

2010

Supporting Sexual Assault Survivors With Disabilities

*A chapter update to the “Support
for Survivors” Training Manual*



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Preface

This publication is a recent chapter update to the Support for Survivors Training Manual, which was first published in 2001 by the California Coalition Against Sexual Assault (CALCASA). The Support for Survivors manual was developed as a comprehensive training tool for staff and volunteers working with sexual assault and/or rape survivors. The training manual contains several chapters written by numerous experts from the sexual and gender violence fields. Collectively, these experts generously imparted their wisdom, knowledge and experience by writing specific chapters in the training manual. As a result, hundreds of staff and volunteers at local rape crisis centers have benefited from the manual's information and have positively changed the life of a sexual assault and/or rape survivor.

But as Marybeth Carter, CALCASA's Executive Director in 2001, noted in the manual's introduction, it is CALCASA's goal to ensure the Support for Survivors Training Manual remains "a fluid, living document that continues to evolve." As the 10th anniversary of the manual's original publication approaches, CALCASA has begun updating various chapters of the manual to acknowledge the many changes that have occurred in the field and in our society since 2001. Updating these chapters will also ensure crisis counselors and advocates receive the most current and accurate information. CALCASA will make these new chapter updates available online through its website at **www.calcasa.org**.

CALCASA is deeply grateful to the many people who contributed to the original Support for Survivors Training Manual and championed its creation, as well as to those who are now contributing their time, knowledge and expertise to update the manual's various chapters. CALCASA also wishes to thank the California Emergency Management Agency (Cal EMA) for their leadership, guidance and financial support for this chapter revision process and for their continued support of California rape crisis centers to provide critical services to sexual assault and rape survivors.

With gratitude,

Sandra Henriquez
Executive Director
CALCASA

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CALCASA also wishes to honor and remember **Dr. Tanis Doe** for writing the original chapter in the 2001 Support for Survivors Training Manual on how to support survivors with disabilities, some portions of which are included in this update. Dr. Doe passed away suddenly in 2004 at her home in Victoria, British Columbia. As a Métis (Ojibway/French Canadian) Deaf woman with other disabilities who was active in disability, queer, and feminist movements internationally, she was widely respected as a disability rights advocate and as an educator. Dr. Doe was a professor of sociology and disability studies at the University of Victoria and, in 2003, became a Fulbright Scholar in Bioethics at the University of Washington. Dr. Doe was an innovative and influential researcher who brought together diverse Deaf, disability, and people of color communities in research; conducted pioneering research on violence against people with disabilities; and developed national and international peer training models for Deaf and disabled people. Her writing, training and research in areas such as gender equity, assistive technology, education, employment, parenting, bioethics, violence and sexual abuse, independent living, community organizing, and disability rights have created a legacy of work that will inform our community for generations.

Introduction

“Susan lived in a group home with three other women diagnosed with cognitive or intellectual disabilities. She was sexually assaulted while working in the stock room of a local department store. Two years later, Susan disclosed the assault at a personal safety and sexuality class. Around the same time, Susan began having trouble falling asleep and was irritable and jumpy most of the time. She was also having outbursts of anger at work for no apparent reason and was at risk of losing her job. Susan’s case manager called the local rape crisis center to arrange counseling. The crisis center staff had never counseled a person with Susan’s disabilities and believed they did not have the necessary training or qualifications. However, they were willing to try to serve her. Susan started her counseling sessions several months later. Although her counselor tried, she never really felt comfortable with Susan. The counselor believed Susan was not understanding or benefitting from the sessions. Susan never felt like she was really welcomed and after the first month, she began missing sessions and soon dropped out. No one followed up with Susan.”

The movement toward ending violence against children, youth and adults with disabilities has made progress over the past decade. Advocates have greater awareness about the service gaps and barriers to accessible sexual assault services for people with a range of disabilities (i.e., physical, cognitive/intellectual, sensory, and mental health disorders). Sexual assault survivors with disabilities are speaking out and giving voice to their experiences of violence and many are connecting with advocates and allies who believe and will bear witness to their accounts — stories of sexual violence that were traditionally explained away as accidents or misunderstandings, symptoms of a disability, gaps in communication, delusions or hallucinations, or simply efforts to get family members or staff in trouble.

Survivors of sexual violence with disabilities live in every community and can benefit from the full range of sexual assault services.¹ Yet, many abuse survivors with disabilities in our communities do not know about services or how to get help when they are sexually assaulted. Still others live in relative isolation or in segregated settings with their abusive partners, family members or paid care providers. Survivors with disabilities in these settings may find limited, if any, opportunities to make an outcry or seek help. Unfortunately, in some communities, people with disabilities are screened out from rape crisis services or feel unwelcomed when they do show up.

It is our hope and belief that rape crisis center advocates do want to provide services to all survivors, including people with disabilities, but may run into barriers. In some cases, center staff may believe they lack critical information, or they may have little confidence that they can ethically or competently provide sexual assault services to a population they have little experience in serving.

When sexual assault agencies recruit and engage volunteers and staff with a range of disabilities, disability expertise can be built internal to the agency. An agency can also make modifications to their buildings and the manner in which they welcome survivors

¹ Including hotline supports, counseling, education, hospital advocacy/accompaniment, information about SANEs and legal advocacy.

who have disabilities. Although some modifications are easy and inexpensive, others may require significant changes in policies and programming, culture and attitudes.

Most of us, on careful review of our policies and practices, could expand our capacities for providing sexual assault services to a broader range of survivors with disabilities. People who have disabilities tell us that the most important aspect about accessibility is generally attitude and that an agency sets a warm tone and welcoming presence to sexual assault survivors with disabilities. When an agency's leadership and staff members embrace and truly believe that being accessible and available to victims of sexual violence with disabilities is the way to do business, policies and practices and necessary modifications that support that belief will follow. We make these modifications not just because it is the law, but because it is the right thing to do. Sexual assault services to survivors with disabilities is not an extension of our work, it is our work.

Similarities and Differences

People with disabilities experience similar forms of overt and covert sexual assault and abuse as people without disabilities (e.g., rape, incest, forced, unwanted or disguised touching, exposure to or making pornography, sexual harassment, sexual trafficking, unwanted sexual jokes or innuendoes, and any other unwanted sexual contact or activity). For people with disabilities, sexual abuse can also take the form of lack of respect for privacy and unwanted exposure during personal care routines like bathing, dressing and toileting; forced abortion, sterilization or pregnancy; and exploitation.

Many rape or sexual assault victims feel put on trial and victimized when they participate in prosecution of their abuser. For abuse survivors with disabilities, the trial may further include questioning about whether or not the perpetrator knew about the person's disability and whether or not the survivor was capable of giving consent to the sexual act because of her/his disability. In addition, individuals who have disabilities may also experience sexual assault and abuse by volunteer or professional care providers - those very people charged with providing assistance with daily life activities. Examples include assistance with transportation, bathing, dressing, toileting, medical procedures, medical testing, physical therapy, job coaching, managing medication, money management, cooking, cleaning and shopping.

People with disabilities may wait longer than people without disabilities to make an outcry and they may have experienced sexual abuse by multiple perpetrators and across multiple years. In addition, sexual assault survivors with disabilities share many of the same general effects of sexual assault and abuse as all survivors. When they are not supported, they may experience problems with substance abuse, eating disorders, depression and other trauma symptoms. Interviews with sexual assault and abuse survivors with disabilities indicate that they, too, experience difficulties with trust, safety and relationships and they, too, may become socially withdrawn and lose previously-gained abilities that support independent living. Abuse survivors with disabilities may also encounter additional problems with self-protection, alienation, dissociation and overly compliant and acquiescent behavior.

Unique Risk Factors

If a person with a cognitive disability is abused at an early age and no one intervenes, abuse can continue into adulthood and is likely to involve a number of perpetrators. Frequently, people with developmental disabilities are trained to be absolutely compliant to the demands of people in authority. This training in submissive behaviors is often achieved through behavioral and classroom management and social skills development programming for people with a range of cognitive, intellectual and developmental disabilities. Early on, people with disabilities learn that compliance with various behavioral goals can be the pathway to privileges, recreational opportunities or advances to less restrictive living environments.

Unfortunately, the power structure inherent in this kind of compliance training risks mimicking the unequal kinds of power structures found in abusive relationships. Many people with disabilities have been socialized to be compliant and may still be living in settings where they are not allowed to say “no” to authority figures. In 1991, Crossmaker² pointed out that the power and control dynamics of institutionalization are practically identical to those that characterize sexual assault and abuse.

There are a number of other factors that increase the risks for abuse for people with disabilities. For example, people may be desensitized to touch if they experience regular help with personal care like bathing and dressing or if they experience routine physical evaluations and treatments that involve touching. Paired with compliance training, people with disabilities are at increased risks for not knowing whether or not they can say no to painful or confusing touches related to sexual abuse. For example, how might a person socialized to comply and desensitized to touch respond to the bus driver who calls himself a friend and then crosses the boundary and demands a kiss or sexually fondles a passenger who has limited social power and does not know she can say “no” to an inappropriate request or touch.

Other factors that increase the likelihood that an individual with a disability will be perceived as an easy target for abuse are listed next:

- People with disabilities may rely on others to meet basic needs, and the use of multiple caregivers increases opportunities for sexual abuse.
- Social isolation results in limited exposure and lack of information about personal relationships and opportunity to disclose if sexual assault/abuse occurs.
- People with cognitive disabilities may have a strong desire for friendship and connection and may be easily tricked or bribed to perform sexual acts if promised friendship or money.
- Some people with disabilities have had limited opportunity to interact and develop social skills in integrated settings.
- Lack of social credibility for people with disabilities who report or disclose sexual violence.

² Crossmaker, M. (1991). Behind locked doors—Institutional sexual abuse. *Sexuality and Disability*, 9, 201-218.

- Sexual assault survivors that are Deaf, have speech difficulties or a limited vocabulary may need communication devices or interpreters to assist with disclosing or reporting abuse.
- People who have developmental disabilities may lack information about sexuality, sexual abuse and personal safety strategies. This information may not have been taught in special education classes or institutions. Parents and care providers may not be providing this information in efforts to protect their loved ones or clients.
- Generally, society is not comfortable with people with disabilities having sexual desires, feelings and needs. Those same members of society are also likely to deny that people with disabilities are sexual or can be sexually abused or victimized.
- The large number of people with disabilities in institutional settings and the physical and emotional contact of caregivers results in power imbalances between the staff and residents. This imbalance of power increases risks for sexual assault, abuse and exploitation.
- Survivors with mental health disabilities may experience harmful or dismissive psychiatric and medical responses when they report a sexual assault.

Incidence of Violence Against People with Disabilities

The most convincing reason for accessible rape crisis services is that people with disabilities are sexually assaulted and abused at staggering rates across our country. If we want to serve our entire community, then our outreach and services will include and be accessible to people with physical, cognitive or intellectual, sensory, mental health or multiple disabilities.

In one of the earliest and most cited studies of sexual violence against people with disabilities, activists and feminists affiliated with the Seattle Rape Relief Center³ collected data across a 19 month period (May 1977 to December 1979) and identified more than 300 sexual abuse cases experienced by women and children with physical or cognitive disabilities in their city (also cited in Lonsdale).⁴ By extrapolating statewide estimates, the center concluded that about 30,000 cases of sexual abuse against people with disabilities were occurring annually in the state of Washington alone.⁵ In a study of 166 abuse cases through the University of Alberta's Sexual Abuse and Disability Project, Sobsey & Doe⁶ reported that 79 percent of those studied reported being sexually abused more than once. Furthermore, treatment services were not adequate or not even offered in 73 percent of those cases.

In 2009, the Justice Department's Bureau of Justice Statistics, Office of Justice Programs released a *First National Study on Crime Against Persons with Disabilities*⁷

³ Elman, A. (2005), January). *Confronting the Sexual Abuse of Women with Disabilities*. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence.

⁴ Lonsdale, S. (1990). *Woman and disability: The experience of physical disability among women*. London: Macmillan.

⁵ Fine, M., & Asch, A. (1985). Disabled women: Sexism without the pedestal. In M. Deegan & N. Brooks (Eds.), *Women and Disability: The double handicap* (pp.6-22). New York: Transaction Books.

⁶ Sobsey, D. & Doe, T. (1991). Patterns of sexual abuse and assault. *Journal of Sexuality and Disability*, 9 (3), 243-259.

⁷ NCVS (2009) Rand, M., and Harrell, E. (2007). *Crime Against People with Disabilities, 2007* (NCJ 227814). The report can be found at [http://HYPERLINK"http://www.ojp.usdoj.gov/bjs/abstract/capd07.htm"www.ojp.usdoj.gov/bjs/abstract/capd07.htm](http://HYPERLINK)

and noted that people with disabilities between the ages of 12-19 and 35-49 reported experiencing violence at nearly twice the rates of people without disabilities in those same age groups. Males with disabilities in this study also experienced higher rates of violence than males without disabilities. People with cognitive disabilities in this study had rates of nonfatal crimes greater than people with any other kinds of disabilities.

Despite these reported high rates of violence against people with disabilities, in a national survey conducted by SafePlace in 2004, only 9 percent of rape crisis and domestic violence agencies reported having a line item in their annual budget for accessibility needs or accommodations.⁸ According to survey respondents, the abuse survivors with disabilities most likely to be receiving victim services were survivors with mental health disabilities. This finding is consistent with the Nosek and Hughes⁹ 1992–2002 *National Study of Violence Against Women with Disabilities*. Further, survivors with disabilities least likely to have received victim services according to respondents in either of these national surveys were people with visual or hearing related disabilities.

In a sample of 144 abuse survivors with disabilities receiving sexual assault counseling services at SafePlace (in Austin, Texas) between 1996 and 2007, 64 percent reported multiple perpetrators of sexual assault and abuse. Among this same group of sexual assault survivors, 76 percent experienced multiple incidences of sexual abuse or assault at different times in their lives and 28 percent experienced both sexual and domestic violence, including abuse by a care provider.¹⁰

Defining Disability

We are likely to become aware of people with disabilities in public areas like schools, places of employment, shopping areas and any other place where people tend to gather. And although it's helpful to have accurate terminology when referring to a disability, many people with disabilities have individual preferences for describing and sharing their understanding of the conditions that impact their lives. Further, most people, including people with disabilities, would prefer to be known as a person rather than as a label. We recommend referring to a person's disability only if necessary and according to person-first language. This means that we will refer to the person first and then to their type of disability. For example, we would say — a person with a physical disability instead of the physically disabled. An all the more respectful way to refer to an individual with a disability is by using their first and or last name.

As stated earlier, it can be helpful to have some understanding of the various types of disabilities that abuse survivors may have. Although not comprehensive, a common understanding of disability includes the following categories:

⁸ Schwartz, M., Abramson, W., and Kamper (2004). A national survey on the accessibility of domestic violence and sexual assault services to women with disabilities [unpublished data]. SafePlace: Austin, Texas.

⁹ Nosek, M.A. & Hughes, R.B. (1992-2002). *National Study: Violence Against Women with Disabilities*. Retrieved July, 2010 from the Center for Research on Women with Disabilities at the Department of Physical Medicine and Rehabilitation of Baylor College of Medicine: www.bcm.edu/crowd/index.cfm?pmid=1409.

¹⁰ Cameron, L.A. (2009). Unpublished raw data. SafePlace: Austin, Texas.

- *Physical disabilities* can affect mobility/walking and moving various parts of the body freely as well as muscles and bones and human body systems that include digestive, respiratory, circulatory, cardiovascular, endocrine and nervous systems.
- *Cognitive or intellectual disabilities* affect thinking, learning, reasoning, processing of new information, memory and concentration.
- *Sensory disabilities* affect touch, taste, smell, hearing and sight.
- *Mental illness* refers to mental health disorders whose symptoms affect thoughts, moods, behaviors and the impact on everyday functioning.

A disability can be apparent at birth or identified before the age of 22. Others are acquired by accident, as a result of violence, through illness or aging. We also recognize that 1) two people having the same disability may be impacted in very different ways, and 2) there is often a great deal of overlap among different kinds of disabilities.

Our culture has historically considered people with disabilities as broken or abnormal in some way. People with disabilities have often been relegated to institutions, special education classrooms, day programs, sheltered work programs and habilitation programs: outside of the typical experiences in life that most people take for granted.

We also live in a society that values people who are strong and attractive and who are both physically and mentally fit. The term for this bias is *abelism* — a set of practices and beliefs that assigns inferior value or worth to people who have developmental, emotional, physical or psychiatric disabilities (www.gobeyondwords.org/Abelism.html). The concept is so ingrained in our cultural experiences that we are not likely to even notice it - unless or until we have a disability, pay close attention to people with disabilities or know someone well who has a disability. Author Kathie Snow reminds us that by 2001, nearly one in five Americans had a disability and that as many of us age we are likely to acquire some kind of disability. Disability is similar to gender and ethnicity, Snow states; it is simply one of the natural characteristics of being human.¹¹

The American's with Disability Act (ADA)

According to the American's with Disabilities Act¹², a person with a disability has a "physical or mental impairment" that substantially limits one or more major life activities -or- they have a record of having such an impairment -or- they the person is regarded as having such an impairment." The Americans with Disabilities Act (ADA) is a civil rights law passed in 1990 which guarantees that people with disabilities have access the very same benefits, goods and services (e.g., employment, public accommodations, transportation, government services and telecommunications) as people without disabilities.

¹¹ Snow, K. (2003, November). The case against special needs. 1 – 2 *Disability in Natural Free Press E-newsletter*. Retrieved from www.disabilityisnatural.com.

¹² Reference ADA here

All rape crisis centers are legally required to provide services to people with disabilities. It is also a violation of the ADA to deny services because of a child or any other member of a person with a disabilities network of family, friends and personal care attendants.

In 2008, the ADA was amended to ensure it is interpreted as originally intended. Among the changes was an expanded definition of what “major life activities” can be: “substantially limited to qualify as a disability. Major life activities now includes both 1) general life activities (e.g., caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working), and 2) major bodily function (e.g., immune system, normal cell growth, digestive, bowels, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions).”

Further, an individual is considered to have a disability even if the impairment is treatable with medications, can be addressed with the help of assistive technology (e.g., power wheel chairs or prosthetic devices), happens only intermittently (e.g., seizure disorders, some forms of mental illness) or if the condition is in remission (e.g., multiple sclerosis or cancer) and if the conditions would be substantially limiting when active. In these cases, rape crisis centers cannot legally refuse services based on the person’s disability.¹³

Screening Practices

Welcoming survivors of sexual assault may result in adapting and modifying the crisis center’s existing policies and protocols. When considering the kinds of changes you might make, educate staff that the agency will be reviewing and potentially revising those policies, protocols and rules that may exclude people with disabilities. Consider developing a process for gathering staff input at each stage of the review and revision process and then seek staff feedback as changes are piloted and implemented.

A rape crisis centers’ intake is one of the first opportunities to welcome a survivor with disabilities. So it is essential to ask questions about disability or disability related needs only after a person’s eligibility for services has been determined and communicated to the abuse survivor. It is also essential that if any questions about disability related needs are to be asked - the question(s) must be asked of all clients. This avoids even the perception that a disability was used to determine eligibility or to screen someone out. The civil rights law is clear: a disability cannot be used to determine an abuse survivor’s eligibility for services.

In addition, it is not appropriate to probe or ask for more details or seek additional information if a sexual assault survivor reveals a disability. It is a violation of the Americans with Disabilities Act to insist on documentation or medical information to confirm a person’s disability status. If one client is required to bring a medical history then all client must be required to do the same.

¹³ Adapted from U.S. Department of Justice, 2009 and B. East, Advocacy, Inc., personal communication, June 15, 2010).

Use any question about disability only as a guide to make sure that sexual assault survivors with disabilities receive appropriate and relevant services. Perhaps a new client is not familiar with the center's services and they may not even realize an accommodation or modification is necessary until after they begin receiving services. However, staff may: 1) want to obtain information to help improve services for all clients, and 2) alert survivors seeking services that the agency wants to provide any needed modifications or accommodations. If an agency decides they do want to develop intake questions about disability related needs consider developing questions that:

- Help identify barriers to using sexual assault services
- Support identifying survivor strengths
- Identify a survivor's understanding of how a disability affects the violence
- Assists in determining available resources because of a disability¹⁴
- Addresses issues related to the persons support system (e.g., will family members align with a care provider who is the survivor's perpetrator?)
- Maintains the survivor's privacy, confidentiality, and autonomy

Caregiver Abuse

A caregiver is anyone who provides assistance with the kinds of things that a person would do for themselves if they did not have a disability. The assistant might be a paid personal assistant or a parent, spouse, friend, romantic partner or even an unpaid friend, volunteer or neighbor. The assistance that is provided can range from occasional help with cooking, cleaning or running errands to ongoing daily assistance with daily personal tasks like bathing, dressing, toileting, transferring in and out of bed, taking medication and managing finances.

Caregiver abuse occurs when someone providing assistance begins to exert her/his will over the will of the person with a disability. The abuse can include all of the forms of sexual and domestic violence and abuse, including maltreatment, neglect and exploitation. It is the abuse of power in a relationship where the person with a disability should have the right to absolute safety wherever she or he lives.

Caregiver abuse may start out with verbal or sexual harassment, unwanted displays of pornography or exhibitionism. These behaviors begin to wear down the person's emotional strength. Over time, the abuse can escalate to sexual touching without consent, and manipulation, tricking or forcing into sexual activity as well as forcible rape and sexual assault. Caregiver sexual abuse can also occur in the form of forced sterilization or forced abortion.

Responding to survivors of violence who have disabilities

Although there is no comprehensive or universal to-do lists when working with sexual assault survivors with disabilities, there are some general suggestions that can be helpful. Still, there is a great deal of individual differences in how a disability manifests itself, how a person understands and regards their disability, and the how they prefer

¹⁴ See Washington State Coalition Against Domestic Violence Model Protocol on Screening Practices. Hoog, C. (2003b). Download at www.wscadv.org/projects/disability_protocols.htm.

interacting with other people regarding a disability. Marcie Davis of the New Mexico Coalition of Sexual Assault Programs, Inc. refers to her practical approach for interacting with people with disabilities: "Talk with people as individuals and don't try to know everything about their disability, because they are not there to see you about their disability, they are there to see you because of a violent act that happened to them" (June 2, 2004).

Disability etiquette and sensitivity

- Make no assumptions based on appearance or communication. A person's disability may be more or less severe than it appears.
- Talk directly to the abuse survivor and not the care provider, family members, case manager, social worker or interpreter.
- Involve parents, caregivers, spouses, partners, service providers and other family members only if a survivor gives full consent.
- Person may be guarded by family members or service providers and support staff may be walking a fine line between the wishes of a client, and their guardian, family members, and agency policies and practices.
- Take special notice of any person who answers for and does not ever leave the survivor. This person may be working with or actually be the abuser.
- People with cognitive disabilities and/or mental illness may take longer to process feelings and information. Take additional time if needed for intake, advocacy and counseling services.
- Abuse survivors may have extremely limited knowledge about sexual activity, their own bodies and they may have been instructed not to talk about either.
- Go slowly and take your cues from the person.
- Support the survivor in making decisions and choices as you would any other survivor.
- Keep in mind that living a *normal* life does not make a person with a disability extraordinary or heroic or special.

Confidentiality

- The sexual assault survivor is the client, but, often, family members, care providers and staff from various disability agencies expect that you will automatically give them all information about the circumstances of the survivor. Check with your state protective services system to determine the reporting mandate in your area.
- All standard rules of confidentiality apply when serving a person with a disability - with the exception of states which have mandatory reporting laws regarding abuse, neglect or exploitation of adults with disabilities. Extend the same respect for client confidentiality for a person with a disability as for any other survivor. Staff must get signed releases before talking about the case with family members, service providers, or others.
- If the person has a legal guardian you may be required by law to provide the information to that guardian. However, guardianship can be limited and not apply to all aspects of a person's life so check it out.

- If a client with a disability has signed a release of information, go over the form with the survivor and make sure they clearly understand what information the staff will share and to whom and under what circumstances.

Accessible Sexual Assault Nurse Exam (SANE)

- Work with Sexual Assault Nurse Examiners (SANEs) and other members of the Sexual Assault Response Team (SART) to make sure needs of sexual assault survivors with disabilities are being incorporated into their service efforts.
- Invite people with disabilities and disability advocacy organizations to be part of the SART.
- Educate members of local hospital SARTs on working with people with disabilities.
- Ensure exam tables are accessible to sexual assault survivors with physical disabilities.
- If need be, repeat information when working with survivors with cognitive or intellectual disabilities in a different way if you are not sure the person understood by using more simplified language.

Working with sign language interpreters

- Ask the survivor to pick the most important circumstances for an interpreter (support group, counseling, intake and assessment, etc.)
- Ask in advance, if the person has any preferences for interpreters. However, there is no guarantee that a preferred interpreter will be available when needed.
- Sexual assault survivor has the right to not accept a particular interpreter. They may know the interpreter personally or a preference for a particular skills level or gender.
- Do not use children to interpret. They may withhold information and the conversation may be traumatic. Asking children to interpret conversations about sexual assault could be considered child abuse.
- Keep in mind that if children or providers or family members can see the individual or interpreter sign, they can listen or eavesdrop.
- Communicate directly with the survivor and not the interpreter. Sit across from the survivor and maintain eye contact with the survivor.

Survivors who are deaf

- Be aware that some people who are Deaf will not have the vocabulary for rape — they may use terminology such as “sex with me.” This can lead to misinterpretation even with an interpreter present.
- Many people who are Deaf do not consider themselves as having a disability but instead, are deeply connected to a tightly knit and highly networked Deaf culture. Use of the capital letter D in Deaf refers to the cultural pride.
- If sign language interpreters are not readily available, consider having communication boards in the reception or intake areas. Though not ideal you can also write or type messages back and forth temporarily. If you are writing keep messages short and concrete and keep sentences to one issue rather than asking several questions at a time.

- The syntax is quite different between ASL and English where English is often the second language for people who are Deaf.
- Let the person who is Deaf choose the method for communicating with a hearing person.
- Ensure an interpreter is present when there is a substantial conversation and when it's important to obtain accurate information to and from a client.
- Should a survivor see staff and the interpreter joking and chatting with each other, that survivor may believe the interpreter has information about them and is sharing it or that the interpreter has aligned with staff instead of being neutral.

Survivors who are blind

- Speak directly to and facing the person rather than through another person without a disability. Use your normal tone of voice and volume.
- Offer any assistance directly. Do not assume help is needed.
- To shake hands, greet the person verbally first and wait for them to put their hand out.
- Identify anyone who enters or leaves a room or begins conversations with a person who is blind, including yourself.
- If person asks for assistance, contact verbally first and then use the back of your hand to contact the back of the persons hand. This helps orient the individual to your body position. Typically an individual will hold a personal guide's right arm just above the elbow and then will walk about a half a step behind the guide.
- If person uses a cane for orientation you can simply give directions to parts of the room or for example a chair. Explain important visual information like room arrangements or when approaching stairs or entrances and exits.
- If a person who is blind uses a service animal, the care and supervision of that animal is the responsibility of her or his owner - not the rape crisis center staff.
- Do not touch or approach or interact with a dog guide without first asking the dog's owner. It is a working animal.
- Service animals must be allowed to stay with the person who has a disability and in all areas of the facility where clients normally go.
- A person with a service animal may not be segregated from other clients or agency activities. You may however, exclude any animal whose behavior constitutes a direct threat to the health and safety of others. For example, a service animal that shows vicious behavior toward other clients can be excluded. However, assumptions may not be made about a particular animal based on past experiences with other animals.
- Make agency materials available in alternate formats like Braille, computer disk/DVD, e-mail, rich text, and large print for abuse survivors who are blind or have low vision. Use at least 14 point Arial font for universal accessibility on all correspondence.
- Most people who are blind do not want to touch your face to get to know you.

Safety planning (unique considerations)

- Explore resources with the person that may be available through disability service agencies (state health and human service programs).
- If the perpetrator is an abuse survivor's personal assistant, explore who else can be available to provide care temporarily (family, friends, faith community members) and long term.
- If a person has a cognitive or intellectual disability or difficulty with memory, consider using pictures, calendars, diagrams, and role plays to practice and discuss critical issues including a safety plan.
- If the person decides they must leave their home either temporarily or permanently gather the following critical information — medical ID information including Medicaid, Medicare, written documentation of disability, social security awards, benefits and payee information, documents that prove identity, all disability related service eligibility documents, prescriptions and medical orders.
- If person uses a service animal, ensure food and water will be available for the animal.

It has been our experience that rape crisis center staff often has genuine concerns that they will do or say something that is offensive to people with disabilities without knowing it. In our field, one of the best ways to dispel these kinds of fears is for people with disabilities to become an integral part of our workforce as staff, board members, volunteers, clients and allies. Staff may also need space and time to work through their own feelings and reactions about working with a new group of survivors without shame or censure.

Staff, volunteers and board members can help plan how the agency can be more accessible to a wider range of people with disabilities. A helpful place to start is to conduct a self-assessment. We can begin determining our own attitudinal accessibility by answering some of the following questions individually or in groups:

- Who are we already serving well? Who do we want to serve better?
- What would we need to change? Whose help and support will we need?
- Who else do we need at the table? Who can we learn from?
- Are we willing to seek out information and supportive others to gain the necessary skills and confidence to provide services to all sexual abuse survivors?

Engaging local disability advocacy/provider groups

To increase accessibility to sexual assault survivors with disabilities, develop working relationships with local disability advocacy and service organizations. Some communities already have committees of disability service agencies who come together to discuss individual cases, policies, community needs and resources. These groups function to better coordinate community services. Rape crisis and blended domestic violence/rape crisis agencies may not always be represented. The possibilities for more engagement with other service systems are made difficult when crisis agencies are not able to join in these community discussions about coordination of social services.

Some communities have addressed the needs for stronger working relationships and connections by developing agreements or Memorandums of Understanding (MOU) between the rape crisis center and disability advocacy or service agencies. These agreements can outline the resources, services and even possible staff or office space that will be shared in the service of clients with disabilities. These formal agreements can also be used to define guidelines for cross referrals and cross training of each others agency staff.

Begin to build relationships by contacting local disability services agencies and inquiring about involvement in local community task forces or coalitions that are focused on disability related topics/issues. Express your interest in learning more about providing services to people with disabilities, the history of the organization and the disability rights movement. Conduct an interview, go for coffee, talk on the telephone; whatever the strategy, get to know the people working in the organization. Invite disability service organizations to provide disability awareness training at for your agency staff and volunteers. Offer to provide cross training for the disability organization's staff about safety, sexual assault and how to make referrals for sexual assault services.

Additional ways to engage and build stronger working relationships with disability advocacy and service provider groups in your community include:

- Enlist qualified people with disabilities to lead and provide input on agency policies, programming changes or service delivery to sexual assault survivors with disabilities.
- Recruit and train volunteers and staff with disabilities to build internal expertise.
- Recruit and train people with disabilities to volunteer as board members and to provide technical assistance.
- Promote and take part in cross trainings that engage and help build relationships among stakeholders (e.g., victim and disability service professionals, law enforcement, criminal justice workers).
- Invite people with disabilities and staff from disability service agencies to be part of the local SART.
- Establish and coordinate a community task force on issues related to sexual assault and people with disabilities. Include people from victim service and disability fields, people with disabilities and family members.
- Partner to conduct a community needs assessment to determine needs related to sexual violence and people with disabilities.

Information in this article is based on training experiences, SafePlace materials, literature review, interviews and dialogue with sexual abuse survivors with disabilities, advocates, allies, and professionals in disability and victim service fields. Greater detail is found in the following SafePlace resources/curriculum: "Stop the Violence, Break the Silence" (2006), "Responding to Violent Crimes Against Persons with Disabilities" (2005), "Balancing the Power" (2007) and "Beyond Labels" (2008). This article is offered as resource for rape crisis and blended rape crisis/domestic violence centers as they seek to increase access to survivors of sexual assault and violence with disabilities.