to alternate formats.	*O:* An array of agency materials available in alternate formats that meet victims' needs. *EM:* Staff/victim feedback (through staff meetings) within 6 months of implementation.

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]C. Hoog, *Increasing agency accessibility for people with disabilities* (Abused Deaf Women's Advocacy Services, Washington State Coalition Against Violence, 2004), through http://www.wscadv.org/resourcesPublications.cfm. This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]A few related resources include: Adaptive Environments Center, Inc. and Barrier Free Environment, Inc., *A checklist for existing facilities* (for the National Institute on Disability and Rehabilitation Research, revised 1995), http://www.ada.gov/racheck.pdf; ADA *accessibility guidelines homepage*, through the Architectural and Transportation Barriers Compliance Board at http://www.access-board.gov/; and a U.S. Department of Justice ADA information line, at 800-514-0301 (voice) and 800-514-0383 (TTY), that provides information and technical assistance (also see the ADA Homepage at www.ada.gov).

[4]Adapted in part from Adaptive Environments Center, Inc., Title II action guide, for the National Institute on Disability and Rehabilitation Research (Horsham, PA: LRP Publications, 1993).

[5]*Adapted from Office for Victims of Crime, Promising Practices in Serving Crime Victims with Disabilities: Making a Plan: Think Strategically, Act Accordingly,* Online Guides from OVC (Washington, D.C.: Department of Justice, Office of Justice Programs, 2008), through http://www.ojp.usdoj.gov/ovc.

[6]Adapted from Adaptive Environments Center, Inc., *Title II action guide.*

[7]Adapted from Adaptive Environments Center, Inc., *Title II action guide.*

[8]Adapted from Adaptive Environments Center, Inc., *Title II action guide.*

[9]Hoog.

[10]National Center on Accessibility, http://www.ncaonline.org.