



CROSS TRAINING WORKBOOK:

VIOLENCE AGAINST

WOMEN WITH DISABILITIES

Partner Organizations:

**Wisconsin Coalition for Advocacy
Wisconsin Coalition Against Domestic Violence
Wisconsin Coalition Against Sexual Assault
IndependenceFirst**

April 2004

CROSS TRAINING WORKBOOK: WORKING TOGETHER TO END VIOLENCE AGAINST WOMEN WITH DISABILITIES IN WISCONSIN

This *Cross Training Workbook* was developed by a work group of the Violence Against Women with Disabilities Project of Wisconsin. Special recognition is given to members of this group who gave willingly of their time and expertise, and provided the original information and authorship for this *Workbook*: Dianne Greenley, Wisconsin Coalition for Advocacy (WCA); Tiffany Lodholz, Wisconsin Coalition Against Sexual Assault; Leslie Myers, IndependenceFirst; Lauri Nichols, ASTOP, Inc.; Deb Spangler, Wisconsin Coalition Against Domestic Violence; Mark Sweet, WCA; and, Christine White, Legal Advocacy for People with Developmental Disabilities, Access to Independence.

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- Wisconsin Coalition Against Domestic Violence (WCADV);
- Wisconsin Coalition Against Sexual Assault (WCASA); and
- IndependenceFirst.

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INTRODUCTION

The Wisconsin Coalition for Advocacy (WCA) was one of 18 organizations awarded a two-year Education and Technical Assistance Grant by the Office of Violence Against Women, Office of Justice Programs, U.S. Department of Justice. These federal grants focusing on violence against women with disabilities were made available through the passage of the Violence Against Women Act (VAWA) of 2000. While WCA serves as the lead organization, this Project's mission and activities are founded on collaboration. The Project partner organizations include Wisconsin Coalition Against Domestic Violence (WCADV), Wisconsin Coalition Against Sexual Assault (WCASA), and *IndependenceFirst*.

Wisconsin has made a promising start in responding effectively to women with disabilities who experience sexual assault, domestic violence, or stalking. This Project's mission is to coordinate and elevate the efforts of the partners and others to forge a unified approach to address the needs of all women who live with disabilities and experience violence. These partnerships include domestic violence agencies, sexual assault agencies, disability services and advocacy organizations, human services, adult protective services, elder abuse services, and women with disabilities. **The Project's goal is to:**

- **permanently elevate collaboration among state and local sexual assault (SA), domestic violence (DV), and disability programs in Wisconsin; and**
- **enhance the capacity of local SA, DV, and disability programs to respond to violence against women with disabilities.**

Most of us have been taught to pay more attention to disability than to ability; and to compare and judge differences in personal presentation (e.g., appearance, communication, movement, etc.) rather than just notice them. We make assumptions, even decisions, about a woman before we have actually learned anything significant about her. We have been taught that there are experts trained to work with "people like that." It might even seem that the most responsible choice is to refer some women to other agencies instead of getting to know them ourselves. Regardless of a person's abilities, there are many ways in which the services and assistance (often referred to as "supports") that are provided could be enhanced to ensure that all women who have experienced violence and who need and want services can receive them.

The same concept applies to issues of violence. Those of us from the disability advocacy and services systems also make assumptions about a woman victim before we actually have learned anything about her experience. We too have been taught that there are experts, such as domestic violence and sexual assault staff, who are trained to work with rape victims, battered women, and women who experience other forms of violence. Regardless of a woman's abilities or her experiences of violence, there are many ways in which the services and supports that are provided could be enhanced to ensure that all women with disabilities who have experienced violence and who need and want services can receive them.

We want to help you feel more comfortable with women who present themselves in ways that are new and possibly challenging for you. We want you to trust that you do not have to be an

expert to interact with a woman whose abilities and experiences are different, even significantly different, than your own. We want to assure you that not every person or every organization has to have all of the know-how.

Even after attending training and reading resource materials, there is still significant value in active collaboration with other people. Our approach will be to focus first on what is generally known about women who experience domestic violence, sexual assault, and/or stalking and then to address some of the unique experiences of women who live with disabilities. Ultimately, we hope:

- that those of you who support women with disabilities will learn more about domestic violence, sexual assault, and stalking;
- that you will become more alert to signs that something potentially dangerous or unwelcome might be happening;
- that those of you who support women who have experienced domestic violence, sexual assault, and stalking will feel more confident and able to extend your valuable support and services to women with more varied abilities in a variety of both direct and indirect ways; and
- that you will become more familiar with working together to ensure an effective response for women with disabilities who experience violence.

How To Use This Workbook

This is a workbook. It is not a textbook on domestic violence, sexual assault, stalking, or women with disabilities. We do not believe that anyone has to be an expert on everything. This Project is based on the knowledge that there is a great deal of experience, expertise, and desire to learn more and do better for women who might be, or who already have been, subjected to violence or abuse. We also are aware that many of you do not know enough about one another. As a result, gaps exist for some women wanting help and support around issues of violence and disabilities. One of our primary goals is to help you find one another and encourage more collaborative efforts.

We are inviting you to figure out strategies and form alliances that will work best where you live. Some of you live and work in areas that have a lot of resources and some live where resources are limited. Some of you have nearby communities to tap and some of you live in areas that are more sparse and distant from one another. We did not try to anticipate every situation you might encounter. We are not offering quick fixes. **Instead, we encourage you to individualize a process that you can and will use, wherever you are, on your own and as part of an organization, to address the needs of each person who might need your help.**

While you read this, we hope that you will actively think about your daily interactions with women who have experienced violence, whether they have or do not have disabilities. There are issues and questions raised throughout these materials. When you see questions, we encourage

you to pause long enough to consider them on your own and with others. Spend some time with someone else who cares as you do about these issues. Ask others what they think, what they need, what they have experienced, what they want to learn, who they know who might be an additional resource.

At the very least, we hope that this *Workbook* will help you ask good questions about this very important subject. **While trying to strengthen alliances among those concerned about domestic violence, sexual assault, stalking and women with disabilities, we hope that among the questions each of you will be asking yourselves and others as you do your work are:**

“Who is this woman and what does she want and need?”

“What else might help her achieve her goals?” and

“Who can I work with to do better with this woman?”

These are questions we all might ask, regardless of what “system” or field we work in on a day-to-day basis. There will be sections that some readers might already be familiar with and feel they can “skip” (e.g., sexual assault service providers might choose to skip the section that defines sexual assault). To strengthen these alliances and address issues of domestic violence, sexual assault, stalking and women with disabilities, we designed this *Workbook* to be multi-disciplinary in its approach.

IMPORTANT NOTE

It is important to state from the outset that there are individuals who do not consider themselves to be “individuals with disabilities” and who do not identify with this designation. However, for the purposes of the Violence Against Women with Disabilities in Wisconsin Project funded by the Office on Violence Against Women, U.S. Department of Justice Disabilities Education Grant Program, “individuals with disabilities” refers to all individuals covered under the definition contained in the Americans with Disabilities Act.

“Disability” means, with respect to an individual, (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment. (42 U.S.C. § 12102(2)).

Similarly, this Project is funded to focus on women with disabilities who experience violence. Male victims/survivors, especially those with disabilities, do experience domestic violence, sexual assault or abuse, and stalking. However, for the purposes of this grant and Project, the focus is centered on adult women with disabilities.

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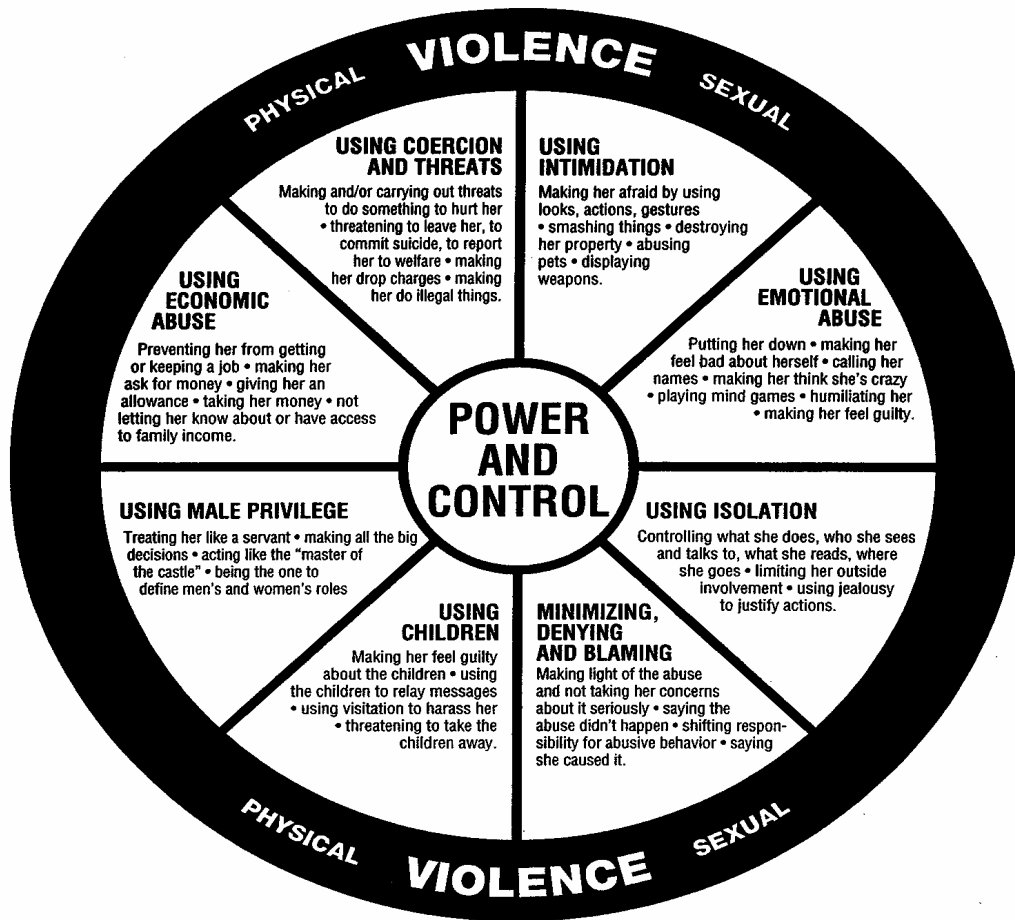
WHAT ARE DOMESTIC VIOLENCE, SEXUAL ASSAULT AND STALKING?

What Is Domestic Violence?

Domestic violence or abuse is a pattern of aggressive and intimidating behaviors that abusers use to control their intimate partners through fear and intimidation, often including the threat or use of violence. It is described as “domestic” violence in response to this movement’s history of women telling other women about the violence they experienced in their own homes. (*See Appendix F for the history of the domestic violence movement.*) Abuse can be verbal, emotional, physical, sexual and/or economic and is based on power and control. The abuser believes he is entitled to control his partner; control how she thinks, feels and behaves. People often think of domestic violence only in terms of the cuts and bruises that we can see. In reality, it is a pattern of assaultive and coercive behaviors designed to control another person. (*See a visual depiction of these tactics on the next page.*)

- Physical abuse: the use of physical force with or without objects that can result in bodily injury, physical pain, or impairment.
- Sexual abuse or assault: non-consensual sexual contact of any kind. This includes sexual contact with a person who is incapable of giving consent (Wis. Stat. Section 940.225).
- Psychological abuse: the infliction of anguish, pain, or distress through verbal or nonverbal acts.
- Emotional abuse: includes threats, name calling, intimidation, degrading or contemptuous behavior, withholding communication, or yelling.
- Destruction of property: includes vandalism of the home, car or other personal assets.
- Threats or acts of abuse against children, significant others or family pets: for the purpose of manipulating or punishing the victim.
- Isolation: includes controlling the victim’s time, activities and contact with others.
- Financial exploitation is described as the illegal or improper use of funds, property, or assets.
- Neglect: the refusal or failure to fulfill any part of a person’s obligations or duties.
- Abandonment: desertion of a person by an individual who has assumed or accepted responsibility for providing care or who has physical custody of that person.
- Homicide-Suicide is described as killing a person and then killing oneself.

Power and Control Wheel



DOMESTIC ABUSE INTERVENTION PROJECT
202 East Superior Street
Duluth, Minnesota 55802
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This power and control wheel was developed by the Domestic Violence Training Project in Duluth, Minnesota to illustrate the variety of tactics used by abusers. The hub of the wheel is power and control, which is widely understood as the primary explanation for abuse. The outer area of the wheel shows physical and sexual abuse. Inside the spokes of the wheel are a variety of additional tactics that abusers use to gain and maintain control in an abusive relationship. Abusers switch tactics often. A victim might try to change her behavior in order to prevent further abuse from occurring. Unfortunately, the abuse will most likely continue regardless of the victim's attempts to prevent it.

Think about . . .

You probably noticed that these descriptions are broad. Select a couple of the above headings and make a list of actions that you think should be included under each. For example, what actions would you include as “sexual assault” or “psychological abuse?” Then, see Appendix A for more extended descriptions and examples.

Who Are Perpetrators Of Domestic Violence?

An abuser can be from any ethnic, social, educational, economical, or spiritual background, as well as be of any age, gender, sexual orientation or ability. There is no typical abuser, although there are tactics commonly used by abusers. Perpetrators of domestic violence believe they are entitled to use whatever means necessary, including physical violence, to get what they want. The abuse originates from a belief system that makes it acceptable to exert control over another person. To avoid being held accountable, abusers might blame the people they harm or otherwise try to rationalize or justify their actions. If they are caught and held accountable, abusers can lose their freedom, reputation, or access to the person they victimized, even if that means losing their home and finances.

Most often, a perpetrator of domestic abuse has been described as an “intimate partner” such as a spouse, life partner, or significant other. More recently, the list of possible abusers has been expanded. Other family members, including children, grandchildren, nieces, nephews as well as caregivers or others with whom the victim has an ongoing, trusted relationship, have been identified as abusers. The expanded list of possible perpetrators was the result of newer information about abuse that is directed against older individuals and people with disabilities.

Think about . . .

Discuss with others the ways that someone might try to prevent abuse from becoming known, and how an abuser might try to justify his or her actions.

What Is Sexual Violence?

“Sexual abuse gives victims the message that they cannot control what happens to their bodies. For some victims this sexual violation is profound and may be difficult to discuss. Some victims are unsure whether this sexual behavior is really abuse, while others see it as the ultimate betrayal.”¹

Sexual violence is a verbal or physical act that is sexual in nature and violates a person’s sense of trust and or a feeling of safety. The term “sexual violence” includes rape or other sexual assault/abuse by a date or acquaintance, a partner, a caregiver, a family member, or a stranger, and reflects the growing awareness of the breadth of sexual violence perpetrated in our society. (*See Appendix F for information about the anti-sexual assault movement.*). It includes sexual harassment, exposure, and voyeurism. Sexual violence can be directed toward children or adults.

When a person does not give consent to sexual contact, this is sexual assault. Sexual contact also becomes sexual assault when a person is unable to appraise the nature and consequences of sexual activity in order to give consent (see *State v. Smith*, 215 Wis. 2d 84 (Ct. App. 1998)). Sexual assault also occurs when licensed professionals or service providers have sexual contact with a client. Described from another perspective, victims/ survivors of sexual violence are people who have been forced, coerced, or manipulated into participating in sexual activity.

Think about . . .

For you, are there any gray areas or questions about the line that distinguishes sexual contact from sexual abuse? Raise this sensitive issue with someone you trust.

Sexual assault is primarily motivated by one person’s need to exert dominance over another person through the use of power and control, including by using force. Some perpetrators target individuals they perceive to be vulnerable based on factors such as isolation, alcohol and drug impairment, age or disability. Often, the perpetrator feels entitled to engage in these sexual actions. Or, the person knows that s/he is committing a crime and believes that s/he can get away with it because the victim will be too afraid to tell anyone or is unlikely to be believed. This is especially common when an inherent power difference already exists between a perpetrator and a victim (e.g., a caregiver and a care receiver).

¹ Ganley, Anne L. Warshaw, Carole, Ganley, Anne L., and Salber, Patricia R. *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers*. San Francisco, Calif.: Family Violence Prevention Fund (1995).

Many offenders will groom their victims before the assault, often violating personal boundaries. While not a sexual activity, this behavior is used to “prepare” a victim to being receptive to sexual acts. This grooming is done over a period of days, weeks, or months to “test the waters” and see how the victim will react. Indicators of grooming behavior include taking a special interest in the victim, claiming the victim is “his/her special one,” giving the victim gifts or treats, allowing special privileges to show “how much I care,” getting the victim used to sensual touch by giving massages, and/or setting up times that they can be alone on a regular basis (e.g., showering the victim late at night when others are not around).

There are a number of ways by which a person can be sexually assaulted:

- Hands-Off or Covert Offenses do not involve physical contact. These offenses often include voyeurism, exhibitionism, forced viewing of pornography, sexual harassment, and threats.
- Hands-On or Overt Offenses involve physical contact and can include genital contact with or without penetration. The contact might be to the victim’s vagina, breasts, anus, or mouth. The perpetrator might be making contact orally, genitally, digitally, or with objects.
- Harmful Genital Practices refers to unnecessary and unwarranted, or excessive, personal care to a person’s genitals, breast, or anus. This type of abuse is specific to individuals who rely on others for intimate personal care of their bodies.² (*See Appendix B for more extended descriptions and examples of sexual assault.*)

Who Are Perpetrators Of Sexual Assault Or Abuse?

In general, perpetrators of sexual assault or abuse are known and trusted by the person who is victimized. They might be acquaintances, intimate partners, relatives, caregivers, peers, or sometimes, strangers.

- Acquaintance Assault is perpetrated by someone who is only casually known by the victim. This is the most common type of sexual assault.
- Partner Assault is perpetrated by someone who is already intimately known by the victim.
- Incest is perpetrated by an immediate or extended family member.
- Caregiver Assault is perpetrated by someone who has a primary responsibility for providing primary care for a person.
- Peer Assault is perpetrated by someone who might be a house-mate or coworker.

² Ramsey-Klawnsnik, Holly. *Widening The Circle: Sexual Assault/Abuse and People with Disabilities and the Elderly*, Wisconsin Coalition Against Sexual Assault (1998).

- Stranger Assault is perpetrated by someone unknown to the victim. Although this type of assault is portrayed most frequently by the media, it occurs rarely.

Other Environmental Factors Leading to Sexual Abuse of Women with Disabilities

Additional factors and circumstances that increase the occurrence of abuse experienced by women with disabilities include:

- Assistance with personal care needs: An abusive caregiver may take advantage of the intimate nature of personal care provision as well as the opportunity afforded in these situations to abuse an individual.
- Learned compliance: Many women with disabilities have been socialized to comply with the instructions of “those in charge,” be they professionals, in-home care workers, volunteers or family members. Many perpetrators take advantage of this power imbalance to control the victim and sexually abuse her.
- Lack of privacy: Women with disabilities may rely on personal care services and may have multiple care providers that serve a number of individuals. In this type of environment, care providers sometimes forget to allow for privacy because it is easier and less time consuming. Conversely, a perpetrator also may use the guise of offering privacy to abuse an individual.
- Inappropriate boundaries: Personal boundaries are often blurred when an individual relies on others to provide intimate personal care. Sometimes an individual will feel close to a care provider because of the personal nature of the care provision or because she feels lonely and the individual is caring toward her. Perpetrators often take advantage of the trust that an individual has developed.

What Is Stalking?

Driving by the home of a new “crush” to see if her car is in the driveway or if her bedroom light is on does not seem like an outrageous or threatening activity when it happens once. Repeating these kinds of actions, including, for example, making phone calls, sending letters, leaving notes, hanging around, contacting family members and friends, or adding a threat changes things. Widespread recognition of stalking as a social problem and a crime is relatively recent and came about as a result of publicity involving public figures. Stalking is a crime that can happen to anyone, although the majority of stalking victims are women.

In **Wisconsin**, a stalker is defined as someone who “intentionally engages in a course of conduct directed at a specific person that would cause a reasonable person to fear bodily injury or the death of himself or herself or his or her family or household.” (Wis. Stat. Sec. 940.32(2)(a)). A “course of conduct” means a series of two or more acts carried out over time, however short or long, that show a continuity of purpose. (Modifications to Wisconsin’s stalking law were signed recently by the Governor. For updated information about the new law’s definitions and effective dates contact WCASA. See the *Technical Assistance and Resource Information* section.

Who Are Perpetrators Of Stalking?

There is no one psychological or behavioral profile for stalkers. Many experts believe that each stalker is different. The most common types of stalking are identified as “simple obsession” and “love obsession” stalking. Several other explanations for stalking include vengeance, narcissism, fantasy, and erotomania.

Simple obsession stalkers are motivated by a need to dominate and intimidate. The stalker’s need to exert power and maintain control over the person being stalked adds the element of danger. According to the Stalking Resource Center (SRC)³, 81% of women stalked by a current or former intimate partner are physically assaulted by that partner; and 31% are sexually assaulted by that same person. Simple obsession stalking represents 70-80% of all stalking cases and is distinguished by the fact that some previous personal or intimate relationship existed between the stalker and the victim before the stalking behavior began. As in most domestic violence cases, stalkers are the most dangerous when the victim ends or attempts to end the relationship. “Stalking cases which emerge from domestic violence situations constitute the most common and potentially lethal cases of stalking”.⁴

Love obsession stalking is characterized by a fixation on another person with whom the stalker has no personal or prior relationship. The target might once have been introduced to the stalker or be a complete stranger. Love obsession stalkers believe that they can make their victims love them. When the victim does not respond as expected, the stalker attempts to force the victim to comply by use of threats and intimidation.

While all stalkers can be described as engaging in predatory behavior, there are some stalkers specifically described as “predatory.” What distinguishes them is their potential for dangerous behavior. The predatory stalker is highly likely to commit a sexual assault and usually has prior convictions. This stalker is motivated to gain power over his victims and by the promise of sexual gratification. These victims are stalked as part of a plan to attack, usually a sexual attack. The predatory stalker will generally attack without warning and will stalk either someone he knows or a complete stranger.⁵

“Each stalking behavior by itself may or may not be illegal and generally does not constitute the crime of stalking. When these behaviors are viewed together, however, a pattern emerges that serves no other purpose than to annoy, alarm or terrorize a victim”.⁶

In order to gain and maintain control, or to establish a relationship with a victim, stalkers use tactics that will intimidate and instill fear. Stalkers can be convincing. They will trick family

³ Stalking Resource Center, National Center for Victims of Crime. Information available on the web at the following address: www.ncvc.org.

⁴ Stalking Resource Center, National Center for Victims of Crime.

⁵ Kropp, P. *The Dynamics of Ex-Intimate Partner Stalking*. BC Institute Against Family Violence Newsletter. (Summer 2000). Mullen, Paul E, and Pathe, Michele. “Stalkers and Their Victims”, *Psychiatric Times*, (April 2001).

⁶ Spance-Diehl, Emily. *Stalking: A Handbook for Victims*. Learning Publications, Inc. Holmes Beach, Florida. (1999).

members and friends into providing information. They might say, for example, that information about the intended victim is needed for a class reunion. To a stalker, any contact is satisfying. A stalker might promise that if the victim will meet in person, or meet “one last time,” he or she will stop making contact. Individual stalking actions might not seem intimidating, but when something unwelcome happens again and again over an extended period of time, there is a cumulative effect. For people who know they are being stalked, the fear of what might happen next can be hard to live with. As a stalker’s attempts to make contact increase, so does the victim’s fear.

Think about . . .

- ***How do you think it might affect you to have repeated and unwelcome contacts?***
- ***How might it affect you physically, emotionally, professionally, etc.?***

ARE SOME WOMEN MORE VULNERABLE TO ABUSE?

Abusers and perpetrators are responsible for abuse and violence – not the victims. Whether a woman has a disability or not, many women are in situations that increase their vulnerability to experiencing violence. Some personally held beliefs or perspectives can increase a woman's vulnerability to violence, although these perspectives never are the causes of the violence. Some of those beliefs or perspectives include the following:

- I will have no one to rely on if he/she is gone.
- It's safer to stay with what I know than to risk an uncertain change or retaliation.
- I don't have enough money to do anything but stay where I am.
- I have children and other family members who might get hurt if I do anything.
- No one will believe me.

A person who is perceived as smart, strong, credible and socially well connected is not immune to being targeted for domestic violence, sexual assault, or stalking. However, a person who is perceived as less smart, less strong, less credible, and less socially well connected is more vulnerable to mistreatment of all kinds. Although many of the issues faced by women with disabilities are the same as those faced by women without disabilities, considerations regarding unique circumstances, prevention education and support planning include some additional factors.

Disabilities can affect a person's thoughts and thinking, comprehension, moods, communication, movement, vision, hearing, medical status, and memory. Some women rely on others for mobility assistance, financial management, housekeeping, meal preparation, etc. Some women with disabilities rely on others for assistance with the personal care of their bodies (e.g., toilet needs, bathing, menstrual hygiene, eating, and dressing). Those who rely on others for this type of assistance are the most vulnerable because the nature of their relationships includes the expectation of some amount of direct physical contact.

Not all of those who rely on others for personal care have learned how they want that care to be provided (e.g., what is enough and what is too much). Some have not learned, or do not understand, that they have the right to define "boundaries" in a care giving relationship. Some women have not learned that they have a right to say "no" in a sexual relationship. Still others, who can communicate, live with the fear that if they try to direct the way caregivers are supporting them, they will be ignored. They might fear worse treatment, and/or the loss of their support and independence altogether. They might worry that others, if they know others with whom they could confide, will not believe them. A smaller, but significant number of women do not have a symbolic method of communication (e.g., speech, manual sign language, and writing). These factors add to their vulnerability of abuse. Are some women more vulnerable? Yes.

- Statistics indicate that women with developmental disabilities are sexually assaulted at twice the rate of women without disabilities. According to one study, 90% of people with developmental disabilities will experience sexual abuse at some point in their lives and 49% of them will experience 10 or more abusive incidents. Only 3% of sexual abuse cases involving people with developmental disabilities are ever reported.⁷
- Sexual victimization among women with psychiatric disabilities is also high. Newmann, JP, et al., found that 74% of women with co-occurring mental health and substance abuse related problems have histories of sexual abuse.⁸
- There are few studies that specifically document sexual assault against women with physical and/or sensory disabilities. Young, M.E., et al. reported that 40% of women with physical disabilities reported being sexually assaulted.⁹
- A national survey of 860 women found that women with and without physical disabilities were equally likely, at 62%, to experience physical or emotional abuse from husbands, live-in partners, or family members; however, for women with disabilities the abuse tended to last longer than for women without disabilities.¹⁰

There are many conflicting myths about women with disabilities that contribute to the prevalence of sexual assault and violence committed against them. Some of these myths are that women with disabilities:

- do not have sexual feelings;
- are oversexed;
- are grateful for any sexual attention;
- are not whole human beings;
- do not feel physical or emotional pain;
- do not experience a full range of emotions;
- are leading wasted lives at taxpayer expense;
- are incapable of leading full lives;
- are unreliable, lie, and are more prone to fantasizing;
- are too undesirable to be targeted for sexual contact/abuse;
- will not communicate about abuse;

⁷ Valenti-Hein, D., Schwartz, L. *The Sexual Abuse Interview for those with Developmental Disabilities* (1995).

⁸ Newmann, J.P., Zeige, A., Sallmann, J. *Women in a Publicly Funded Mental Health and Substance Abuse Services in Dane County, Wisconsin: A Preliminary Report*. Madison: Women and Mental Health Study Site, School of Social Work, University of Wisconsin- Madison (2001).

⁹ Young, M.E., Nosek, M.A., Howland, C.A., Chanpong, G., Rintala, D.H. *Prevalence of Abuse of Women with Physical Disabilities*. Archives of Physical Medicine and Rehabilitation Special Issue. Vol.78 (12, Suppl.5) (1997).

- will not be believed if they do communicate about abuse; and
- are not able to make any decisions for themselves.

One viewpoint that makes people with disabilities (as well as children and older adults) particularly vulnerable is that most people cannot believe that anyone would deliberately harm them.

Who Are “Women With Disabilities?”

One of the difficulties in trying to answer the question, “who are women with disabilities” is that the question implies that there is a discrete and helpful answer. Women (people) with disabilities can be categorized and defined for diagnostic or statistical reasons, but not in any helpful or practical way, for our purposes. Women with disabilities are more than an “impairment” or “limitation.” They are whole and individual. Each has her own personality, life experiences, sense of humor, values, strengths, and ways of learning and communicating. Each is also someone who might have a past or ongoing problem due to violence in her life.

Categorical disability labels are determined by medical and educational researchers or diagnosticians. Their aims are to determine whether a person operates in the world differently than most people of the same age. They might try to determine why. Those are research concerns. In recent years, there has been some attention to understanding that diagnostic measures might also have to consider a person’s cultural background or personal learning history. But, we are not all researchers. In a pragmatic world, we need usable information.

Disability labels do not usually provide immediately usable information. For example, a label of physical disability does not convey what a person can do, how she can move, what strength, dexterity, or coordination she controls. It does not inform us about what she can do when she has access to good assistive technology and/or personal assistance.

A label of cognitive disability (formerly described as mental retardation) is still frequently defined in terms of intelligence test scores and conveyed using comparative words such as mild, moderate, severe, or profound. For some women, a cognitive disability occurs later in life (e.g., individuals with Alzheimer’s disease or a related dementia). Some psychiatric labels are so broad (e.g., psychotic) or negative (e.g., chronic) that we are left with almost no usable information. These labels do not inform us about what a woman understands or how she learns. They do not help us to understand what she is capable of. They certainly do not help us to understand what she values and how she tries to cope with the internal and external stresses in her life.

Usable information is what we try to gather when we begin an interaction in order to consider what someone might need or how we can help.

¹⁰ *Ibid.*

Life Example

Many years ago, a woman described as psychotic explained that everyone she went to for help refused to engage her because when they asked who she was, she said that her name was Gandhi. That's right, she said that she was the man who led the liberation of India and became internationally known as a practitioner and teacher of social justice through nonviolent resistance. She said that no one would talk with her until she told them her real name. From her perspective, at that time, she was telling them her real name. She was Gandhi.

Think about . . .

In your current role, how would you respond to a woman who came to you for help and introduced herself as Gandhi?

When this woman was asked how she would have wanted people to respond to her, while they perceived her as delusional, she said that it might have been helpful for someone to have asked when she had last eaten, whether she had a safe place to stay, whether she had children to be considered...the basics.

The most important answer to the question, “Who are women with disabilities?” is this: they are mothers, sisters, friends, daughters, wives, girlfriends, lovers, nieces, cousins, aunts, neighbors, coworkers.... They are professional people and blue collar workers. Some are employed and some cannot find employment. Some have observable characteristics and many have disabilities that are invisible. They are women.

What Are Disabilities?

A reminder: using this *Workbook* is not supposed to make you an expert about the diagnostic labels used to describe people. We want only to provide enough information to make you feel more at ease. We want to pose questions that you might ask yourselves and others, questions that might make doing your work easier and more effective. One of the goals of this Project is reminding us all that we do not have to do this work, or resolve all situations, alone. Partnering with a woman and other agencies can provide needed information and services – we all do not have to be “experts” in everything. Sometimes, our natural tendency is to be so distracted by perceived disability or disability labels that we forget to find out about the basics and get to know a woman.

Umbrella categories are often used to define people based on some personal characteristics. Developmental, psychiatric, and sensory disabilities are three of the most common umbrella categories. You will find some people who want to distinguish among words such as disability, handicap, disorder, and impairment. Others define people based on legal terms. We have provided, in the next few pages, some general information to help you be more aware of the terms and some of the characteristics that you might think about as you progress through this *Workbook*. These descriptions are not meant to define a person with a particular label, but to assist in understanding some of the characteristics associated with a specific disability label or diagnosis.

Developmental Disabilities

Developmental disabilities include, for example, cognitive disabilities (formerly identified as mental retardation), autism spectrum disorder, and cerebral palsy among others. They are called developmental disabilities because they occur during what are considered the “developmental” years, birth through a person’s 22nd birthday. The effects of a developmental disability are noticed in a woman’s ability to care for herself, to understand and use language, to learn, to move voluntarily and purposefully, to become self-directed, financially self-sufficient, and to live on her own.

Use of the term **cognitive disability** means that to some degree a person has difficulty learning in all areas of her/his life. The diagnosis is generally determined as a lower measure of intelligence when compared to others of the same chronological age. People have to notice millions of details every day in order to operate successfully. One of the primary difficulties for people with cognitive disabilities might be best understood as the problem of not noticing and remembering which details are the most relevant.

Probably the biggest misunderstanding about people described as having a cognitive disability is that “they are children forever.” If given opportunities to learn and participate they would not remain the same. Rather than treating them as children forever, it might be more helpful to think that some people with cognitive disabilities do not become as mature or sophisticated as those without cognitive disabilities. More importantly, learning can continue throughout a person’s lifetime.

Autism spectrum disorder is still being studied and researched. It is described as a “spectrum” disorder because of the enormous variability in how people participate. Autism is determined by direct observation, interaction, and interviews with parents and others who know the person well. It is currently best understood as a neurological disorder. Some people with autism describe those who do not have autism as “neuro-typical.” People without autism, to a greater or lesser degree, can integrate sensory stimulation (e.g., sound, light, color, texture, touch) and carry on. People with autism often experience the same stimulation in very different ways. For example, what feels like gentle touch to a neuro-typical person might be experienced as painful to someone with autism. Average sound and light settings might seem clamorous and overwhelming to a person with autism.

People with autism might be of average or above average intelligence, or autism can co-occur with a cognitive disability. Many people say that the primary area of “disability” for people with

autism is in social interaction and/or the use of language. People with autism have difficulty “reading” other people - their facial expressions, vocal inflections, humor and sarcasm, their uses of slang or metaphors. Understanding, for someone with autism is more often very concrete and literal. There might be great comfort in predictability. Living with autism has been compared to living in a culture where the customs, language, and expectations are all confusing. Add a bit of generalized anxiety to that and you might begin to understand what life is like every day for many people with autism.

Cerebral palsy affects a person’s physical participation. The person with cerebral palsy knows what she wants her body to do, and her brain sends the right message, but her body does not follow instructions. Some people with cerebral palsy appear tight and rigid, even jerky, in their attempts to move. Others might appear loose and floppy, possibly unable to hold their heads in an upright position or to swallow in time to prevent drooling. Imagine having the intention to do something and a body that does not carry out your intentions. Because speech is, in part, a physical activity, you might notice some people with cerebral palsy using a lot of effort to control the quality of their speech. The same is true of mobility. Some people with cerebral palsy are able to walk on their own, possibly with a distinctive gait, or with a device (e.g., a walker) in order to maintain balance and move safely. Others do not walk independently. (They are not “wheelchair bound” or “confined to a wheelchair.”) They might **use** wheelchairs as a method of mobility. People with cerebral palsy might be of average or above average intelligence or cerebral palsy can co-occur with a cognitive disability.

Psychiatric Disabilities

Psychiatric diagnoses include, for example, mood disorders such as depression and bipolar disorder (previously known as manic-depression), and thought disorders such as schizophrenia and dissociative disorders. As is true with other disability categories, a specific psychiatric diagnosis does not tell us much about a person. It is a label, often one that carries with it sometimes enormous barriers imposed on a person. Public assumptions about people with psychiatric disabilities are stigmatizing. Public portrayal of someone with a thought disorder often is synonymous with violence. The fear that lurks just below our conscious thoughts is that dangerousness to others is a characteristic that can be generalized to “people like that” even though this is not the case. People’s fears are raised when they find out that someone takes psychotropic medications, even though when well used, for some people, the medication helps them to think more clearly.

For our purposes, what is more helpful to consider is how women with psychiatric disabilities experience their disability, especially in relation to violence that happened in their past or currently is a part of their daily existence. There is a spectrum of behaviors, feelings and thoughts that a woman with a psychiatric disability might exhibit. Some women might experience recurrent depression, panic attacks, anxiety, and other behaviors, feelings or thoughts. Understanding the “source” of these symptoms might increase the effectiveness of interactions you have with women with psychiatric disabilities.

Some psychiatric disabilities are biological in that a person is hereditarily predisposed to a disorder, and stress or being in crisis (e.g., experiencing abuse) can trigger the disorder. Yet, for many women, the psychiatric disability they experience today is a manifestation of a coping

response they developed to survive past experiences of domestic violence and/or sexual abuse, such as Post Traumatic Stress Disorder (PTSD). (*See Appendix B for information about the short and long term effects of experiencing violence.*) Some of the effects of surviving abuse are manifested in women who exhibit depression or anxiety, or a woman who abuses drugs or alcohol, or responds through self-injury. It is important to learn about and understand these sources from a woman to ensure that your services and support for women with psychiatric disabilities is most effective for and appropriate to them. In other words, some of the “symptoms” you observe could be related to coping with and healing from abuse. How might that knowledge affect your interactions with a woman?

Sensory Disabilities

Sensory disabilities refer to vision and hearing. Only a small percentage of people who are blind have no sight at all. Most have some degree of functional vision, which may vary from light perception to being able to read regular-sized print with the help of specialized lenses or low vision aids. There are two main elements of vision: visual acuity -- the eye's ability to perceive central or fine detail, used in reading and recognizing facial features; and visual field -- the scope of visual perception; the part of vision that allows us to see peripherally and to move about easily. **Legal blindness** can mean tunnel vision, no central vision, cloudy or extremely blurred vision, seeing just shadows, or no vision at all. People, who are partially sighted, also known as having **low vision**, can vary in the limitation in their sight but the thing they have in common is that they all have usable vision. People who are partially sighted may or may not be classified as legally blind. They also can have a wide range of eye conditions, which vary from person to person in what types of limitations their vision disability cause.

Generally, the term "**deaf**" refers to individuals who are unable to hear well enough to rely on their hearing and use it as a means of processing information.

“We use the lowercase deaf when referring to the audiological condition of not hearing, and the uppercase **Deaf** when referring to a particular group of deaf people who share a language, American Sign Language (ASL) and a culture. The Deaf community uses sign language as a primary means of communication among them and holds a set of beliefs about themselves and their connection to the larger society. We distinguish them from, for example, those who find themselves losing their hearing because of illness, trauma or age; although these people share the condition of not hearing, they do not have access to the knowledge, beliefs, and practices that make up the culture of Deaf people.”¹¹

Persons are considered **hard of hearing** when their hearing loss does not preclude understanding spoken language, usually with the assistance of a technical aid. The person's hearing loss may range from mild to severe, but, with the use of a hearing aid, a person who is hard of hearing can still communicate primarily by speech. A person also may rely on speech reading and assistive listening devices to communicate; sign language may or may not be used. "Hard-of-hearing" can denote a person with a mild-to-moderate hearing loss or it can denote a deaf person who doesn't have/want any cultural affiliation with the Deaf community or both.”¹²

¹¹ Padden, Carol and Humphries, Tom. *Deaf in America: Voices from a Culture* (1988).

¹² *Deaf Life* magazine's "For Hearing People Only" article (October 1997, page 8).

Other Disabilities

A variety of physical disabilities result from congenital conditions, accidents, experiencing abuse, or progressive neuromuscular diseases. These disabilities may include conditions such as spinal cord injury (paraplegia or quadriplegia), cerebral palsy, spina bifida, amputation, muscular dystrophy, cardiac conditions, cystic fibrosis, paralysis, polio/post polio, and stroke. Therefore, there are many other ways in which our bodies and minds might be affected significantly enough that we might at some time in our lives be perceived or described as disabled. A **traumatic brain injury** can happen at any time during our lives and affect some or all of our abilities, temporarily or permanently. **Spinal cord injuries** can result in changes in our abilities to move parts or most of our bodies. Multiple Sclerosis (MS) and **Amyotrophic Lateral Sclerosis** (ALS or “Lou Gehrig’s Disease”) can reduce the voluntary control we have over our bodies over time. **Macular degeneration** can destroy our central vision.

Each of us has the possibility, some would argue the probability, of becoming a person with a disability.

Think about . . .

How do you want people to respond to you, if, at some time in your life:

- *your thoughts or speech become less clear;*
- *your ability to move and physically do things independently are diminished;*
- *you experience significant changes in mood and composure;*
- *your own thoughts become frightening or confusing;*
- *you become seriously disorganized or forgetful;*
- *managing your emotions, your life, seems out of your control; or*
- *frustration, fear, and anger seem to be the only emotions you are having?*

Even if you have skipped over some of the other questions presented in this Workbook, please slow down here.

Think seriously about these questions. We really do have uncertain futures, and it might be helpful to think about what you would want for yourself if the changes just described happened to you.

How Should We Think About Disabilities?

There are people who are diagnostically and statistically labeled as having a disability, who have been living and learning throughout their lives and do not consider themselves to be lacking. They are operating with their full and unique blend of abilities. Other individuals who have disabilities want to understand why their minds and bodies operate as they do. Those explanations, known as causes or etiologies, however fascinating, are not essential in order to have a purposeful interaction with someone.

One way to think about disability and being a victim of violence is as a measure of how one person's abilities and violent experiences compare to most others; or, how one person participates in the world differently than most others. Using that perspective, there are a number of general factors to consider. We could consider cognitive ability, communicative ability, physical ability, social ability, learning ability, and coping ability. We could consider visual and hearing abilities. We could consider temperament. We also could consider fear, self-esteem and trust.

Think about . . .

Select a few of the factors listed above and describe yourself. (Really, describe yourself.) Then, name people who you think manage better than you. Now name people who do not (in your estimation) manage as well.

What does that kind of comparison achieve? Does it motivate you to feel and act differently? Or are you left with a useless sense of superiority or inferiority? Regardless, you have to wonder if making the comparison was helpful.

All of the ability and experiential factors listed above are significant. We actually could create a much longer list to consider. But, what would happen if we spent less time comparing for the purpose of noticing what someone cannot or does not do "like most other people?"

- *What would happen if, instead, we made the decision to spend more time noticing what one person does and how she does it?*
- *What if our main focus was to notice how she is participating, in this moment, just as she is?*
- *What if we made it a priority to learn what she might need or want and how we might be able to help?*

The more we focus on what someone cannot or does not do, the more we burden her with our own beliefs and biases. The more we focus on how she uses her abilities, lives her life, and learn what she values, the more able we make ourselves to be helpful and responsive. First, we have to learn how not to be distracted.

Here's a tip:

One of the ways to get over being distracted by someone's "disability" or the violence they experienced is called "sanctioned staring." This means you notice someone with the intention to learn and wonder rather than to compare and judge.

Think broadly about the ways we present ourselves to one another. Some of those factors would include surface characteristics that can be seen or heard. Right handedness or left handedness is an observable characteristic. At one time, those who had a left hand preference were considered as having a disability and forced to switch. How we dress and move is observable. How we use language is observable. Whether you have big energy or more subtle energy is observable.

Think about . . .

- ***What characteristics do you imagine are most noticeable about you?***
- ***How do you think people perceive you after a first encounter?***
- ***Are there any other factors that you would want people to consider before they define you?***

There also are factors that are not observable. Our feelings and motivations, the ways we think and set priorities, are not always discernable. We all operate with variability. Within our families and among our friends and coworkers, we do not all present ourselves with uniformity. It might be easier if each of us came with an instructional manual. Understandably, we tend to want our interaction to be clear and easy. Ease and comfort of communication is considered one of the highest rated factors in job satisfaction. We are not comfortable when communication is difficult.

We might notice differences related to movement, thought, comprehension, expression, emotion, biology, neurology, and medical health. When we encounter someone and notice a particular characteristic, we have a choice. We can notice and make a judgment about the characteristic. For example, "look at the way she's moving - she must be drunk, on drugs, mentally ill, sick...."

Any one of those assumptions might be true... or not. But, as with the woman who introduced herself as Gandhi, do those assumptions help us learn more about the basics? Do not be too hard on yourself if you notice that you make assumptions. Do try to observe yourself in the act.

Upon seeing the same woman we might begin to generate more helpful questions.

- How successfully is she moving? Are there obstacles?
- What is she noticing; what seems most important to her right now?
- Do some kinds of information seem easier for her to understand than others?
- How much time does she seem to need (e.g., to process information)?
- What is her mood or emotional state, at this time?
- How do her sensory systems work? What does she hear? What can she see? What does she feel (e.g., sensations such as pressure, temperature, texture)?
- How comfortably does she relate to other people? To you?
- How might her abuse experiences affect your interaction?
- **What else could you do that might help?**

Please notice that, so far, we have not really said anything about a specific disability. Any of these considerations might apply to people who have no identified disability. You might even try to answer the above questions about yourself or someone you know. Are these useful factors to consider with any person who approaches you for support, assistance, or advocacy?

Some human differences are described for medical, educational, or therapeutic reasons as disabilities. In some situations, diagnoses or labels might mean eligibility for financial or other services. For relationship purposes, these differences are not what matters most. What matters most is allowing yourself on the spot to get to know how someone else operates.

Some human differences are present at birth and others are acquired. Some are acquired by accident or injury, some due to the aging process, some as a result of disease or illness, and some by irregularities in body chemistry. Other differences result from domestic violence, sexual assault, and stalking. For some women with disabilities the characteristics that result in a diagnosis or label are permanent and do not change over time. For some women, those same characteristics can change over time. They might be temporary or episodic. Many women adapt and learn to operate with the abilities and histories they have and do not consider themselves to have a disability or to be a victim. They are people doing the best they can to live their lives.

It has been said that the people who have the power to categorize and label have more power than the people who are categorized. One woman said that the single word she hoped she would never hear used to describe her again was “manipulative.” She explained that from her perspective, she was always just trying to get people to help her keep her life in balance and to get the assistance she needed to make her life work. For that, she had been categorized and labeled over many years as manipulative. Because she lived with a psychiatric label, reports

were written about her. While it is not supposed to happen, gossip often preceded her. When the information someone has received about you describes you as “manipulative,” how do you think that influences the meeting?

Think about . . .

How would it influence you, if you were told that someone who is seeking help from you is “manipulative”?

The practical fact is that anyone who is labeled or diagnosed as having a disability or seeks your assistance as a result of violence is probably trying to make her life work and come into balance, like everyone else. For women victims with disabilities, labels can be a distraction. We frequently do not take the time to get to know someone after we perceive a disability or hear a label. Learning about people with disabilities is the same as learning about people without disabilities. There is wide variability in how people live their lives, what they value and enjoy, what they aspire to, and how they try to achieve those outcomes.

WHAT IS YOUR COMFORT ZONE?

The work we do reflects a “personal and professional comfort zone.” Domestic violence and sexual assault service providers have not traditionally extended their services to women with disabilities. Disability services and support providers traditionally have not addressed domestic violence, sexual assault or stalking issues. Throughout this *Workbook*, we have tried to encourage you to actively consider what it might take and what you might need to include women with disabilities and abused women in the work you do - or even to share what you know with others. Traditionally, providers of support to women with disabilities have not asked about or screened for histories of domestic violence, sexual assault, or other forms of trauma. (*See What Does It Mean to Screen for Abuse or Violence, for A History of Trauma? section and Appendix G for information on screening techniques and recommendations.*) There are probably many reasons for this lack of extended services and for the lack of screening that relates to our personal and organizational comfort.

Most often, there is resistance by the people close to the woman with a disability to consider that abuse might have happened or be happening. Changes in behavior are often too easily dismissed as an aspect of the woman’s disability. And among domestic violence and sexual assault providers, the entire system of separating people with disabilities beginning at school age and moving up through models of sheltered workshops and group homes has created a culture that suggests you have to be specially trained to have an interaction with women who have disabilities.

This Project is asking you to examine and possibly change your personal and organizational practices. We understand that this means examining your thoughts, beliefs, emotions, and fears about how you do what you do and who you serve. We acknowledge that while inviting you, even encouraging you, to consider change, we are also positioning you for some challenges, individually and organizationally. Many of those challenges begin with your personal comfort zone. Some individuals feel inadequate or afraid to work with people who might move, communicate, or even think in ways that seem very different from them. Some individuals feel afraid or unskilled to ask about abuse. Some organizations experience similar reactions, while others are already struggling to consider how they can do more, and do better.

In her article, [On Being Invisible in the Mental Health System](#), Dr. Anne Jennings discussed resistance to considering the effects of trauma. She quoted J.A.. Parker about making significant shifts: “...they cause change, disrupt the status quo, create tension and uncertainty and involve more work.” The changes we are asking you to consider will require some of you to make significant shifts in how you define your comfort zone. It might require you to rethink the ways you have considered the lives of other people and your own role as a service and/or support provider. Because we are asking you to extend hope and healing to women with disabilities who have experienced violence in their lives, we are first suggesting that you pay attention to your personal and professional comfort levels and values, as well as those of your organizations.

It is our hope that you will not only accept the challenges but that you might begin to gently challenge others. In doing so, you will start a shift that will ripple through other individuals and organizations and influence whole communities.

One fundamental challenge each person will have to address is how you feel about extending your services to a woman with a disability who has experienced violence.

Think about . . .

- *How will you feel if you can't understand her speech?*
- *How will you feel if she can't provide the details you want?*
- *How will you feel if she is loud and demanding?*
- *How will you feel if you've never met anyone like her before?*
- *How will you feel if you find it hard to hear about what she has experienced?*

If your work is to provide support to women with disabilities, how prepared are you to consider the possibility that she has already been, or is being, victimized? Are you prepared to consider that some of what is being discussed about a woman you know as having “challenging behavior” is actually an indirect message or side-effect of some kind of abuse or violence that has occurred or is occurring? If so, her behavior does not need to be stopped; it needs to be better understood. (*Please refer to Appendix B for information about some indicators of abuse.*)

Think about . . .

- *Have you ever participated in designing or implementing a “treatment” plan to address a person’s “challenging behavior” without first screening to learn more about her life?*
- or*
- *Have you ever participated in designing a safety plan for a woman without first learning more about her life?*

We are asking ourselves how we feel about opening ourselves to possibly difficult and uncharted areas of inquiry. This is a good time to remind ourselves that we do not have to be experts in everything. We have to notice what we need. **Are you more uncomfortable with a particular characteristic of another person or with not knowing what to do?** For example, would your discomfort come from being with a woman who is blind or not knowing how to interact with her because she does not see?

Informal Self-Awareness Inventory

The following is an informal self-awareness inventory. There are many other questions that you might decide to ask yourselves. Use these to explore possible thoughts and feelings you might have about working with women who have disabilities who have experienced violence. Let these questions stimulate others that you might want to answer or discuss with someone else. It is suggested that you try to answer these questions with a trusted peer.

Think about . . .

- *What individual characteristics result in my feeling uncomfortable or confused?*
- *Does my discomfort cause me to feel badly about myself? Why?*
- *Do I want to increase my comfort? Why or why not?*
- *How could I increase my comfort when working with someone who....?*
- *What resources am I aware of, and what additional resources do I want?*
- *Am I willing to notice and acknowledge what I do not know?*
- *Do I believe that I should extend my support to all women who have been affected by violence? If not, who should I leave out? Why?*
- *What would happen if I thought about the fact that women with disabilities I currently support have been or are being abused now? What would I need to help me help these women I currently support?*
- *How do I feel about hearing about the physical or sexual abuse that a woman has experienced?*

In addition to individual considerations of comfort, organizations and groups also can develop “collective” comfort zones. For example, “We do this, but we don’t do that.” Here are some additional inventory awareness questions intended for groups and organizations.

Think about . . .

- *Do we have an inclusive mission statement? Do we honor it?*
 - *How did we decide to operate as we currently operate?*
 - *What do we need to learn about the effects of physical or sexual abuse?*
 - *How do we ask about physical or sexual abuse?*
 - *Who do we typically turn away?*
 - *Do we turn some people away out of habit or history?*
 - *Could we do more if we collaborated with others or learned more from others?*
 - *What kind of training or consultation might help us to be more inclusive?*
 - *What organizations or service providers could we ask to collaborate with us?*
 - *What would make us a more accessible organization?*
-
-
-

Making changes has something to do with gaining new information and a lot to do with emotion and comfort. Making time to be honest with yourself is a good place to start. Notice your feelings, thoughts, and beliefs about women with disabilities, and the abuse of women with disabilities. Notice how you could begin to make connections in order to learn more and do more. Consider what it might be like for a woman with disabilities to seek services from you or your organization. Can we consider several factors about how we define our comfort zones and then move from there?

Discomfort is a signal. It does not have to be a decision. Even the possibility of change can be loaded with emotional reactions - notice them. Our goal is to support women whose lives are affected by violence. (We can and should generate as many ways as possible to accomplish that goal. Not everyone has to do everything, but everyone has something more to offer.) Collaboration, when done mindfully, can ease our discomfort during change.

If I Don’t Understand Her Disabilities, Can I Interact With Her?

“Can I interact with her if I don’t understand her disabilities?” is a reasonable question. No one needs to be embarrassed by asking it.

- Can you interact with a woman who speaks and understands Spanish, if you only speak and understand English? Yes.
- Can you interact with a woman who does not hear your voice? Yes.
- Can you interact with a woman who cannot see you clearly or at all? Yes.
- Can you interact with a woman who cannot lift her arms? Yes.
- Can you interact with a woman who says her name is Gandhi? Yes.
- Next, we start to ask, how? With how much depth? With what assistance?

Interacting with a person who has a disability is not so different from interacting with any new person, or stranger. Can you be welcoming? Can you offer comfort? We actually never know immediately how deep or involved our interactions might become, but, if we do not freeze up, we can “interact” a little with anyone. Good practice is good practice. Can you have the same depth of communication with every person, the same ease of interaction? No. Sometimes there are limits to how much we can learn or share. And then, we have to be humble enough to find assistance - to collaborate, to accept help from others.

Some people are familiar with the concept of “**active listening.**” Some people practice active listening by nodding, saying, “uh huh,” “I see,” and “I know where you’re coming from.” In reality, **active listening has a far deeper meaning: to actively try to understand another person’s situation.** It might include noticing her effort, her pace, her emotions, her comfort, what she values, etc. It means respecting her attempts to express herself even when these expressions are not immediately clear to you.

Our understanding of active listening could be expanded to mean being a good host; thinking about ways to make her more comfortable - physically and emotionally. One useful practice to try when meeting someone in a helping relationship is to notice what she is doing and what you are doing. For example, you might be asking questions, explaining, giving direction, or listening. How fast is the pace of this interaction?

Think about . . .

- *When you are with someone, in your role as a provider or support person, do you do what you do automatically or routinely; or, do you decide what to do and how to do it by following the other person’s lead?*
- *What guides your interaction?*

When you are trying to be a good host and an active listener, the issue is not just whether your intentions are good. Intentions are extremely important, but a better measure of your success is whether the person with whom you are interacting feels acknowledged.

- **Notice what you are doing and notice her reactions or responses to you.**
- **Assess whether you think you are having a helpful, neutral, or not helpful effect.**
- **If you think you are having a helpful effect, carry on. If not, make some adjustment.**
- **You can ask with words, with gestures, in writing, etc. if there is something that might make her feel more comfortable or at ease. She might or might not know the answer.**
- **Sincerely wondering and asking questions can affect the establishment of a relationship.**

You will notice once again that there is nothing special about these suggestions. They are about good, e.g., mindful and respectful, interactions. The question of disability and interaction is in some ways a trick question. **You can have a lot of diagnostic information and it will not necessarily result in your having a more successful interaction.** What will result in having a more successful interaction is letting yourself be influenced by the person presenting herself. Let her teach you what is helpful before trying to do what you always do. Before trying to be influential, pause to let yourself be influenced.

HOW COULD SHE BE MORE SAFE AND FEEL LESS AFRAID?

In an ideal world, all people would have a large number of friends, coworkers, neighbors, family members, and others who would be attentive to our well being. They would notice and wonder about our presence or absence, about changes in our demeanor or participation, and would ask about those changes when they were noticed. The reality is that some people have a very limited number of contacts. And some of those contacts might have values that prevent them from checking in, believing that it would be perceived as being nosy or intrusive. Or those contacts are actually the perpetrators of abuse or violence in their lives. Or those contacts are not asking questions that would cause them to wonder whether violence or other problems are occurring. The bottom line is that we do not live in an ideal world and not all people are socially well connected.

Some victimization of women with disabilities might be prevented if changes were made in the relationships that are developed with children, adolescents, and adults with disabilities.

Think about . . .

Which of these learned qualities makes a woman more vulnerable? Feistiness? Rebelliousness? Assertiveness? Boldness? Compliance? How does it increase her vulnerability?

While having a cadre of individuals interested in a woman's well being is helpful to ensuring safety, it is not the only strategy that could be employed. Far too many people with disabilities are taught to be compliant. Some, from the time they are very young are taught to do everything they are told to do. As they reach the ages when their peers who do not have disabilities are being taught and encouraged to make choices, to say "no," to assert a sense of independence, people with disabilities are still being encouraged to be compliant. Some are systematically discouraged from learning about their own feelings and desires and are expected to make the choices that others have determined are "appropriate." **While it is wrong to assume that every person with a disability is able to make all decisions independently, it is also wrong to assume that because she has a disability she is incapable of learning to make any.**

There are no guarantees that any strategy prevents abuse. Yet, there are methods that decrease the likelihood. For example, one aspect of protective behavior is learning to actively reject and say "no" to someone touching you in a way that causes you to feel uncomfortable or unsafe. What complicates this strategy for some women with disabilities is that often a child or teenager with a disability is taught or expected to let people touch them to assist with a task or provide personal care. Or, women with disabilities are told that their feelings are wrong. A teenage girl

was over heard saying, “that hurts” to a teacher who was trying to have the girl do something by physically guiding her movement. The teacher’s response was “No it doesn’t.” We go so far as to tell people that their own feelings are not trustworthy.

Those individuals who have the most people concerned about their well being are less likely to be neglected or harmed. The converse is also said. Those who have the fewest number of people checking in on them, asking questions, and dropping by might be more vulnerable. This is not said to malign the hard work of most individuals who provide care, but there might be something to learn here. Does someone have one or two, three or four people who are showing interest? Does a long period of time go by when the only contacts that someone has are with paid support staff or caregivers?

Think about . . .

- ***Think about yourself. Who would notice if you were in trouble? How would they know? Would they know how to help?***
- ***If you know someone with a disability, who would notice if she was in trouble? If anyone would notice, would that person have any idea about what to do?***

How do support providers and family members respond when a woman with a disability has a change in behavior? She indicates that she does not want to go somewhere, or do something. She complains directly or indirectly about ailments and discomforts. She actually refuses or resists. Many (but not all) providers will arrange medical appointments to rule out a medical explanation for these “behavioral” changes. The more common response, particularly when someone has a developmental or psychiatric diagnosis is to design a treatment or behavioral plan to make the person be more compliant. Some people acquiesce. They go along with the program. Others continue to refuse or resist. The treatment or behavioral plan might be intensified or become more restrictive or forceful. Then, the situation is described as “escalating,” which means the person is still not complying or acquiescing. New or additional medication might be recommended. Additional consequences - restrictions or rewards - might be used as an incentive to make this person stop “being difficult.”

Think about . . .

- *What would happen if you believed that there was some valid reason for resistance?*
 - *What would happen if we acknowledged that a person's hesitation, discomfort, resistance, unwillingness... to acquiesce, was significant?*
-
-
-

When someone changes how she has typically participated in her own life, there are probably valid reasons for those changes. What if we trusted that her actions had value; and we trusted that her message was that "something is not OK." Not all changes in behavior suggest that abuse, neglect, or violence is occurring. But one of the questions that is not asked often enough, especially when a woman is identified as having a disability, is whether there might be a problem in a relationship between this person and any of the other people with whom she has contact.

The issues of power and control that were discussed at the beginning of this document are not always about overt violence and abuse. A person with a disability is expected to take some action, e.g., to dress, eat, take medication, or clean up. She is not doing it. Maybe she is not doing it fast enough. Maybe she is making choices that the caregiver does not think are "appropriate." What happens next might be called treatment, intervention, support, or instruction. It might be documented and approved and well intentioned. It might even be described as gentle and least restrictive. The question that has to be asked is how the person with a disability might be experiencing the implementation of this plan. Will she experience this plan as gentle and helpful? Will it be addressing what she values? Were her concerns considered? Or, will she be discussed in terms of how well she went along with the program?

Think about . . .

How long would you encourage a valued friend or family member to work with a supervisor or coworker, live with a room-mate, or accept a ride from someone who clearly made them so uncomfortable that their lives were starting to unravel?

This is a confusing time to be supporting people with disabilities in the community -- trying to weigh values, such as a woman's right to self-direction, choice and autonomy, against the

responsibility of others to assist her in daily life activities and keep her on schedule. We say that everyone has the right to say “no,” but does she have the right to say “no” to you, in response to what you want her to do, when you want her to do it. Can she say “no” to taking medication? or bathing? or physical contact? Does she have the right to say “yes” to alcohol? cigarettes? sexual activity on her own or with a person of her choosing? Does she have a right to privacy?

Caregivers have their own beliefs about what they are responsible for. They have different ideas about how much intervention or force is part of their job. Some intervene, even forcefully, because they believe it is in the person’s best interest, or for their own good. But then, some people say they cannot intervene at all, because this woman is making her own decisions. To say the least, this is a time of confusion among those who provide support to people with disabilities.

Think about . . .

- *What is the relationship between some treatment plans that purport to be “for her own good” or “in her best interest” and domestic violence?*
- *Is it possible that family members and providers are actually engaging in domestic violence?*
- *Asked from another perspective, is it possible that women with disabilities sometimes feel victimized and afraid as a result of the good intentions of caregivers?*
- *How might family members and support staff balance a woman’s safety against her autonomy (e.g., protection from potential abuse versus experiencing a healthy sexual and intimate relationship)?*
- *What does a phrase like, “institutionalized / organizational victimization” mean?*
- *How can you challenge or address it in order to help someone feel more safe or less afraid?*
- *As a sexual assault or domestic violence service provider, how might these issues affect your services and support to a woman with disabilities?*

At this time in the development of community support for people with disabilities, these questions and more should be raised over and over again. It is important to find the distinctions between paternalism and “treatment” on one hand and autonomy and choice on the other.

Besides navigating these distinctions, disability services and support providers have another resource to assist the women they serve to enhance their safety. One strategy that has been used successfully in the domestic violence and sexual assault fields is the development of safety plans. These plans are developed with a woman to help her devise specific steps she can take to try to become or remain as safe as possible. Safety planning is one way to empower someone who has been or currently is being abused. Because each person who is being abused is living in different circumstances, and because perpetrators are not all the same, safety plans have to be individualized. When you are already under pressure it can be helpful to refer to other sources to stimulate your planning process. As you can imagine, there are issues regarding transportation, safe locations, money, possible legal action, and many other considerations. There is in-depth information available regarding safety planning from your local domestic abuse and sexual assault programs or from the state domestic violence and sexual assault coalitions. (*See the Technical Assistance and Resource Information section for contact information.*) Individuals who work in these agencies are trained to help people think about their personal circumstances when designing a safety plan.

What Does It Mean To Screen For Abuse Or Violence, For A History Of Trauma?

In this *Workbook*, we have asked you to extend hope and healing to women with disabilities who have experienced violence in their lives. When considering what it means to screen or deliberately inquire about the violence women with disabilities have or are experiencing, we are first suggesting that you pay attention to your personal and professional comfort levels and values, as well as those of your organizations.

Think about . . .

- *How prepared are you to consider the possibility and actually hear from a woman with disabilities that she has already been, or is being, victimized?*
- *How does her disclosure challenge your comfort zone?*
- *How equipped is your agency to respond appropriately and effectively to her?*

How might her experiences affect how she views the world? Her life? Her relationship with you and others potentially available to provide support?

- *If the woman currently is experiencing abuse, how might she become more safe and feel less afraid?*
- *If she has a history of abuse, how might she become more safe and feel less afraid?*

Who can assist both this woman and you to ensure she receives the support and services she wants and needs?

Not every woman will share with you what abusive experiences she has endured. Yet, building rapport and trust can open the possibility that you will discover what she wants you to know. Affirming ways to initiate a relationship are through observing, inquiring, active listening and exploring with her what she needs and wants. Many women do not reveal this information because they have never been asked. It is okay and important to ask about abuse in a careful and thoughtful manner. Based on her identified needs and desires, explore with her what support you and your agency could provide, and identify others in your community to ally with to best serve and support the woman.

Since building effective relationships depends upon mutual communication, there might be some initial obstacles that hinder meaningful dialogue. For example, your communication with a woman who is Deaf might be stymied if you do not use American Sign Language (ASL) to communicate with her. Or you might work with a woman who has been adjudicated incompetent by a court and has a guardian. You are unsure what that means for you and for the woman you are working with, and you are unsure about how to proceed.

Think about . . .

- *What are some obstacles that I have or might encounter?*
- *What are some strategies I might employ to ensure that a woman and I are communicating in a respectful and mutually meaningful way?*

- *Who might assist me if I am unsure or anxious about how to communicate with her?*

Considering these obstacles and others you might encounter, there are no simple answers to ensuring effective communication. However, there are additional resources and opportunities for technical assistance and support to help you figure out some effective solutions.

To assist you in learning how to think about screening for and asking about abuse issues, we have included information in *Appendix G* for your reference. The information contained therein includes a description of “Best Practice Recommendations for the Screening and Assessment of Trauma” which was developed by Wisconsin’s Trauma Work Group, and a sample “Trauma Assessment” developed by the State of Maine, Department of Behavioral and Development Services. As you review these materials, think about how your agency might benefit from either developing a similar tool or working jointly with another agency (e.g., disability and sexual assault agencies partnering) to develop methods for responding to abuse issues.

Employing a screening tool to ask about abuse must be coupled with knowing how to respond if a woman discloses that she has been or is being abused. Disability and anti-violence agencies working together is vitally important to creating an effective and safe response for women who disclose abuse. (*See the How Do We Begin to Participate as Collaborators section for information.*)

IS YOUR SUPPORT CONDITIONAL?

Organizational mission statements are often broad and inclusive. Statements of mission and purpose are often, by design, big. “To end violence.” “To protect.” “To advocate.” “To inform.” “To provide services.” It is wise for both organizations and individuals to consider what they want to accomplish and what they can do well. As members of groups and on our own, we make commitments. In the context of both paid and volunteer activities we agree to adhere to certain roles and responsibilities.

Think about . . .

What is your organizational commitment?

Fill in the blank: We, as a group, are committed to...

What is your individual commitment within the organization?

I am personally committed to...

Consider just some of the roles and responsibilities of sexual assault, domestic violence, and disability support people. The role for some is “to believe.” The role is not to be the investigator or prosecutor. The responsibility is to support someone else through a process. The role for others is “to inform.” The role is not to tell someone else what to do or want. The responsibility is to help someone else understand what options are available so that an informed choice can be made. The role for still others is “to teach.” The role is not just to decide what someone should learn to do. The responsibility is to discover what the person has interest in learning.

One responsibility that goes along with each of these jobs is to play out the assigned roles consistently. The role is “to believe” even when you might have doubt; “to inform” even when the right course of action might seem obvious to you; and, “to teach” even when you think it might be easier to just leave things as they are.

We say “yes” to roles and agree to carry them out consistently. But because we are human, and can feel challenged, we can falter. We might be moved out of our comfort zones. What happens to you when you encounter people or circumstances that push you out of your comfort zone?

Think about . . .

What characteristics or circumstances challenge you?

I feel challenged when...

What happens to you when you feel challenged?

When I am challenged, I think...

When I am challenged, I feel...

Community support is rich with vague, feel-good, language. Words and phrases such as autonomy, choice, self-direction, self-advocacy, survivor, recovery, and empowerment are used. However, not everyone using these words has the same understanding of what they mean. Use of certain language often precedes comprehension; and, comprehension often changes based on experience and reflection.

We sometimes approach our work with beliefs and statements that justify and explain our practice. What we tell ourselves and say to others might start with “I know...,” “I believe...,” or “We always...” In other words, we can keep doing what we have been doing, practice as we have practiced, and assure ourselves that we are the state of the art. This might be described as a mindless, or automatic, practice. Or, we can approach our work with humility and questions that explore and stretch our practice. Our internal and external language might start with “I wonder...,” “How else could we...,” or “What else might help?” This might be described as a mindful, or learning, practice.

It is reasonable to have some beliefs and clearly defined goals. It is only a problem when our beliefs and goals become so fixed that they interfere with accomplishing our mission. Our

practice can become habitual, even rigid and brittle, and our responses to people and circumstances outside of our comfort zone can become defensive or even fearful (rather than curious). In practice, we can keep doing what we have been doing and saying we are state of the art, or we can keep asking whether there are more, different, or better ways to achieve and honor our commitments -- even when personal characteristics and circumstances challenge us.

Think about . . .

What is your natural tendency when presented with a suggestion to try something other than what you usually do?

- *Do you tend to respond quickly, to rule things in or out?*
 - *Does your mind actively consider the possibilities? or actively resist?*
 - *Does your body tighten up? or feel excited and energized?*
 - *Do you wonder how you could approach what you do differently?*
 - *Do you resent others who do not seem to understand what you know to be true?*
 - *What is your natural tendency when presented with a suggestion to try something other than what you usually do?*
-
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-

When trying to work mindfully, the challenge is in not rigidly adhering to too many rules and boundaries. Flexibility can be valuable when practiced as an openness to learn and an acknowledgment that better or different questions can lead to better or different ways of operating. What happens to your commitments when a suggestion to try something new or someone's presence feels challenging? When there is an implied suggestion that you carry out your commitment consistently, even though you are not in your comfort zone, what happens to you?

Think about . . .

When you feel challenged, what happens to your intention to consistently carry out your role? When I feel challenged, my commitment and intention...

Whether you work in domestic violence, sexual assault, or disability related organizations, it is helpful to consider how we approach our work, even with the very best of intentions. Ethics is the branch of philosophy that tries to determine right action. What is the right thing to do? Because the “right” action, or the “best” thing to do, is not always clear, it might be more accurate to ask, “what is almost right?” or even, “what is less wrong?” Some people make these ethical decisions based on a set of rules or beliefs. Some people make these decisions based on a process of examination and reason. Others incorporate community or cultural standards into their decision making process. Still others are not aware that a decision, a choice, is even being made. Default takes over and we just keep doing what we have been doing, without any active consideration of why.

Think about . . .

- *Is my/our support conditional?*
 - *Does it depend on being able to keep doing what I have done, for and with people who do not challenge my comfort or confidence?*
-
-
-

Are there others who could help with this? One critical difference between an automatic approach and a more flexible approach is how we think. An **automatic approach** is limited to what is already known, or what has already been experienced. The answer is:

- “Yes” or “no.”
- “We can” or “we can’t.”
- “We will” or “we won’t.”
- “It fits” or “it does not fit” (our current design).

A **more flexible approach** suggests that we believe less and consider more. Mindful decision making can help to move organizations and individuals closer to our missions. Active consideration of important questions is characterized by more questions and slower answers:

- “I wonder.”
- “How else could we do this?”
- “What else would we need and how could we learn?”

The difference between automatic and flexible approaches to making decisions has everything to do with deciding to stretch and grow.

It is reasonable, even advisable, for organizations and individuals to be aware of their strengths and their limitations. However, a more flexible approach suggests exploring that area of limitation to recognize it as potentially temporary, rather than a permanent condition.

Think about . . .

- *What kind of decision maker are you?*
- *What kind of decision maker are you when you feel challenged?*

When you hear about a situation, are you usually the person who immediately says “yes” or immediately says “no?” Are you someone who has a quick response of, “That’s just wrong?” What happens to your original intention, when you are presented with situations that are (or you think might be) different than what you generally experience? What happens to your attitude, your curiosity, your energy, your confidence, or even your sense of competence? What happens to your sense of humor?

So far, this has been personal but broad. Now, let’s be more specific. **If you are reading this, you have interest in ending violence and abuse. You already care about people who are at risk. The question is, how far does that commitment go?** Think back to anyone whose personal characteristics or circumstance edged you out of your comfort zone.

Is your support conditional? Probably. Are those conditions the same as permanent boundaries? Can we learn how to extend our services to people who have generally not received them? Sometimes, instead of creating parallel systems to offer support, we can learn how to extend ourselves. Comfort zones can change. It has been apparent each time that phrase was typed - comfort zone - that those of you who regularly hear personal stories of force, injury, and violence already understand more than most people what it means to function outside of your comfort zone. It is not comfortable to hear about or witness the painful experiences of others – let alone be the person who actually has experienced it. Among other things, caring and compassion allowed you to stretch and do what you are now doing. If you did it once....

Think about . . .

- *What would you need now if you wanted to be less conditional about who you support?*
- *What would you want to learn?*
- *Whose assistance might be valuable?*

Also think about . . .

- *When someone talks about physical or sexual violence, do you want to hear it or do you tend to shut it off?*
- *Do you believe women who say they have been assaulted by a caregiver?*
- *Do you want to terminate services to someone whose behavior is out of control (even though that behavior could be a reaction to abuse)?*

HOW DO WE BEGIN TO PARTICIPATE AS COLLABORATORS?

This Project is intended to stimulate the possibilities for greater inclusiveness of women with disabilities by domestic abuse and sexual assault providers. It also is intended to increase awareness among those who support women (people) with disabilities who are abused and to recognize that violence is a serious problem and may have serious, long-term consequences for the individual. The message throughout has been that we do not think that everyone can or has to address all of the needs of every person who needs help.

Collaborative Experiences in the Field

One director of a supported living organization recently told us that when she became aware that someone receiving support was experiencing domestic violence, she knew that she could not simply make a referral to the local domestic violence service provider. She knew that staff from her organization would need to be involved throughout every step of what might happen. More importantly, she said that she did not know what the path of that help might be. She reached out to the domestic violence provider and collaboration began. It took compassion as well as humility and intelligence to say, “We need some help.” They had to learn about each other’s values and typical ways of operating. They had to learn how to share each other’s strengths and not get bogged down in their differences. Neither the supported living provider nor the domestic violence provider owned or controlled the situation.

Another provider of support to people with disabilities noted the difficulty in breaking from the unspoken tradition among disability providers to remain somewhat insular. The motto for many people is that no one will understand, so “we take care of our own.” It was new and unnerving for the provider to consider that contacts with people who work in rape crisis centers, hospital emergency rooms, police departments, and others might actually have positive roles in the lives of people with disabilities.

No one we have heard from while working on this Project has talked about surrendering their roles or responsibilities. We have heard about people extending themselves in their communities. Someone who traditionally worked only with people who have disabilities started being an active participant in local crisis response planning meetings. When issues of responding to crises in the community were raised she made sure that there was discussion about people with disabilities.

How do we begin to participate collaboratively?

Collaboration can begin with a direct question or a community issue. It can be a hypothetical situation or it can be about a person with a specific disability and situation. The phrase we have heard over and over is that “we have to be sitting around the same tables.” Time has to be made to engage in these discussions. Support providers for people with disabilities, sexual assault providers, domestic violence providers, people in law enforcement, mental health professionals, elder abuse and adult protective services workers, women who have been victims and survivors

have to be around the same tables, in the same rooms, agreeing and disagreeing. The focus has to be on making sure that everyone who needs help receives it, and working to create a social climate in which fewer people will need help because abuse and violence will not be so common.

Think about . . .

- *What are some questions or issues that could be addressed in your community?*
- *What ongoing groups could you get yourself invited to?*
- *What could be the theme of a conference about violence in your community?*
- *Take the opportunity to raise awareness about violence against women with disabilities in conversation with influential people: “Did you know.... What do you think we should do about that?”*

Getting collaborators to the “same table” often is the most challenging step. There isn’t **one** way that proves successful for every community. Each of you is familiar with the individual and organizational dynamics and relationships that exist in your communities. A useful starting point is to reach out to disability, domestic violence, and sexual assault programs in your community to convene a discussion about the issues facing women with disabilities who experience violence. If you aren’t certain who these contacts might be, tap the resources listed in this *Workbook’s Technical Assistance and Resource Information* section for ideas.

The first gathering might involve each person sharing their thoughts about the following:

- why each person is interested in coming together to focus on women with disabilities and violence;
- what each person’s particular experiences have been in this arena;
- what obstacles to providing support to women victims with disabilities have participants encountered; and
- what strengths do they feel they have to offer to support and serve women with disabilities.

Think about . . .

How would you respond to each of the questions raised above, if you were participating in an initial meeting of individuals interested in women with disabilities, sexual assault, domestic violence and stalking?

Whether these experiences, obstacles and strengths are individually or organizationally driven is less important than creating an opportunity to share information and get to know one another. In response to these initial discussions, it's useful to identify some themes or issues that are common, and figure out as a group what else might help.

Think about . . .

- *Is there a specific goal or action that the group could tackle together?*
- *What does the group want to achieve in the short term? The long term?*
- *Who else might we need or want at the table?*
- *What resources and technical assistance might we want to begin to take action on our identified goals?*
- *Where could we find those resources and assistance?*
- *How do we sustain our momentum and action-focus over time?*
- *How do we institutionalize change in our communities and organizations instead of relying only on specific individuals for change?*

Remember what we said at the beginning of this Workbook:

This Project is based on the knowledge that there is a great deal of experience, expertise, and desire to learn more and do better for women who might be, or who already have

been, subjected to violence or abuse. We also are aware that many of you do not know enough about one another. This means there are potentially big gaps in terms of who receives help. One of our primary goals is to help you find one another and encourage a more collaborative effort.

Encouraging an action-oriented community effort to build alliances helps all of us to do better for women with disabilities who experience domestic violence, sexual assault and stalking.

Additional Resources to Consider When Collaborating

The Violence Against Women with Disabilities Project also has developed a couple of resources that might alleviate some of your frustration, fear or confusion about communication obstacles. One resource available to you is the ***Accessibility Guide for Domestic Violence and Sexual Assault Services Providers***. This *Guide*, though written for domestic violence and sexual assault services providers, contains information and practice tips that are applicable to disability support providers as well. It will assist you by:

- **Providing a basic understanding** of the laws that protect people with disabilities from discrimination and ensure their equal access to programs and services, such as the Americans with Disabilities Act (ADA).
- **Exploring the systemic, communication and physical barriers** that impact an agency's accessibility for women and their children with disabilities generally.
- **Reminding you that no one response works** for every woman or for every program addressing a similar accessibility barrier.
- **Identifying and suggesting practical resolutions** to barriers that arise when collaborating with other systems and conducting outreach to women with disabilities.

Another resource made available to you through this Project provides useful background information about managing potential barriers to collaboration due to **confidentiality** requirements and **substitute decision makers, such as guardians**. These resources also include sample "release of information" forms that you might use to ensure legally permissible communication with others, if a woman gives her informed consent for you to do so.

These resources, as well as ongoing information about additional technical assistance contacts and other resources, are included in your cross training materials. In addition, the Project partner organizations each have a commitment to providing quality technical assistance to you as your needs arise, or if you would just like to talk through some concerns or "comfort zone" issues that you have encountered. (*See the Technical Assistance and Resource Information section of this Workbook for specific contact information for the Project partner organizations.*)

TECHNICAL ASSISTANCE AND RESOURCE INFORMATION

The following is a selective list of resources and organizations which may be of assistance to you in work with women with disabilities who have been victims of violence. We have done our best to ensure that the information is accurate; however, it is possible that some of it may have changed.

Violence Against Women with Disabilities Project Partners

Wisconsin Coalition for Advocacy (WCA)

State's protection and advocacy agency for people with disabilities; provides individual advocacy, systems advocacy, and training and technical assistance to people with disabilities, their families, and a variety of professionals.

Madison office:

16 North Carroll St., Suite 400
Madison, WI 53703
608-267-0214 Voice/TTY
800-928-8778 Voice/TTY
www.w-c-a.org

Milwaukee office:

2040 W. Wisconsin Ave, Suite 678
Milwaukee, WI 53233
414-342-8700 Voice/TTY
800-708-3034 Voice/TTY

Rice Lake Office:

113 North Main Street
Rice Lake, WI 54868
715-736-1800 Ext. 3 Voice/TTY

Wisconsin Coalition Against Domestic Violence (WCADV)

Statewide membership organization of domestic abuse programs, formerly battered women, and others; activities include technical assistance and training regarding domestic violence, networking and support for victims, their families and for professionals working with victims, batterers, and their children; and policy development.

Madison Office:

307 South Paterson Street, Suite 1
Madison, WI 53703
608-255-0539 Voice/TTY
www.wcadv.org

Wausau Office:

PO Box 6068
Wausau, WI 54402-6068
715-849-3610 Voice

Wisconsin Coalition Against Sexual Assault (WCASA)

Statewide organization providing education and training around sexual assault issues to local sexual assault programs, schools, law enforcement, and other community-based organizations.

600 Williamson Street, Suite N-2
Madison, WI 53703
608-257-1516 Voice/TTY
www.wcasa.org

IndependenceFirst

Independent living center, serving four counties in the Milwaukee area; provides information and referral, counseling, abuse prevention classes, and advocacy to women victims with disabilities.

600 West Virginia Street, 4th Floor

Milwaukee, WI 53204-1516

414-291-7520 Voice/TTY

www.independencefirst.org

Wisconsin Disability Resources**The Arc – Wisconsin**

Provides a variety of assistance to people with developmental and related disabilities and their families; 33 local chapters in Wisconsin.

600 Williamson St., Suite J

Madison, WI 53703

608-251-9272 Voice

www.arc-wisconsin.org

Brain Injury Association of Wisconsin

Provides information, education, support and advocacy to people with brain injury, their families and other community members.

2900 North 117th Street, Suite 100

Wauwatosa, WI 53222

414-778-4144 Voice

800-882-9282 Toll-free

www.biaaw.org

Grassroots Empowerment Project

Mental health consumer-run organization with groups in many areas of the state.

PO Box 26515

Wauwatosa, WI 53226

414-454-0221 Voice

800-770-0588 Toll-free

Wisconsin Independent Living Centers

Provides an array of services, including: peer support, information and referral, independent living skills training, advocacy, community education, personal care and service coordination to people with a variety of disabilities and information and access to assistive technology.

Access to Independence Counties served: Columbia, Dane, Dodge, Green

2345 Atwood Avenue

Madison, WI 53704

608-242-8484 Voice

608-242-8485 TTY

800-362-9877 Toll-free

Center for Independent Living for Western Wisconsin Counties served: Barron, Chippewa, Clark, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St. Croix
2920 Schneider Avenue East
Menomonie, WI 54751
715-233-1070 Voice/TTY
800-228-3287 Toll-free

Rice Lake Office:
113 N. Main Street
Rice Lake, WI 54868
715-736-1800 Voice/TTY

Independent Living Resources, Inc. Counties served: Buffalo, Crawford, Grant, Iowa, Jackson, Juneau, La Crosse, Lafayette, Monroe, Richland, Sauk, Trempealeau, Vernon
4439 Mormon Coulee Road
La Crosse, WI 54601
608-787-1111 Voice
608-787-1148 TTY
888-474-5745 Toll-free

Richland Center Office:
149 East Mill Street, Suite A
Richland Center, WI 53581
608-647-8053 Voice/TTY
877-471-2095 Toll-free

IndependenceFirst
(Listed above under Violence Against Women with Disabilities Project Partners.)

Midstate Independent Living Consultants Counties served: Adams, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Taylor, Vilas, Wood

Rhineland Office:
203 Schiek Plaza
PO Box 369
Rhineland, WI 54501-0369
715-369-5040 Voice/TTY
800-311-5044 Toll-free

Stevens Point Office:
3262 Church Street, Suite 1
Stevens Point, WI 54481
715-344-4210 Voice/TTY
800-382-8484 Toll-free

Wausau Office:
10101 Market Street, Suite B
Mosinee, WI 54455
715-241-6927 Voice/TTY
877-711-6452 Toll-free

North Country Independent Living Counties served: Ashland, Bayfield, Burnett, Douglas, Iron, Price, Sawyer, Washburn

Superior Office:

2231 Catlin Avenue
PO Box 1245
Superior, WI 54880
715-392-9118 Voice/TTY
800-924-1220 Toll-free

Ashland Office:

422 W. Third Street, Suite 114
Ashland, WI 54806
715-682-5676 Voice/TTY
800-499-5676 Toll-free

Options for Independent Living Counties served: Brown, Calumet, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Menominee, Oconto, Outagamie, Shawano, Sheboygan, Waupaca, Waushara, Winnebago

Green Bay Office:

555 Country Club Road
PO Box 11967
Green Bay, WI 54307
920-490-0500 Voice
920-490-0600 TTY

Appleton Office:

820 W. College Avenue, Suite 5
Appleton, WI 54914
920-997-9999 Voice/TTY

Society's Assets Counties served: Jefferson, Kenosha, Racine, Rock, Walworth

Racine Office:

5200 Washington Avenue, Suite 225
Racine, WI 53406
262-637-9128 Voice/TTY
800-378-9128 Toll-free

Kenosha Office:

5727 Sixth Avenue
Kenosha, WI 53140
262-657-3999 Voice/TTY
800-317-3999 Toll-free

Elkhorn Office:

615 E. Geneva Street
Elkhorn, WI 53121
262-723-8181 Voice/TTY
800-260-7704 Toll-free

National Alliance for the Mentally Ill –Wisconsin (NAMI-WI)

Provides information, support, advocacy regarding mental illness to consumers, families, and friends of people with severe mental illnesses; 34 affiliates serving 40 counties throughout the state.

4233 West Beltline Highway
Madison, WI 53711
608-268-6000 (will transfer to TTY)
800-236-2998 Toll-free
www.namiwisconsin.org

National Multiple Sclerosis Society -Wisconsin Chapter

Provides advocacy and education to people with multiple sclerosis, their families, and the general public.

1120 James Drive, Suite A
Hartland, WI 53029
262-369-4400 Voice
800-242-3358 Toll-free
www.nationalmssociety.org/wig

People First Wisconsin

Statewide self-advocacy organization for people with disabilities.

Marian Center, 3195 South Superior Street
Milwaukee, WI 53207
414-483-2546 Voice
888-270-5352 Toll-free
www.peoplefirstwi.org

Wisconsin Association of the Deaf

Advocate for the civil rights of the Deaf and hard of hearing, including legal, employment and educational rights; provide information and referral on Deaf related topics; work toward telecommunications and technological access; provide education and training; chapters in various areas of the state.

Linda Russell, President
519 Heatherstone Ridge
Sun Prairie, WI 53590
608-250-5076 TTY
www.wi-deaf.org

Wisconsin Council for the Blind

Provides variety of services to people who are blind or have visual impairments; advocates legislation, and education to the general public.

754 Williamson Street
Madison, WI 53703
608-255-1166 Voice
800-783-5213 Toll-free
www.wcblind.org

Wisconsin Council on Developmental Disabilities

Advocates for adequate and appropriate supports on behalf of individuals with developmental disabilities and for improvements in the disability service system.

201 West Washington Ave., Suite 110
Madison, WI 53703
608-266-7826 Voice
608-266-6660 TTY
www.wcdd.org

For information re: Real Time Captioning and Hearing Interpreters

Deaf and Hard of Hearing Regional Offices

Northern Region Counties: Adams, Ashland, Florence, Forest, Iron, Juneau, Langlade, Lincoln, Marathon, Marquette, Oneida, Portage, Price, Taylor, Vilas, Waushara, Wood
Jason Altmann
2801 N. 7th St.
Wausau, WI 54401-3281
715-842-1211 TTY
AltmaJR@dhfs.state.wi.us

Northeastern Region Counties: Brown, Calumet, Dodge, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Menomonie, Oconto, Outagamie, Ozaukee, Shawano, Sheboygan, Washington, Waupaca, Winnebago
Marge Liberski
200 N. Jefferson St., Suite 311
Green Bay, WI 54301-5191
920-448-5295 Voice Interpreted and TTY
LiberMA@dhfs.state.wi.us

Southern Region Counties: Columbia, Dane, Grant, Green, Iowa, Jefferson, Lafayette, Richland, Rock, Sauk, Walworth
Bette Mentz
2917 International Lane, Suite 230
Madison, WI 53704-3135
608-243-5732 TTY
608-243-5733 Voice
MentzBJ@dhfs.state.wi.us

Southeastern Region Counties: Kenosha, Milwaukee, Racine, Waukesha
Rebecca Steele
141 NW Barstow St., Room 157
Waukesha, WI 53187
262-548-5858 TTY
SteelRL@dhfs.state.wi.us

Western Region Counties: Bayfield, Barron, Buffalo, Burnett, Clark, Chippewa, Crawford, Douglas, Dunn, Eau Claire, Jackson, La Crosse, Monroe, Pierce, Pepin, Polk, Rusk, St. Croix, Sawyer, Trempealeau, Vernon, Washburn
Carolyn Small
610 Gibson St., Suite 1
Eau Claire, WI 54701
715-836-2107 Voice/TTY
SmallCM@dhfs.state.wi.us

For information re: Wisconsin's Adult Protective Services System

Adult Protective Services (APS) Agencies

Wisconsin State Statute (Chap. 55) requires each county board to designate its adult protective services (APS) agency. Contact your county's human services or social services agency; refer to the blue section for county government in your local telephone book. Or contact the **Wisconsin Department of Health and Family Services**, Bureau of Aging and Long Term Care Resources 608-266-2536 Voice

For information re: Guardianship

Wisconsin Coalition for Advocacy (WCA)

(Listed under the Violence Against Women with Disabilities Project Partners at the beginning of this section.)

Guardianship Support Center

Elder Law Center
Coalition of Wisconsin Aging Groups (CWAG)
2850 Dairy Drive, Suite 100
Madison, WI 53718
608-224-0606 Voice
www.cwag.org

Wisconsin's Domestic Violence and Sexual Assault Programs

Wisconsin Domestic Violence Programs

Advocates of Ozaukee

| | | |
|---------------------|------------------------|--------------------------|
| P.O. Box 80166 | 262-284-3577 Voice | |
| Saukville, WI 53080 | 877-375-4034 Toll-free | 262-284-6902 Crisis Line |

Asha Family Services

| | | |
|---------------------|--------------------|--------------------------|
| 6001 W. Center St. | | |
| Milwaukee, WI 53210 | 414-875-1511 Voice | 414-875-1511 Crisis Line |

Assoc. for the Prevention of Family Violence

| | | |
|------------------------|--------------------|--------------------------|
| W3929 Cty. NN | | |
| Elkhorn, WI 53121-4362 | 262-723-4653 Voice | 262-723-4653 Crisis Line |

AVAIL, Inc.

| | | |
|------------------|--------------------|--------------------------|
| PO Box 355 | | |
| Antigo, WI 54409 | 715-623-5177 Voice | 715-623-5767 Crisis Line |

Bad River Chippewa Tribe DAP

PO Box 55

Odanah, WI 54861 715-682-8379 Voice

Barron County Domestic Abuse Program

330 East La Salle

Barron, WI 54812 715-537-5691 Voice 800-924-0556 Toll-free

Beloit Domestic Violence Center

PO Box 476

Beloit, WI 53512-1096 608-364-1083 Voice 608-365-1119 Crisis Line

Bolton Refuge House

PO Box 482

Eau Claire, WI 54702 715-834-0628 Voice 800-252-4357 Toll-free

Bolton Refuge House - Jackson County

PO Box 457

Black River Falls, WI 54615 715-284-4301 Ext.8 Voice 800-252-4357 Toll-free

Bridge to Hope

PO Box 700

Menomonee, WI 54751 715-235-9075 Voice 800-924-9918 Toll-free

Bridge to Hope - Pepin Outreach

PO Box 161

Durand, WI 54736 715-672-3150 Voice 800-924-9918 Toll-free

CAP Services/Family Crisis Center

1616 West River Drive

Stevens Point, WI 54481-3430 715-345-5208 Voice

Caring House, Inc. - Florence County Outreach

PO Box 230

Florence, WI 54121 715-528-5161 Voice 800-392-7839 Crisis Line

Caring House, Inc.

1305 Prospect

Iron Mountain, MI 49801 906-774-1337 Voice 906-774-1112 Crisis Line

800-392-7839 Toll-free

CASDA

2231 Catlin Ave.

Superior, WI 54880 715-392-3136 Voice 800-649-2921 Toll-free

CASDA - Bayfield County Outreach

PO Box 41

Washburn, WI 54891 715-373-0870 Voice 800-649-2921 Crisis Line

CASDA - Douglas County Outreach Office

8978 E. Cty. Rd. A, Suite 5

Solon Springs, WI 54873 715-378-4306 Voice

Catholic Charities Diocese - La Crosse128 S. 6th St. La Crosse

PO Box 337

Prairie du Chien, WI 53821 608-326-1616 Voice

888-200-8426 Crisis Line

Catholic Charities of Green Bay

1825 Riverside Dr.

PO Box 23825

Green Bay, WI 54305-3825 920-437-7531 Voice

888-345-5898 Toll-free

Christine Ann Domestic Abuse Services

163 W. Huron St.

Berlin, WI 54923

920-361-1158 Voice

800-261-5998 Toll-free

Christine Ann Domestic Abuse Services, Inc.

1215 Doctors Drive

PO Box 99

920-729-5727 Voice

920-235-5998 Crisis Line

Neenah, WI 54957-0099 800-261-5998 Toll-free

Clark County Domestic Violence Project

216 Sunset Place

Neillsville, WI 54456

715-743-6401 Voice

Community Referral Agency

PO Box 365

715-825-4414 Voice

715-825-4404 Crisis Line

Milltown, WI 54858

800-261-7233 Toll-free

Domestic Abuse Intervention Services

PO Box 1761

608-251-1237 Voice

608-251-4445 Crisis Line

Madison, WI 53704

800-747-4045 Toll-free

Domestic Abuse Support Center

PO Box 665

715-526-3421 Voice

715-526-3421 Crisis Line

Shawano, WI 54166

888-303-3421 Toll-free

Domestic Violence Intervention Project205 5th Ave. S. St., #325

La Crosse, WI 54601

608-785-7670 Voice

DOVE

PO Box 366

906-932-4990 Voice

906-932-0310 Crisis Line

Ironwood, MI 49938

800-711-6744 Toll-free

DOVE Outreach Iron County

15 Hwy 51

Hurley, WI 54534

715-561-5033 Voice

800-711-6744 Toll-free

Family Advocates, Inc.

PO Box 705

Platteville, WI 53818

608-348-5995 Voice

800-924-2624 Toll-free

608-348-3838 Crisis Line

Family Advocates, Inc. - Iowa County

101 W. Leffler, Suite C

Dodgeville, WI 53533

608-935-3936 Voice

800-924-2624 Toll-free

Family Advocates, Inc. - Lafayette County

307 Main Street

Darlington, WI 53530

608-776-3936 Voice

800-924-2624 Toll-free

Family Center531 - 10th Ave. North

Wisconsin Rapids, WI 54495

715-256-1136 Voice

715-421-1511 Crisis Line

Family Crisis Center - Waupaca County

101 Tower Rd.

Waupaca, WI 54981

715-256-1136 Voice

800-472-3377 Crisis Line

Family Crisis Center - Waushara Co.

205 E. Main St.

Wautoma, WI 54982

920-787-3889 Voice

800-472-3377 Toll-free

Family Crisis Center/CAP Services

1616 W. River Dr.

Stevens Point, WI 54481

715-343-7125 Voice

800-472-3377 Toll-free

Family Service

128 E. Olin Ave., Suite 100

Madison, WI 53713

608-252-1320 Voice

Family Support Center

PO Box 143

Chippewa Falls, WI 54729

715-723-1138 Voice

800-400-7020 Toll-free

Family Violence Center

1120 University Ave.

Green Bay, WI 54302

920-435-0100 Voice

877-431-4321 Toll-free

920-432-4244 Crisis Line

FAVR

PO Box 1752

92 Amory St.

Fond du Lac, WI 54936-1752

920-923-1743 Voice

920-923-1700 Crisis Line

Forest County Potawatomi DAP

PO Box 396

Crandon, WI 54520

715-478-4317 Voice

Friends of Abused Families, Inc.

PO Box 117

West Bend, WI 53095

262-334-5598 Voice

262-334-7298 Crisis Line

Great Lakes Inter-Tribal Council

PO Box 9

Lac du Flambeau, WI 54538 715-588-3324 Voice

Green Haven

PO Box 181

1811 - 11th St.

Monroe, WI 53566

608-325-6489 Voice

800-836-9788 Toll-free

608-325-7711 Crisis Line

Gundersen Lutheran DV & SA

1910 South Ave.

La Crosse, WI 54601

Harbor House Domestic Abuse Program

720 West Fifth Street

Appleton, WI 54914

920-832-1667 Voice

800-970-1171 Toll-free

920-832-1666 Crisis Line

Harbor House - Calumet County Outreach

18 W. Main St., Suite T

Chilton, WI 53014

920-849-7819 Voice

800-970-1171 Crisis Line

HAVEN, Inc.

710 E 3rd St.

PO Box 32

Merrill, WI 54452

715-536-9563 Voice

877-345-1300 Toll-free

715-536-1300 Crisis Line

HELP of Door County

332 Pennsylvania Ave.

Sturgeon Bay, WI 54235

920-743-8785 Voice

800-914-3571 Crisis Line

Hmong American Friendship Assoc.

3824 W. Vliet St.

Milwaukee, WI 53205

414-344-6575 Voice

Ho Chunk Nation

PO Box 40 715-284-2622 Voice 800-236-7660 Crisis Line
Black River Falls, WI 54615 888-343-8190 Toll-free

Hope House

PO Box 432 608-356-9123 Voice 608-356-9109 Crisis Line
Baraboo, WI 53913 800-584-6790 Toll-free

Hope House - Adams County

PO Box 158 608-339-9559 Voice 608-339-9559 Crisis Line
Adams, WI 53910-0158 800-584-6790 Toll-free

Hope House - Columbia County

204 Edgewater St. 608-745-4722 Voice 608-745-4722 Crisis Line
Portage, WI 53901 800-584-6790 Toll-free

Hope House - Juneau County

1 Kennedy St., Suite 3 608-847-3331 Voice 608-847-3331 Crisis Line
Mauston, WI 53948 800-584-6790 Toll-free

Hope House - Marquette County

PO Box 822 608-297-9289 Voice 608-297-9289 Crisis Line
Montello, WI 53949 800-584-6790 Toll-free

Lac Courte Oreilles Women's Program

13394 W. Trepania Rd.
Domestic Abuse Shelter
Hayward, WI 54843 715-634-9360 Voice 877-552-7474 Toll-free

Lac du Flambeau DA Program

PO Box 67
Lac du Flambeau, WI 54538 715-588-7660 Voice 800-236-7660 Toll-free

Maehnowesekiyah Treatment Center

N2150 Kesaehkahtek
Gresham, WI 54128 715-799-3835 Voice 715-799-3861 Crisis Line

Manitowoc County DVC

PO Box 1142 920-684-4661 Voice 920-684-5770 Crisis Line
Manitowoc, WI 54221-1142 877-275-6888 Toll-free

Milwaukee Women's Center

611 N. Broadway, Suite 230
Milwaukee, WI 53202 414-272-6199 Voice 414-671-6140 Crisis Line

Monroe County Domestic Abuse Project

PO Box 161

101 N. Water St.

Sparta, WI 54656

608-269-7853 Voice

888-886-2327 Toll-free

Monroe County Domestic Abuse Project - Tomah Outreach

1118 W. Veterans Drive

Tomah, WI 54660

608-374-6975 Voice

608-346-0374 Crisis Line

New Horizons Shelter

PO Box 2031

La Crosse, WI 54602

608-791-2604 Voice

888-231-0066 Toll-free

608-791-2600 Crisis Line

New Horizons - Buffalo County Outreach

PO Box 6 Courthouse Annex

317 S. 2nd Ave.

Alma, WI 54610-0006

608-685-2424 Voice

888-231-0066 Toll-free

Northwoods Women Inc. /New Day Shelter

PO Box 88

Ashland, WI 54806

715-682-9566 Voice

800-924-4132 Toll-free

715-682-9565 Crisis Line

Oneida Nation Domestic Abuse Program

PO Box 365

Oneida, WI 54155

920-490-3824 Voice

888-490-2457 Toll-free

PADA - People Against Domestic Abuse

PO Box 395

Jefferson, WI 53549

920-674-6748 Voice

800-228-7232 Toll-free

920-674-6768 Crisis Line

Passages, Inc.

PO Box 546

Richland Center, WI 53581

608-647-8775 Voice

800-236-4325 Toll-free

Pathways of Courage, Inc.

PO Box 1643

1511 - 56th St.

Kenosha, WI 53141

262-656-3560 Voice

800-594-5272 Toll-free

262-657-5272 Crisis Line

PAVE

1403 N. Center Street

PO Box 561

Beaver Dam, WI 53916

920-887-3810 Voice

800-775-3785 Toll-free

Personal Development Center

630 S. Central Ave., Suite 101R

Marshfield, WI 54449

715-384-2971 Voice

715-384-5555 Crisis Line

Personal Development Center - Clark County DV

216 Sunset Place

Neillsville, WI 54456

715-743-6401 Voice

715-748-5140 Crisis Line

Rainbow House DA Services, Inc.

PO Box 1172

Marinette, WI 54143

715-735-6656 Voice

800-956-6656 Crisis Line

Rainbow House - Oconto County Outreach

1201 Main Street

Oconto, WI 54153

920-834-5299 Voice

800-956-6656 Crisis Line

Red Cliff Family Violence Program

88385 Pike Rd, Hwy 13

Bayfield, WI 54814

715-779-3826 Voice

715-779-3769 Crisis Line

S.A.S.S.Y., Inc.

12 W. Marshall St., Suite 204

PO Box 727

Rice Lake, WI 54868

715-234-8445 Voice

715-234-8445 Crisis Line

Safe Harbor

PO Box 582

Sheboygan, WI 53082

920-452-8611 Voice

800-499-7640 Toll-free

920-452-7640 Crisis Line

Sixteenth St. Community Health Center

1032 South 16th Street

Milwaukee, WI 53204

414-672-1315 Voice

Sojourner Truth House

PO Box 080913

Milwaukee, WI 53208

414-643-1777 Voice

414-933-2722 Crisis Line

Sokaogan Chippewa Tribe

10960 Cty. Rd. M

Crandon, WI 54520

715-478-7667 Voice

St. Agnes Domestic Violence Program

430 E. Division St.

Fond du Lac, WI 54935

920-926-4207 Voice

920-926-4290 Crisis Line (Pager)

St. Croix Tribe - Alternatives to Violence

PO Box 45287

Hertel, WI 54845

715-349-2195 Voice

800-236-2195 Toll-free

888-557-8758 Crisis Line

Stepping Stones, Inc.

PO Box 224

Medford, WI 54451

715-748-3795 Voice

715-748-5140 Crisis Line

Stockbridge Munsee Mohican Nation

PO Box 70

Bowler, WI 54416

715-793-4800 Voice

715-793-4080 Crisis Line

Task Force on Family Violence, Inc.

1400 N. 6th St.

Milwaukee, WI 53212

414-276-1911 Voice

414-278-5079 Toll-free

Time Out Family Abuse Shelter

PO Box 406

107 E. Lindoo

Ladysmith, WI 54848

715-532-6976 Voice

800-924-0556 Toll-free

715-532-7089 Crisis Line

Time Out - Washburn County Outreach

321 N. Front St.

Spooner, WI 54801

715-635-5245 Voice

800-924-0556 Toll-free

Time Out - Price County Outreach

126 Cherry St., Rm. 5

Price Co. Courthouse

Phillips, WI 54555

715-339-4521 Voice

800-924-0556 Crisis Line

Tri-County Council on DV & SA

PO Box 233

Rhineland, WI 54501

715-362-6841 Voice

800-236-1222 Crisis Line

Tri-County Council on DV & SA – Vilas County

PO Box 1867

Eagle River, WI 54521

715-479-2912 Voice

800-236-1222 Crisis Line

Tri-County Council on DV & SA - Forest County

PO Box 158

Crandon, WI 54520

715-478-3780 Voice

800-236-1222 Crisis Line

Turning Point for Victims - St. Croix County

105 A South Knowles Ave.

New Richmond, WI 54017

715-246-9216 Voice

888-321-9216 Toll-free

Turning Point for Victims of D&SV, Inc.

PO Box 304

River Falls, WI 54022

715-425-6751 Voice

800-345-5104 Toll-free

Turning Point Shelter - Pierce County

PO Box 304
River Falls, WI 54022

Vernon County Domestic Abuse Project

PO Box 149
Viroqua, WI 54665 608-637-7052 Voice 608-637-7007 Crisis Line

Violence Intervention Project, Inc.

1405 Division Street 920-487-2111 Voice 920-837-2424 Crisis Line
Algoma, WI 54201 877-847-3223 Toll-free

Waukesha Women's Center

726 N. East Ave.
Waukesha, WI 53186-4807 262-547-4600 Voice 888-542-3828 Toll-free

Women and Children's Horizons, Inc.

PO Box 792 262-652-1846 Voice 262-652-9900 Crisis Line
Kenosha, WI 53141-0792 800-853-3503 Toll-free

Women's Community, Inc.

2801 N. -7th St., Suite 300 715-842-5663 Voice 715-842-7323 Crisis Line
Wausau, WI 54403 888-665-1234 Toll-free

Women's Resource Center

1547 College Ave.
PO Box 1764
Racine, WI 53401 262-633-3233 Voice 800-794-7057 Toll-free

YWCA Alternatives to Violence

1735 S. Washington St.
Janesville, WI 53546 608-752-5445 Voice 608-752-2583 Crisis Line

Wisconsin Sexual Assault Service Providers

The service providers listed below are members of the Wisconsin Coalition Against Sexual Assault (WCASA) who are in good standing and have stated that they agree with WCASA's mission statement. However, WCASA does not audit, regulate, license or certify these agencies and is not responsible for their services.

Advocates of Ozaukee County: Ozaukee

PO Box 80166
Saukville, WI 53080 262-284-3577 Voice 262-284-6902 Crisis Line

Association For the Prevention of Family Violence County: Walworth

W3929 Co. NN
Elkhorn, WI 53121 262-723-4653 Voice 262-723-4653 Crisis Line

ASTOP, Inc. County: Fond du Lac

430 E. Division St.

Fond du Lac, WI 54935 920-926-5395 Voice 800-418-0270 Crisis Line

AVAIL, Inc. County: Langlade

PO Box 355

Antigo, WI 54409-0355 715-623-5177 Voice 715-623-5767 Crisis Line

Bolton Refuge House Counties: Eau Claire, Jackson

PO Box 482

Eau Claire, WI 54702-0482 715-834-0628 Voice 715-834-9578 Crisis Line

CASDA Counties: Bayfield, Douglas, Sawyer

2231 Catlin Ave.

Superior, WI 54880 715-392-3136 Voice 715-392-3136 Crisis Line

Central Wisconsin Area-SAVS County: Wood

503 S. Cherry Ave.

Marshfield, WI 54449 715-387-2729 Voice 715-384-5555 Crisis Line

Community Referral Agency Counties: Burnett, Polk

PO Box 365

Milltown, WI 54858 715-825-4414 Voice 800-261-7233 Crisis Line

Domestic Abuse Support Center County: Shawano

PO Box 665

Shawano, WI 54166 715-524-6759 Voice 715-526-3421 Crisis Line

Family Advocates Counties: Grant, Iowa, Lafayette

PO Box 705

Platteville, WI 53818 608-348-5995 Voice 608-348-3838 Crisis Line

Family Support Center Counties: Chippewa, Eau Claire

PO Box 143

Chippewa Falls, WI 54729-0143 715-723-1138 Voice 800-400-7020 Crisis Line

Franciscan Skemp Healthcare - Safe Path County: La Crosse

800 West Ave. So.

La Crosse, WI 54601 608-791-7804 Voice 608-791-7804 Crisis Line

Friends of Abused Families County: Washington

PO Box 117

West Bend, WI 53095-0117 262-334-5598 Voice 262-334-7298 Crisis Line

Gundersen Lutheran-SA Counseling Counties: Crawford, La Crosse, Monroe, Trempealeau

Prog./Behavioral, 1910 South Ave.

La Crosse, WI 54601-5400 608-782-7300 Voice 800-362-8255 Crisis Line

Haven House Counties: Green Lake, Marquette, Waushara
PO Box 136
Berlin, WI 54923 920-361-1511 Voice 888-884-2836 Crisis Line

HAVEN, Inc. County: Lincoln
PO Box 32
Merrill, WI 54452 715-536-1300 Voice 715-536-1300 Crisis Line

Hope House Counties: Adams, Columbia, Juneau, Marquette, Sauk
PO Box 432
Baraboo, WI 53913 608-356-9123 Voice 800-584-6790 Crisis Line

Monroe County Domestic Abuse Project County: Monroe
PO Box 161
Sparta, WI 54656 608-374-6975 Voice 866-346-0374 Crisis Line

New Day Shelter Counties: Ashland, Bayfield
PO Box 88
Ashland, WI 54806 715-682-9566 Voice 715-682-9565 Crisis Line

Passages Counties: Crawford, Juneau, Richland, Vernon
PO Box 546 608-647-8775 Voice 800-236-4325 Crisis Line
Richland Center, WI 53581-0546

People Against a Violent Environment Counties: Dodge, Jefferson
PO Box 561
Beaver Dam, WI 53916 920-887-3810 Voice 800-775-3785 Crisis Line

Rape Crisis Center County: Dane
128 E. Olin Ave.
Madison, WI 53713 608-251-5126 Voice 608-251-7273 Crisis Line

REACH Counseling Services County: Winnebago
1244C Midway Rd.
Menasha, WI 54952 920-722-8150 Voice 920-722-8150 Crisis Line

Safe Harbor County: Sheboygan
PO Box 582
Sheboygan, WI 53082 920-452-8611 Voice 920-452-7640 Crisis Line

Sexual Assault Center Counties: Brown, Door, Oconto
PO Box 22308 920-436-8890 Voice 920-436-8899 Crisis Line
Green Bay, WI 54305-2308

Sexual Assault Crisis Center-Fox Cities Counties: Calumet, Outagamie
17 Park Place, Ste. 950
Appleton, WI 54914 920-733-8119 Voice 920-733-8119 Crisis Line

Sexual Assault Recovery Program Counties: Rock, Green
423 Bluff St.
Beloit, WI 53511 608-365-1244 Voice 866-666-4576 Crisis Line

Sexual Assault Resource Center County: Manitowoc
333 Reed Ave., Rm. 270
Manitowoc, WI 54220 920-686-8560 Voice 920-683-9922 Crisis Line

Sexual Assault Services County: Racine
1220 Mound Ave., Ste. 304
Racine, WI 53404 262-619-1634 Voice 262-637-7233 Crisis Line

Sexual Assault Treatment Center County: Milwaukee
Heart Institute
960 N. 12th Street, Rm. 2120
Milwaukee, WI 53201 414-219-5850 Voice 414-219-5555 Crisis Line

Sexual Assault Victim Services Counties: Portage, Waupaca, Wood
1608 W. River Dr. 715-343-7101 Voice 800-472-3377 Crisis Line
Stevens Point, WI 54481-3430

Stepping Stones, Inc. County: Taylor
PO Box 224
Medford, WI 54451 715-748-3795 Voice 715-748-5140 Crisis Line

The Bridge to Hope Counties: Dunn, Pepin
PO Box 700
Menomonie, WI 54751 715-235-9074 Voice 800-924-9918 Crisis Line

The Counseling Center of Milwaukee County: Milwaukee
2038 N. Bartlett Ave. 414-271-2565 Voice 414-271-9523 Crisis Line
Milwaukee, WI 53202-1059

The Healing Center County: Milwaukee
PO Box 342
Milwaukee, WI 53201-0342 414-219-3475 Voice 877-727-7577 Crisis Line

The Women's Center County: Waukesha
505 N. East Ave.
Waukesha, WI 53186-4807 262-547-4600 Voice 262-542-3828 Crisis Line

The Women's Community County: Marathon
2801 7th St., #300
Wausau, WI 54403-3222 715-842-5663 Voice 715-842-7323 Crisis Line

Time Out Family Abuse Shelter Counties: Barron, Price, Rusk

PO Box 406

Ladysmith, WI 54848-0406 715-532-6976 Voice 800-924-0556 Crisis Line

Tri-County Council on SA & DV Counties: Forest, Oneida, Vilas

PO Box 233

715-362-6841 Voice 800-236-1222 Crisis Line
Rhineland, WI 54501-0233

Turning Point for Victims of DV & SV Counties: Pierce, St. Croix

PO Box 304

River Falls, WI 54022 715-425-6751 Voice 800-345-5104 Crisis Line

Violence Intervention Project County: Kewaunee

1405 Division St.

Algoma, WI 54201-1431 920-487-2111 Voice 877-847-3223 Crisis Line

Women's & Children's Horizons/Pathways of Courage County: Kenosha

PO Box 1643

Kenosha, WI 53141-1643 262-656-3500 Voice 262-657-5272 Crisis Line

YWCA Alternatives to Violence County: Rock

1735 S. Washington St.

Janesville, WI 53546 608-752-5445 Voice 608-752-2583 Crisis Line

Wisconsin's Lead Elder Abuse Agencies and Helpline Telephone Numbers

These Lead Elder Abuse contacts are listed in this order: county, the designated Elder Abuse agency in that county, the HELPLINE number and the after hours/weekend phone numbers.

Adams: County Aging Unit

608-339-4251 HELPLINE 911 (Local) or 608-339-3304 After hours/Weekend

Ashland: Ashland County Human Services Department

715-682-7004 ext. 121 HELPLINE 715-682-7023 After hours/Weekend

Barron: Human Services Department

715-537-5691 HELPLINE 715-537-3106 After hours/Weekend

Bayfield: Department of Human Services

715-373-6144 HELPLINE 715-373-6120 (Sheriff) After hours/Weekend

Brown: Human Services Department

920-448-6095 HELPLINE 920-436-8888 After hours/Weekend

Buffalo: Department of Health & Human Services

608-685-4412 HELPLINE 608-685-4433 (Sheriff) After hours/Weekend

Burnett: County Aging Program
715-349-7600 HELPLINE 608-685-4433 After hours/Weekend

Calumet: Human Services Department
920-849-1400 HELPLINE 920-849-9317 After hours/Weekend

Chippewa: Department of Human Services
715-726-7799 HELPLINE 715-726-7830 After hours/Weekend

Clark: Department of Social Services
715-743-5233 HELPLINE 715-743-3157 (Sheriff) After hours/Weekend

Columbia: Department Health & Human Services
608-742-9227 HELPLINE 911 or Sheriff at 608-742-4166 After hours/Weekend

Crawford: Department of Human Services
608-326-0248 HELPLINE 608-326-8414 (Sheriff) After hours/Weekend

Dane: Area Agency on Aging of Dane County
608-224-3666 HELPLINE 911 or leave message 608-224-3666 After hours/Weekend

Dodge: County Human Services/Health Department
920-386-3750 HELPLINE 800-924-6407 After hours/Weekend

Door: Senior Resource Program
920-746-2546 HELPLINE 911 or Non-Emergency (Sheriff) 920-746-2400 After hours/Weekend

Douglas: Department of Health & Human Services
715-395-7457 HELPLINE 715-395-7457 After hours/Weekend

Dunn: Department of Human Services
715-232-1116 HELPLINE Contact Local Law Enforcement (911) After hours/Weekend

Eau Claire: Human Services Department
715-831-5730 HELPLINE 715-839-4972 After hours/Weekend

Florence: Human Services Department
715-528-3296 HELPLINE 715-528-3346 (Sheriff) After hours/Weekend
888-452-3296 Toll-free HELPLINE

Fond du Lac: Department of Social Services

920-929-3400 HELPLINE

920-929-3466 HELPLINE

888-435-7335 Toll-free HELPLINE

920-929-3391 or 911 After hours/Weekend

Forest: Department of Social Services

715-478-3351 HELPLINE

715-478-3331 (Sheriff) After hours/Weekend

Grant: Department of Social Services

608-723-2136 HELPLINE

608-723-2157 After hours/Weekend

Green: Human Services Department

608-328-9499 HELPLINE

608-328-9393 After hours/Weekend

Green Lake: Health & Human Services Department

920-294-4070 HELPLINE

920-294-4000 (Sheriff) After hours/Weekend

Iowa: Department of Social Services

608-935-9311 HELPLINE

608-935-3314 (Sheriff) After hours/Weekend

Iron: County Aging Unit

715-561-2424 HELPLINE

715-561-3800 (Sheriff) After hours/Weekend

Jackson: Department of Health And Human Services

715-284-5898 HELPLINE

715-284-5898 After hours/Weekend

Jefferson: Human Services Department

920-674-8133 HELPLINE

920-674-8133 or 920-674-3105 (24-hour Crisis Line) After hours/Weekend

Juneau: Human Services

608-847-2400 HELPLINE

608-847-2461 (Hess Hospital) After hours/Weekend

Kenosha: Aging & Disability Resource Center of Kenosha County

262-605-6646 HELPLINE

262-657-7188 After hours/Weekend

Kewaunee: Human Services

920-388-0626 HELPLINE

920-388-3100 (Sheriff) After hours/Weekend

La Crosse: County Human Services

608-785-6101 HELPLINE

608-785-5700 After hours/Weekend

Lafayette: Commission on Aging

608-776-4888 HELPLINE

608-776-4888 After hours/Weekend

Langlade: Department of Social Services

715-627-6500 HELPLINE

715-627-6411 After hours/Weekend

Lincoln: Commission on Aging

715-536-0311 HELPLINE

715-536-1300 After hours/Weekend

Manitowoc: Aging Resource Center

920-683-4180 HELPLINE

920-323-2448 After hours/Weekend

Marathon: Department of Social Services

715-261-7500 HELPLINE

715-261-6050 or 1-888-486-9545 After
hours/Weekend

Marinette: Health and Human Services Department

715-732-7700 HELPLINE

715-732-7600 (Sheriff) After hours/Weekend

888-732-7549 Toll-free HELPLINE

Marquette: Human Services Department

608-297-9135 HELPLINE

608-297-2115 After hours/Weekend

Menominee: Health and Human Services Department

715-799-3861 HELPLINE

715-799-3861 After hours/Weekend

Milwaukee: County Department on Aging

414-289-5866 HELPLINE

414-289-5866 After hours/Weekend

Monroe: Human Services Department

608-269-8956 HELPLINE

608-269-2117 or 911 After hours/Weekend

Oconto: Commission on Aging, Inc.

800-649-6568 HELPLINE

920-834-6900 After hours/Weekend

Oneida: County Department on Aging

715-369-6170 HELPLINE

715-361-5100 (Sheriff) After hours/Weekend

800-379-7499 Toll-free HELPLINE

Oneida Tribe: Oneida Nation Elderly Services

920-869-2448 HELPLINE

920-869-2448 After hours/Weekend

Outagamie: Health and Human Services Department

920-832-5169 HELPLINE

920-832-4646 After hours/Weekend

Ozaukee: Department of Social Services

262-284-8200 HELPLINE

Contact Local Law Enforcement
After hours/Weekend

262-238-8200 (Metro) HELPLINE

| | |
|--|--|
| Pepin: Department of Human Services 715-672-8941 HELPLINE | 715-672-5944 (Sheriff) After hours/Weekend |
| Pierce: Office on Aging 715-273-6780 HELPLINE | 715-273-5051 Ext. 235 After hours/Weekend |
| Polk: Human Services Department 715-485-8411 HELPLINE | 715-485-8300 After hours/Weekend |
| Portage: Health and Human Services 715-345-5350 HELPLINE | 715-343-7125 After hours/Weekend |
| Price: Price County Human Services & Aging Department 715-339-2158 HELPLINE | 911 After hours/Weekend |
| Racine: Human Services Department 262-638-6448 HELPLINE | 262-638-6321 After hours/Weekend |
| Richland: Health and Human Services 608-647-8821 Ext.258 HELPLINE | 608-647-2106 After hours/Weekend |
| Rock: Council on Aging 608-757-5416 HELPLINE | 608-757-5025 After hours/Weekend |
| Rusk: County Senior Services 715-532-7089 HELPLINE | 715-532-7089 After hours/Weekend |
| St Croix: Department of Human Services 715-246-8250 HELPLINE | 911 After hours/Weekend |
| Sauk: Department of Human Services 608-355-4200 HELPLINE 800-533-5692 Toll-free HELPLINE | 800-533-5692 After hours/Weekend |
| Sawyer: Department of Health and Human Services 715-634-4806 HELPLINE 800-569-4162 Toll-free HELPLINE | 715-634-4858 (Sheriff) or 911 After hours/Weekend |
| Shawano: Social Services Aging Unit and Aging & Disability Resource Center 715-526-4700 HELPLINE | 715-526-3111 (Sheriff) or 911 After hours/Weekend |
| Sheboygan: Health and Human Services Department 920-459-3224 HELPLINE | Contact Local Law Enforcement After hours/Weekend |

Stockbridge-Munsee: Elderly Program

715-793-4236 HELPLINE

715-526-3111 After hours/Weekend

Taylor: Human Services Department

715-748-3332 HELPLINE

715-748-2200 After hours/Weekend

Trempealeau: Department of Social Services

800-273-2001 (24 hrs.) HELPLINE

911 After hours/Weekend

Vernon: Department of Human Services

608-637-5210 HELPLINE

608-637-7007 After hours/Weekend

Vilas: Department of Social Services

715-479-3668 HELPLINE

715-479-4441 (Sheriff) After hours/Weekend

Walworth: Department of Health and Human Services

262-741-3200 HELPLINE

262-741-3200 After hours/Weekend

Washburn: Human Services Department

715-468-4747 HELPLINE

715-468-4700 After hours/Weekend

Washington: County Resource Center

262-306-2222 HELPLINE

Contact Local Law Enforcement

877-306-3030 Toll-free HELPLINE

After hours/Weekend

262-335-4670 TTY HELPLINE

Waukesha: Department of Senior Services

262-548-7828 HELPLINE

262-548-7122 (Sheriff) or Contact Local Law
Enforcement After hours/Weekend

Waupaca: Department of Health and Human Services

715-258-6300 HELPLINE

800-472-3377 After hours/Weekend

Waushara: Department of Human Services

920-787-6505 HELPLINE

Contact Sheriff's Department After hours/Weekend

877-883-5378 Toll-free HELPLINE

Winnebago: Department of Human Services

Oshkosh: 920-236-4615 HELPLINE

Neenah/Menasha: 920-727-2882 Ext. 4615 HELPLINE

920-233-7707 or 920-722-7707 After hours/Weekend

Wood: Department of Social Services

Marshfield: 715-387-6374 HELPLINE

715-387-6374 After hours/Weekend

Wisconsin Rapids: 715-421-8699 HELPLINE 715-421-8699 After hours/Weekend

Appendix A: Domestic Violence Information and Services

These descriptions were created using material from Ganley (1995) on domestic abuse; the National Center on Elder Abuse website; and materials created by the Wisconsin Coalition Against Domestic Violence (WCADV) and Wisconsin Coalition Against Sexual Assault (WCASA). The description of sexual abuse includes definitions developed by Holly Ramsey Klawnsnik published in "Widening the Circle" by WCASA, 1998.

Physical Abuse

Description: use of physical force that may result in bodily injury, physical pain, or impairment.

Behaviors include but are not limited to:

- Acts of violence such as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, scratching, biting, grabbing, throwing, twisting, burning and/or use of weapons (e.g., household objects, knives, guns) against the victim.
- Holding another person against his/her will.
- For persons with disabilities, additional behaviors may include inappropriate handling, over-use of restraints, inappropriate behavior modification, using medication to sedate person for care provider convenience, withholding necessary care or medication, or limiting access to adaptive aids essential for daily living.

Sexual Abuse/Assault

Description: nonconsensual sexual contact of any kind. Sexual contact with any person incapable of giving consent is also considered sexual abuse.

Behaviors include but are not limited to:

- Unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity and sexually explicit photographing.
- Coerced or forced sex the victim does not want (e.g., sex with third parties, physically painful sex, sexual activity they find offensive, verbal degradation during sex, viewing sexually violent material) or at a time they do not want it (e.g., when exhausted, when ill, when asleep).
- Unwarranted, intrusive, and/or painful procedures in caring for the victim's genitals or rectal area. This includes application or insertion of creams, ointments, thermometers, enemas, catheters, fingers, soap, washcloths, or other objects when not medically prescribed and unnecessary for the health and well being of the individual.
- Attacking victims' genitals with blows or weapons.
- Denying victim protection against sexually transmitted diseases.

"Sexual abuse gives victims the message they cannot control what happens to their bodies. For some victims this sexual violation is profound and may be difficult to discuss. Some victims are unsure whether this sexual behavior is really abuse, while others see it as the ultimate betrayal." (Ganley, 1995). (*Descriptions are combined examples from Ganley, 1995; NCEA Website, WCADV and WCASA.*)

Psychological Abuse

Description: infliction of anguish, pain, or distress through verbal or nonverbal acts.

Behaviors include but are not limited to:

Threats of violence and harm

- Threats against the victim or others important to the victim.
- Suicide or homicide/suicide threats.
- Violence toward others (e.g., neighbors, family members).

Attacks against property or pets/service animals and other acts of intimidation

- Attacks against property, prized possessions, and pets/service animals.
- Intimidation through screaming, driving recklessly, stalking, or putting the victim under surveillance.

Emotional Abuse

- Repeated verbal attacks against the victim's worth as an individual or role as a parent, family member, friend, coworker, or community member.
- Verbal attacks emphasizing the victim's vulnerabilities (reading/language abilities, size, disabilities, immigration status, or sexual orientation).
- "Mind games" or sleep deprivation to undercut the victim's sense of reality.
- Humiliating the victim in front of family, friends or strangers. Perpetrators may repeatedly claim that victims are crazy, incompetent, and unable "to do anything right."
- Treats victim like a servant or a child. Makes all decisions.
- Silent treatment.
- Threatening institutional placement.
- Hiding or destroying important documents.
- Threatening to call BCIS (formerly INS).
- Lying about the victim's immigration status.

Isolation

- Controlling victim's time, activities and contact with others.
- Distorting reality by lying or withholding information. Through incremental isolation, some perpetrators increase psychological control to determine reality for the victims.
- Acting jealous and interrupting social/support networks. Some perpetrators act very possessive about their victim's time and attention.
- Dominating treatment decisions by speaking for the victim and intercepting communications from caseworkers and other potential helpers.
- Cutting off contact with family, friends and visitors.
- Behaving offensively with victim's friends/family so victim cuts off contact with others.
- Isolating the victim from anyone who speaks the same language.
- Not allowing the victim to learn English.

Use of other family members

- Misleads members of family about extent and nature of illnesses/conditions and abuse.
- Excludes or denies access to family (including grandchildren for older adults).
- Forces to keep family secrets.

Ridiculing values/beliefs/spirituality

- Denies access to church, synagogue, spiritual center, clergy, or faith community.
- Makes fun of victim's personal values.
- Ignores or ridicules religious/cultural/traditions/personal tastes.
- May coerce victims into doing something immoral/illegal (e.g., sign papers, larceny) and then threaten to expose them, or may make false accusations against them (e.g., reports to police or Adult Protective Services (APS) or to immigration).

Abusing dependencies/withholding needed supports

- Using medication to sedate the person for perpetrator's convenience.
- Ignoring equipment safety requirements.
- Breaking or not fixing assistive devices.
- Refusing to let use or destroying communication devices.
- Withdrawing care, medication, nutrition or equipment to immobilize the person.
- Using equipment to torture people.

Financial Exploitation

Description: Financial or material exploitation is defined as the illegal or improper use of an elder's funds, property or assets.

Behaviors include but are not limited to:

- Cashing another person's check(s) without authorization/permission.
- Forging another person's signature.
- Misusing or stealing another person's money or possessions.
- Coercing/deceiving another person into signing documents (e.g., contracts, deeds, wills).
- Using conservatorship, guardianship or power of attorney improperly.
- Controlling access to family resources; time, transportation, food, clothing, shelter, insurance, and money. Victims are put in the position of having to get "permission" to spend money on basic family needs.
- Using economics as a way to maintain control or force the victim to return; refusing to pay bills or victim's health insurance, instituting legal procedures costly to the victims, destroying assets in which the victim has a share.
- "Emotional blackmail" – give us the money, etc. or we will abandon you or not let you see your friends.

Neglect

Description: the refusal or failure to fulfill any part of a person's obligations or duties to an elder.

Behaviors include but are not limited to:

- Failure of a person who has fiduciary responsibilities to provide care for the person (e.g., pay for necessary home care services).
- Failure on the part of an in-home service provider to provide necessary care.
- Refusal or failure to provide a person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed-upon responsibility to an a person with a disability or elder.

Abandonment

Description: desertion of a person by an individual who has assumed responsibility for providing care to that person, or by a person with physical custody of another person.

Behaviors include but are not limited to:

- Deserting a person at a hospice, a nursing facility or other similar institution.
- Deserting a person at a shopping center or other public location.
- Deserting a person at his/her residence.

Homicide/Suicide

Description: Killing a person (often spouse/partner) followed by suicide of the killer.

Dynamics include but are not limited to:

- A dependent-protective attachment to the spouse/partner and the need to control the relationship.
- Perpetrator feels unacceptable threat to the relationship.
- Known domestic violence present in about 1/3 of the later life cases of homicide/suicide. (Cohen, 1998)

Sexual Homicides

Description: Killing a person following a sexual assault.

Issues related to this form of violence:

- Often occurs after a violent, premeditated sexual assault.
- Often occurred in their own home, perpetrated by a stranger or minor acquaintance.

- Victims were often robbed, but robbery is not considered the primary motive for the homicide.

(Adapted from "Sexual Homicides of Elderly Females: Linking Offender Characteristics to Victim and Crime Scene Attributes," Safarik, Mark E., Jarvis, John P. and Nussbaum, Kathleen E., Journal of Interpersonal Violence, Vol. 17, No. 5, May 2002.)

What supports and services do domestic violence programs provide?

The domestic violence movement provides services primarily for women abused by an intimate partner, a family member or someone with whom they have a trusting relationship. Most of the services were designed originally for women and their young children, although many programs provide services for male victims as well. Victims self-identify as a person needing domestic violence services and contact the program if they want help. Their account is believed; they do not need to provide "proof" of being abused.

Domestic abuse services generally include, but are not limited to:

- 24 hour crisis line,
- emergency shelter,
- peer counseling,
- legal advocacy,
- support group,
- public education, and
- systems advocacy.

These services are not available to abusers. Generally, domestic abuse programs do not serve abusers. Rather, the justice system holds abusers accountable through arrest and prosecution. Batterers may attend intervention programs.

Often, staff is formerly battered women and other individuals committed to improving conditions for women or ending domestic abuse. Their role is defined as an advocate. Advocates provide victims with information about available resources and support the victim in their choices. Advocates work not only with individual victims, but also for systemic change.

Appendix B: Sexual Assault Information and Services

Sexual Assault Related Definitions and Acronyms

Advocacy: Refers to legal, medical, court and other advocacy provided by sexual assault program staff and/or volunteers or other professionals. Individuals providing this service are knowledgeable of sexual assault laws and procedures, the forensic examination procedures, other criminal justice procedures and other relevant systems, unless otherwise noted.

Coordinated Community Response (CCR): An organized group of community professionals and concerned individuals who meet on a regular basis to discuss community needs surrounding sexual assault. This group also may initiate projects, events, new service delivery systems, education, and other activities.

Consent: Legal term in sexual assault statutes to mean “words or overt actions by a person who is competent to give informed consent indicating a freely given agreement to have sexual intercourse or sexual contact.” (*Wis. Stat. Sec. 940.225(4).*)

Perpetrator: General term used to describe the person who committed a crime against another person.

Sexual Abuse (SA): Generally refers to instances of sexual assault that are on-going and involve multiple sexual assaults.

Sexual Assault (SA): Sexual intercourse or sexual contact with a person without his or her consent or with a person who is legally incapable of giving consent. Also, any act (verbal and/or physical) which breaks a person’s trust and/or safety and is sexual in nature including: rape, incest, child sexual assault, ritual abuse, date and acquaintance rape, marital or partner rape, unwanted sexual contact, sexual harassment, exposure, and voyeurism.

Sexual Assault Nurse Examiner (SANE): Sexual assault nurse examiners are nurses trained to collect forensic evidence for use in criminal sexual assault prosecutions and to understand the dynamics of sexual assault victimization.

Sexual Assault Response Team (SART): Usually applied to teams that work together in the criminal justice system to immediately respond to a specific sexual assault. This organized team is specifically established to use a multi-disciplinary approach to respond to the immediate needs of sexual assault victims. There are three (3) main components: 1) emotional; 2) medical; and 3) legal. The individuals providing these components may vary from situation to situation depending on case specifics. In general, the intent of a SART is to provide comprehensive, consistent and coordinated responses to EVERY victim of sexual assault regardless of whom the victim or the perpetrator is or where the assault took place.

Sexual Assault Service Provider (SASP): This is an individual or agency that provides services to victims/survivors of sexual violence in a community. Services that are provided include a 24 hour crisis line, follow-up services, legal advocacy, medical advocacy, supportive

services, support groups, peer support, community education, prevention education, information and referrals.

Sexual Contact: Defined by statute to mean; **1.** Intentional touching by the complainant or defendant, either directly or through clothing by the use of any body part or object, of the complainant's or defendant's intimate parts if that intentional touching is either for the purpose of sexually degrading; or for the purpose of sexually humiliating the complainant or sexually arousing or gratifying the defendant or if the touching contains the elements of actual or attempted battery. **2.** Intentional penile ejaculation of ejaculate or intentional emission of urine or feces by the defendant upon any part of the body clothed or unclothed of the complainant if that ejaculation or emission is either for the purpose of sexually degrading or sexually humiliating the complainant or for the purpose of sexually arousing or gratifying the defendant.

Sexual harassment: A form of discrimination based on gender prohibited by both state and federal law. Sexual harassment is prohibited in schools and in the workplace.

Sexual intercourse: Defined by statute to mean vulva penetration as well as cunnilingus, fellatio or anal intercourse between persons or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal opening either by the defendant or upon the defendant's instruction. The emission of semen is not required.

Support Groups: “Regular facilitated meetings of victims/survivors of sexual abuse/assault with a supportive and educational focus.”

Supportive Services: Term refers to “counseling” provided by staff that is trained to work with sexual assault clients. “Counseling” involves supportive listening, identifying and providing options, skill development (coping strategies, relaxation techniques, etc.), education, and guidance. This individual need not be a certified therapist or social worker to provide this service. Services under this category, provided by a SASP agency, are free unless otherwise noted.

Victim/ Witness Specialists: Individuals who work in a prosecutor’s office and victims and witnesses of crime which ensure that victims and witnesses are informed about the criminal justice process and ensure that their rights are upheld. Typically (but not always) these professionals work directly in the district attorney’s office.

What are the Effects of Sexual Abuse?

People with disabilities, like anyone else, are affected by the trauma of a sexual assault. Everyone experiences trauma differently. Some people will be severely traumatized by their abuse while others may not outwardly appear to have any long-term effects. A “hands off” offense can severely traumatize one person while a person who was forcibly raped may not seem to experience long-term traumatic effects. Sexual abuse can cause harmful psychological, physical, and behavioral effects. If the sexual abuse is left unaddressed, these effects can potentially be very damaging to the individual.

| Short-term effects: | Long-term effects: |
|---------------------------------|--|
| Anxiety | Post traumatic stress disorder |
| Fear | Persistent anxiety and fear |
| Anger | Feelings of shame or guilt |
| Withdrawal | Low self esteem |
| Sexualized behavior | Emotional numbness |
| Nightmares, or trouble sleeping | Relationship and sexual problems |
| Acting out | Sleep disturbances |
| | Flashbacks, nightmares or intrusive thoughts |
| | Chronic stress and other health problems |
| | Drug and alcohol abuse |
| | Suicidal thoughts |
| | Self injury |
| | Eating disorders |
| | Clinical depression |
| | Dissociative Identity Disorder |
| | Exacerbation of symptoms of disabilities |

Indicators

There are a number of things to look for if you suspect that a person with a disability has been sexually assaulted or abused. Barriers to reporting often prevent individuals from verbally disclosing their abuse. However, there are physical and behavioral indicators that a person has experienced abuse or is in a potentially abusive situation. The presence of one or more of the indicators listed below does not provide proof that a sexual assault has occurred, but can serve as a guide for professionals when conducting an investigation or interviewing an adult.

Physical Indicators:

These are abnormal physiological occurrences that alone do not indicate that sexual assault/abuse has occurred. However, these indicators should be treated as possible “signals” that require more investigation.

- Bleeding, bruising, infection, scarring, or irritation to a person’s genitals, rectum, mouth, or breasts.
- Genital pain or itching.
- Difficulty walking or sitting.
- Sexually transmitted diseases.
- Pregnancy.
- Signs of physical abuse.
- Changes in personal hygiene.
- Weight gain or loss.

Behavioral Indicators:

These are seemingly unexplained changes in the behavior of an individual. An individual with a developmental disability may regularly exhibit some of the behaviors described below.

Therefore, a behavioral indicator of possible sexual assault/abuse would involve a significant **change** in behavior.

- Any significant change in behavior.
- Depression, withdrawal, suicidal feelings, or excessive crying spells.
- Substance abuse; eating disorders.
- Displays shame or guarded responses when asked about physical signs.
- Sudden avoidance or fear of specific people, specific genders, or situations.
- Acting out, attention seeking, aggression, or delinquent behaviors.
- Changes in work performance, or non-participation in work or social activities.
- Sleep disturbances.
- Noncompliance or overly compliant.
- Resists examination by doctors.
- Shying away from being touched.
- Sexually inappropriate behaviors, compulsive masturbation, promiscuity.
- Wearing multiple layers of clothing.

What supports and services do sexual assault programs provide?

Sexual assault service providers offer victim-centered services which make them uniquely qualified to provide assistance that is found nowhere else. The main job of a sexual assault provider is to believe and empower victims. Victims are continually offered options in order to encourage them to make the decisions about what happens with their case. For example, if an adult victim does not want to go to the police, s/he is not forced. Sexual assault service providers can accompany victims to the hospital for a sexual assault exam or go to court with them if they desire. Confidentiality is also a very important component of this type of victim services.

The core services of a sexual assault service provider agency include free access to the following services for victims/survivors of sexual violence as implemented in your community. At the least, these services include:

- 24 Hour Crisis Line,
- Follow-Up Services,
- Advocacy (legal, medical),
- Supportive Services,
- Support Groups,
- Peer Support,
- Community Education and Prevention Education,
- Information and Referral,
- Provide Assistance with Child Care and Transportation, and
- Safe and Accessible Facility/Building and Services.

Definitions of Sexual Assault Services

Adopted by Statewide Planning Meeting Participants, Statewide Assessment of Sexual Assault Victim Services, Wisconsin Coalition Against Sexual Assault, 1998.

1. **24-Hour Crisis Line:** A telephone number that provides immediate access to crisis intervention including advocacy, crisis counseling, and information and referral.
2. **Follow-Up Services:** Can be a range of services that include referrals and/or information and are based upon client-presented need.
3. **Advocacy:** Acting on behalf of and in support of victims/survivors of sexual abuse/assault to ensure their interests are represented and their rights upheld, including legal and medical advocacy.
4. **Supportive Services:** This service involves an ongoing process of identifying and providing options; skill development; (i.e. coping strategies, relaxation techniques, etc.); and education, support and guidance.
5. **Support Groups:** Regular facilitated meetings of victims/survivors of sexual abuse/assault with a supportive and educational focus.
6. **Peer Support:** This service includes time-limited interaction, crisis intervention, minimum problem solving, personal support and involves crisis line personnel.
7. **Community Education and Prevention Education:** Informing the community and increasing awareness and expertise about sexual abuse/assault issues.
8. **Safe and Accessible Facility/Building and Services:** All core services should be provided in an accessible manner, literally under the requirements of the Americans with Disabilities Act (ADA) and figuratively throughout the communities they serve.

Some sexual assault service providers also provide counseling and therapy services. Contact your local sexual assault service provider agency for specific information on services provided. Contact information to locate the provider nearest you is listed in the *Technical Assistance and Resource Information* section of this *Workbook*, or on the web at www.wcasa.org.

Appendix C: Overview of County Human Services

Introduction

As a sexual assault or domestic violence service provider you may work with a person with a disability who also is receiving or needs county funded or provided services. Thus, it is important to have some understanding of how services are organized and funded. In Wisconsin most support services for people with disabilities are delivered through county Departments of Human Services. These departments are responsible for providing or paying for an entire range of community based services, such as supported employment, supported apartments, case management, counseling, day services, community support programs, respite care, and residential facilities. In some situations they must also pay for institutional care; in other cases such care is funded through Medicaid. (Medicaid is also known as Medical Assistance or MA in Wisconsin.) The counties receive funds from the state to pay for most of the services they deliver and the state provides some oversight regarding the type and quality of services provided. Counties often also add some of their own local tax dollars to the state funds they receive. In all circumstances, the counties have considerable discretion about how to allocate their funds and about how they will deliver services.

County Organization of Services

The counties have several options about how to organize their service delivery system. The most common structure is the department of human services. These departments are responsible for delivering the entire range of social and human services in the county. This may include services for persons with disabilities, child welfare and juvenile delinquency services, economic assistance, and services for the elderly.

The second most common option is having a separate department of community programs and department of social services. The department of community programs is responsible for providing services for persons with developmental disabilities, mental illness, alcoholism, and drug dependence. The department of social services is responsible for services to children and their families, economic assistance, and services for persons with physical disabilities and the elderly. A variation on this option which is exercised by only a very few counties is to have a separate department for persons with developmental disabilities. It is also possible for several counties to join together to have a multi-county department of community programs; in this case each county would have a separate department of social services. (*Contact information for your county's department of human services, department of community programs, and department of social services is located in the government section of your local telephone book.*)

Regardless of structure, the counties have discretion about whether to provide services directly or to contract with private agencies to provide services. Some counties provide most of the services with county staff and operate their own inpatient facilities and nursing homes. Other counties contract for the vast majority of their services. In most counties it is a combination of the two approaches. Contact the director of the county department(s) to find out how services are provided in your county.

Eligibility for Services

Chapter 51 of the state statutes sets out the requirements of county services for persons with developmental disabilities, mental illness and substance abuse. Definitions of these disabilities are:

Developmental disability: a disability attributable to brain injury; cerebral palsy; epilepsy; autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. "Developmental disability" does not include senility which is primarily caused by the process of aging or the infirmities of aging.

Mental illness: a mental disease to such extent that the person requires care and treatment for his/her own welfare, or the welfare of others, or the community.

Drug dependent: a person who uses one or more drugs to the extent that the person's health is substantially impaired or his/her social or economic functioning is substantially disrupted.

Alcoholism: a disease which is characterized by the dependency of a person on the drug alcohol, to the extent that the person's health is substantially impaired or endangered or his/her social or economic functioning is substantially disrupted.

Eligibility for services is also to some extent tied to funding sources and thus has become more complex. Eligibility for services under Chapter 51 is essentially based on the individual's need for the service; there is no financial eligibility test. However, counties are able to establish priorities for services and waiting lists. Thus, even though a person is eligible for a service s/he may have to wait to receive it unless s/he is under a court order. County waiting lists for services vary from service to service and might be quite lengthy. Check with your county department(s) to find out how long the waiting lists are for particular services.

Eligibility for services funded through the Medicaid program, Community Options Program, or Family Care depends on the eligibility criteria set up for these particular programs; they generally include a disability test as well as a consideration of one's finances. Similarly, other programs have their own eligibility criteria.

Generally speaking, an individual must be a resident of the county in order to receive services through the county department of human services or community programs. One major exception is emergency situations. A person is a resident if s/he is voluntarily physically present in the county and intends to stay there. Guardians may exercise the intent of their wards to become a resident of a county where the ward is physically present. (Another resource made available to you through this Project provides useful background information about guardianship.) Sometimes disputes arise between counties regarding where an individual resides and thus which county is responsible for providing services. Residency disputes may be resolved by appealing to the regional office of the Department of Health and Family Services.

Services Provided or Funded by the Counties

The statutes set forth lists of services which counties are required to provide. These are "mandated services". There are also optional services which counties can choose to provide. These lists vary by disability group. It must be noted that the mandate to provide services is limited to the amount of funding available to the county by the state and federal governments and the amount the county is required to furnish to match these funds.

The services which are required for **persons with mental illness or drug dependence** include:

- diagnosis and evaluation,
- inpatient treatment,
- outpatient treatment,
- residential services (such as independent apartments, adult family homes, or community based residential facilities),
- emergency services,
- community support programs (for persons with chronic mental illness), and
- services to help persons make the transition from an institution to the community.

Optional services include other rehabilitation services, consultation, and public information and education.

Services for **persons with developmental disabilities** include:

- diagnosis and evaluation,
- treatment,
- personal care,
- day care,
- special living arrangements,
- training and employment services,
- protective services, and
- transportation necessary for the delivery of services.

Services for **persons with alcoholism** include:

- prevention and early intervention,
- emergency and non-emergency medical treatment,
- inpatient treatment,
- outpatient treatment and follow-up,
- residential treatment, and
- day treatment programs.

Counties have significant flexibility in determining how much of a particular service to provide. For example, some counties rely much more heavily on institutional care than others. Also quality of services may vary by county and by provider. Many county providers of mental health or disability services are not well informed about the long term consequences of physical or sexual abuse. Thus, when referring women it is a good idea to ask about their experience in working with people who are abuse survivors and perhaps to offer to collaborate closely in working with particular women.

Many people with disabilities who are receiving services through the counties have a case manager. This individual should be knowledgeable about the person and the services s/he is receiving. Thus, it is important to find out if the woman with a disability has a case manager and to obtain consent to contact him/her.

If the woman is not yet receiving services but appears to be in need, an advocate, the person, a family member, guardian, etc. can contact the county department to learn about what services are available, what agencies provide them, and how to apply for services. Some counties have a Resource Center for persons who are elderly or have physical or developmental disabilities which can provide this information.

Funding for Services

The funding system for county delivered services is complex and has become increasingly so over the years. The basic funding source is **Community Aids** which is a combination of state and federal funds and is distributed from the state to the counties based on a formula. This money is used to fund the basic array of county mandated and optional services described above. However, counties have considerable discretion about how to allocate this money.

The counties are required to match these funds at the rate of 9.9%. Most counties significantly over-match their Community Aids funds which means that the counties have to use locally raised funds, such as property tax, to pay for human services. The amount of Community Aids funding received is fixed and thus it does not automatically increase with the number of people to be served or the cost of services. Thus, the counties have flexibility under the statutes to establish priorities for services and waiting lists. Consumers of services do not have an entitlement to these services, even though the statutes mandate that the counties provide certain services. The only people with such an entitlement to county funded services are persons under court orders; others can be placed on waiting lists.

Another funding source used by counties is **Medicaid** which is generally funded with federal and state dollars. Persons under Medicaid are entitled to receive Medicaid funded services and should not be placed on waiting lists for these services. Thus, over the years Medicaid has become an increasingly attractive funding source. Medicaid funds services such as nursing homes, certain hospital care, outpatient counseling, community support programs, home health care, personal care, therapies, medications, and case management. It also funds services through certain Medicaid waiver programs such as the Community Integration Program (CIP), which provide a more flexible package of services. If the county department directly provides Medicaid reimbursable services, it can receive the funding. If a county contract agency or another agency, such as a private nursing home, provides the service, it will receive the Medicaid reimbursement.

The **Community Options Program (COP)** is another major funding source for county services for persons with disabilities or who are elderly. This funding resource has two different components. One is a general state COP allocation to counties which must be divided between various disability populations based on a state formula and allocated to individual persons within

each disability group. The other component or program works like a Medicaid waiver as described above and is based on a certain number of "slots". Thus, a county has a certain number of persons who can be served through this COP program. This program is funded through a combination of federal and state funds.

A new state/county program is called **Family Care**. It is a managed care program that provides a flexible array of community based services to persons with long term care needs. It uses a combination of Medicaid and other state funds to pay for services. People who meet the eligibility test are entitled to these services. Family Care is currently being piloted in several Wisconsin counties. *(Contact the Wisconsin Department of Health and Family Services for information about the counties participating in Family Care.)*

Additional funding for county services comes from a variety of sources such as the Birth to Three Program, Family Support Program, Vocational Rehabilitation, and other grants and programs.

Fees for Services

Fees for county services will vary based on the type of service and to some extent the funding source. For services that are provided through Community Aids and county funds there is a uniform fee schedule established by state regulations. Fees are based on the individual's or family's ability to pay. The individual, his/her spouse, and the parents of minor children may be responsible to pay fees. Fees are mandatory for some services, optional for others, and prohibited for some. For children in out of home placements, including foster care, group homes, or child caring institutions, parents may be court ordered to pay in accordance with child support percentages.

Services funded by Medicaid may charge a co-payment in accordance with state regulations. However, an individual may not be charged above the co-payment amount. Thus, if a provider receives a reimbursement under Medicaid that is less than what s/he billed, the consumer may not be billed for the balance.

Other services, for example the Community Options Program and the Family Support Program, have a cost sharing arrangement. Thus, the amount the person will have to contribute toward the cost of services is based in part upon their income and service needs.

Complaints, Grievances, Appeals

There is no uniform complaint or grievance system for persons receiving services through county funded or operated programs. It depends on the type of service or the funding source. However, some counties have tried to establish a uniform system which combines the rights that one may have under a variety of programs. Contact your county department and ask for a copy of their complaint or grievance procedure.

Persons receiving services under Chapter 51 or Chapter 55 (the Protective Services Law) are covered by the Patient Rights under Section 51.61 of the Wisconsin Statutes. Thus, they may file a grievance or a lawsuit if one of their rights has been violated.

Persons receiving services funded by Medicaid, Community Options Program, Family Support Program, Family Care or other specific programs may have certain appeal rights if they are denied or terminated from services or question their service plan. The Wisconsin Coalition for Advocacy (WCA) has more information about these various programs and the rights of individuals receiving services through them. Rights and Reality II: An Action Guide to the Rights of People with Disabilities, a comprehensive guide on all the laws, rights, and services affecting adults and children with disabilities in Wisconsin which includes practical strategies for people to use to advocate for their own rights or the rights of others, is available for purchase. (See the *Technical Assistance and Resource Information* section for WCA contact information.)

Other Service Providers

In addition to county funded or provided services, there is a wide array of other service providers. Independent Living Centers provide advocacy and other services to enable persons with significant disabilities to live in the community. They are regionally based around the state. (See the *Technical Assistance and Resource Information* section and *Appendix E of this Workbook* for information.) In addition, there are many private outpatient mental health clinics and programs such as Family Service, Lutheran Social Services, etc. that provide therapy, counseling, and other support services. There are consumer run organizations, such as drop in centers and peer support groups. A number of organizations provide specialized housing such as community based residential facilities (CBRFs), supported apartments, or adult family homes. Employment services for persons with disabilities are available through a number of supported employment programs and the Division of Vocational Rehabilitation. Private insurance may pay for some of these services, such as outpatient mental health or substance abuse treatment. Other funds, such as United Way, may pay for other services.

If a woman needs services, but the county does not provide what s/he needs or there is a long waiting list, it is important to look for other possible resources. Information may be available through local advocacy/support groups or a community's "First Call for Help" or other similar information and referral sources. Another resource might include Wisconsin's elder abuse or adult protective services system. These services are described in *Appendix D* and contact information for the lead elder agency and adult protective services in your county is located in the *Technical Assistance and Resource Information* section of this *Workbook*.

Appendix D: Lead Elder Abuse Agencies and Adult Protective Services

A variety of agencies and organizations exist in Wisconsin to provide services to older individuals and/or some individuals with disabilities. Many of these agencies are county-based, and specific services provided may differ from county to county.

Lead Elder Abuse Agencies

Wisconsin Statute §46.90 requires each county to establish a publicized phone number where elder abuse can be reported in the county office on aging or the county social services/human services agency. These agencies will either investigate the report or refer the report to another agency for investigation. (*The Technical Assistance and Resource Information section of this Workbook lists these telephone numbers for each county in Wisconsin.*)

Adult Protection Services (APS)

Wisconsin Statutes Chapter 55 establishes a protective services system for protecting individuals with:

- infirmities of aging,
- chronic mental illness,
- mental retardation,
- other developmental disabilities, or
- like incapacities incurred at any age

from exploitation, abuse, and degrading treatment. Adult Protective Services coordinates the organization and delivery of services already existing in the community and determines when services or placement should be provided without consent of the individual. To identify your county APS program, contact your county social services/ human services agency. (*See the Technical Assistance and Resource Information section for more information.*)

Principles that Govern APS

An essential and overriding distinctive feature of protective services for adults is the potential for the use of legal authority (intervention). The point is “that if legal action should be required the (APS) agency needs to be empowered, equipped and willing to undertake it.” For example, when an Adult Protective Services worker is unable to gain access or entry to a home to verify abuse or neglect, the worker relies on law enforcement to gain entry. Once face-to-face with the adult at risk, the social service worker uses advice, persuasion, and encouragement (e.g., the client is motivated to leave unsuitable living quarters, assisted with money management, encouraged to take a medical or psychiatric examination, encouraged to participate in a nutrition program, and/or encouraged to apply for public benefits). Only when advice, persuasion, and encouragement fail and risk is still present would an adult protective service worker potentially

use more strident (legal) intervention. This is because competent adults are presumed to be self-determining and independent. Any efforts to interfere with the right to self-determine must be based on the belief that the adult's situation, problems, circumstances, or actions are so hazardous or harmful to the adult or others that it overrides the usual right to be left alone.

Protective services are expected to be available to all persons when in need of them. Ideally, they place the least possible restriction on personal liberty and exercise of constitutional rights consistent with due process and protection from abuse, exploitation, and neglect.

Adapted from "Overview of Adult Protective Services (APS) Expectations and Functions" by Jane A. Raymond, pages 3 & 45 from "Elder Abuse Interdisciplinary Team (I-Team) Manual, "written by Betsy J. Abramson for the Wisconsin Department of Health and Family Services in cooperation with the Waushara County Department of Human Services (February 2002).

Appendix E: Wisconsin Independent Living Centers Service System

Independent Living Centers (ILCs) are non-residential, private, non-profit, consumer-controlled, community-based organizations providing services and advocacy by and for persons with all types of disabilities. There are nearly 500 independent living centers in the USA. Centers are funded by state, federal, local and private dollars. They are run by people with disabilities who themselves have been successful in establishing independent lives. Independent living centers are mandated under the Rehabilitation Act to provide four core services that are essential to people with disabilities, these four core services are: information and referral, independent living skills training, peer support and advocacy.

Information and Referral

Independent Living Centers keep extensive information/referral resources on the availability of accessible housing, transportation, employment opportunities, personal care attendant services, interpreters, readers for visually impaired people, etc. in the communities they serve. They also have information on local, state and federal government agencies and programs that provide services to people with disabilities, etc.

Independent Living Skills Training

Independent Living Centers also provide training classes to help people with disabilities gain skills that will enable them to live more independently. Courses may include:

- Using the different public transportation systems.
- Managing a personal budget.
- Dealing with insensitive and/or discriminatory behavior by other people.

Peer Support

Independent Living Centers offer a service in which a person with a disability can work with other persons who have disabilities to explore options and to solve problems. The two will work with the staff on an independent living goal such as:

- Adjusting to a newly acquired disability.
- Making changes in living arrangements.
- Learning to use community services more effectively.

Advocacy

Independent Living Centers provide two kinds of advocacy:

- (1) Individual advocacy, which involves a staff member working with persons with disabilities to obtain necessary support services from other agencies in the community.
- (2) Systems advocacy, which involves center staff, board members, consumers and volunteers initiating activities to make changes in the community that make it easier for all persons with disabilities to live more independently.

In addition, ILCs offer a number of other services, which often depend on the specific needs of the consumers they serve. Wisconsin's eight ILCs each offer the four core services, but each also offers additional programs that are unique to their areas. Some additional services that programs may offer include:

- Sports and Recreation,
- Community Education,
- Personal Care Services,
- Homebuyers Programs,
- Assistive Technology,
- Computer Classes,
- Computer Recycling, and/or
- Benefits Counseling.

Appendix F: Background Histories of the Movements

Brief History of the Sexual Assault Movement:

- 1966: National Organization of Women (NOW) founded—serves as incubator for the anti-rape movement.
- 1971: First rape crisis center established.
- 1972: First crisis line started.
- 1973: First rape crisis center started in Wisconsin (Rape Crisis Center of Dane County).
- 1978: National Center for the Prevention and Control of Rape established.
- 1979: At least one rape crisis center in each state (little/no funding).
- Late 1970's: Angela Davis and other leaders spoke out about the anti-racist perspective within the anti-rape movement.
- 1984: Victims of Crime Act (VOCA) authorized federal grants for assisting and compensating victims of crime.
- 1985: Wisconsin Coalition Against Sexual Assault, Inc. (WCASA) founded.
- 1994: Violence Against Women Act (VAWA) was enacted to provide funding for programs that addressed sexual assault, domestic violence, and other gender related violence.
- 1997: (or so) WCASA began its initiative to end sexual assault against people with disabilities.

Domestic Abuse: A Historical Perspective

The movement to end domestic violence officially began in Chiswick, England in 1974. Here in the United States, the first domestic violence program began in Duluth, Minnesota in 1974 as well. Wisconsin was not far behind the wave of reform with the first Wisconsin domestic violence program incorporating in 1976 in Kenosha. The Wisconsin Coalition Against Domestic Violence (WCADV) was formed in 1978 as the Wisconsin Coalition Against Woman Abuse. Its primary purpose as a membership organization for domestic violence programs throughout the state was to provide a voice in Madison for funding and policy concerns and to provide training and technical assistance to staff of local battered women's programs and communities.

Since the creation of the very first program in Kenosha, the number of domestic abuse programs has greatly expanded throughout the state. Since 1998, funding increases by the State of Wisconsin have supported the expansion of services to all 72 Wisconsin counties and within each of the 11 tribal nations.

The domestic violence movement began when young battered women began telling other women about the violence in their homes. As a result, women began creating help or crisis lines and shelters so women could live free from battering. Understanding the nature of abuse and analysis about power and control came directly from battered women. Advocates saw their role

as not only helping victims, but also engaging in social change to challenge systems and society to acknowledge domestic violence and change its beliefs and practices.

| | Domestic Violence |
|------------------------|---|
| Identified the problem | Young battered women telling other women (consciousness raising groups) |
| Cause of the problem | Abuse of power and control (entitlement/oppression) |
| Core beliefs | Abuse was rooted in patriarchy. Women had the right to be safe in their homes. Battering was a crime. |
| Systems change | Systemic response to battered women considered crucial to the work. |

The domestic violence movement provides services primarily for women abused by an intimate partner, a family member or someone they have a trusting relationship with. Most of the services were originally designed for women and their young children, although many programs provide services for male victims as well. Victims self-identify and contact the program if they want help. Their account is believed; they do not need to provide “proof” of being abused.

Domestic abuse services generally include, but are not limited to, a 24 hour crisis line, emergency shelter, peer counseling, legal advocacy, support group, public education and systems advocacy. These services are not available to abusers. Generally, domestic abuse programs do not serve abusers. Rather, the justice system holds abusers accountable through arrest and prosecution. Batterers may attend intervention programs.

Often staff is formerly battered women and other individuals committed to improving conditions for women or ending domestic abuse. Their role is defined as an advocate working not only with individual victims, but also for systemic change.

| | Domestic Abuse |
|---------------------------------------|--|
| Abuse | Primarily abuse by family members or trusted others |
| Services include (but not limited to) | 24 hour crisis line, shelter, legal advocacy, peer counseling, support groups, systems advocacy, safety planning |
| Contact with abusers | Work with victims. Batterers may attend separate intervention program. Debate within battered women movement re: how to hold batterers accountable |
| Record keeping | Case file contains limited information |
| Source of information | Accept victim’s word |
| Staff role | Advocates, not case managers |
| Staff qualifications | Often hire formerly battered women and peer counselors |
| Goal plans | Safety plan included as element of all activities |

| | |
|----------------------------|--|
| | Domestic Abuse |
| Referral | Self selected and initiated. Victim may chose from an array of options |
| Model of service provision | Empowerment and options, peer counseling and advocacy |

Working with persons from a different system creates challenges. Using our own language and jargon can lead to misunderstandings. Professionals may have conflicting philosophies or understanding of why abuse occurs. There can be conflict around defining eligibility and service delivery.

However, victims benefit from the variety of services available from various systems. When professionals work together, victims can choose from a wider array of options. Since our goal is the same: victim safety and ending abuse, workers save time and resources recognizing how we can learn from each rather than working in isolation.

Compilation of above text from two resources: From A Web of Fear and Isolation To a Community Safety Net, NCALL/WCADV & PCADV (2000) and Madison Times article, The long road to social change: The Wisconsin Coalition Against Domestic Violence turns 25 September 26-October 2, 2003.

Historical View: Independent Living Movement and Philosophy

There were five movements occurring during the late 1960s and early 1970s that greatly influenced the disability rights movement they were Deinstitutionalization, the Civil Rights Movement, the "Self-Help" Movement, Demedicalization and Consumerism.

Deinstitutionalization, was a movement led by providers and the parents of people with developmental disabilities, it was based on the principle of "normalization" which says that people with developmental disabilities should live in the most "normal" setting possible if they were expected to behave "normally." The objective of this movement was to move people out of institutions and nursing homes and back into the community.

Civil Rights Movement, even though people with disabilities were not included as a protected class under the Civil Rights Act, the civil rights movement proved that people could achieve their rights, at least in law and as a class. "Watching the courage of Rosa Parks as she defiantly rode in the front of a public bus, people with disabilities realized the immediate challenge of even getting on the bus."

"Self-Help" Movement, begun in the 1950s with the start of Alcoholics Anonymous, it began to flourish in the 1970s with self-help books becoming popular and an increasing number of support groups starting up. Self-help and peer support are key points in independent living philosophy. According to the self-help theory, people with similar disabilities are more likely to assist and understand each other than individuals who do not share experience with similar disability.

Demedicalization, this movement began to look at more holistic approaches to health care, moving towards the "demystification" of the medical community and shifting away from the authoritarian medical model. This shift towards a new model, one of individual empowerment and responsibility for defining and meeting one's own needs lays another cornerstone of the independent living philosophy.

Consumerism, Ralph Nader was the most outspoken advocate for this movement, and his staff and followers came to be known as "Nader's Raider's," was one in which consumers began to question product reliability and price. This is possibly the most essential movement to the independent living philosophy today because it brought the idea of control by consumers of goods and services over the choices and options available to them.

The independent living paradigm, developed by Gerben DeJong in the late 1970's, suggested a shift from the medical model to the independent living model. This theory saw problems or "deficiencies" as being located in the society, not in the individual. People with disabilities no longer saw themselves as "broken or sick" and they were certainly not the ones in need of repair. Issues like social and attitudinal barriers were the real problems facing people with disabilities. The answers were changing and "fixing" society, not people with disabilities. The most important thing was that the individual must make his/her own decisions, not the medical or rehabilitation professional. People began to view themselves as powerful and self-directed, when they used these principles, as opposed to passive victims, objects of charity, cripples, or not whole. Disability began to be seen as a natural, not uncommon, experience in life, not a tragedy. People with disabilities should have the same civil rights, options and control over choices in their own lives as do people without disabilities.

| Traditional Rehabilitation And Independent Living Paradigm Comparison (Comparison Of Models) | | |
|--|---|--|
| Issue | Rehabilitation | Independent Living |
| Limitations | Impairments resulting in functional limitations related to walking, seeing, hearing, learning, etc. | Community barriers, including stereotypes, stigma, prejudice, discrimination, low expectations, and structural barriers. |
| Label/Role | Patient, victim, sufferer. | Person with a disability, advocate, consumer. |
| Objectives | Fix deficits to overcome limitations. | Systems change to reduce structured inequality, disability awareness to minimize restrictive perceptions. |

| Traditional Rehabilitation And Independent Living Paradigm Comparison (Comparison Of Models) | | |
|--|---|--|
| Organizational Structure And Response | Professional control. Knowledge base is advanced degrees. Professional counseling. Professional therapy. | Consumer control. Knowledge base is experiential, focusing on achieving independence. Peer support and counseling. Independent living skills training. |
| Community And Self Perceptions Of Person With A Disability | A person who, as a result of an impairment, is unable to participate in a variety of roles due to lack of function. | A person identified as having an impairment, who, as a result of community perceptions and structural barriers, is restricted from participating in a variety of social roles, including roles related to education, employment, recreation, social, worship, civic activities, etc. |

From: IMPACT Inc., 2735 E. Broadway, Alton, IL, USA at www.impactcil.org/phil_history/il_rehab.htm

Ed Roberts: The Father of Independent Living

Ed Roberts grew up in Burlingame, a suburban town on the San Francisco Peninsula. In 1952 his entire family contracted polio, everyone recovered except for Ed, who was left paralyzed, able to move only one finger. He continued his education at home with an innovative "school-to-home phone system" developed by Pac Bell. After graduating from high school he attended the College of San Mateo and from there he decided he wanted to go on to the University of California, Berkeley.

Ed had to fight the State Department of Rehabilitation and the University before finally being able to enroll in the fall of 1962. Because of Ed's success at the school the University admitted five more students with severe disabilities and nine more in the following year. All of these students lived in the Cowell Hospital on campus and they called themselves the "rolling quads". Ed wrote a grant proposal to the Student Special Services Program at the U.S. Office of Education, and the university was awarded the grant which was to develop the first Physically Disabled Students Program (PDSP) on a college campus. PDSP provided students with disabilities with assistance, including wheelchair repair, attendant referral, housing referral, benefits counseling, peer support and more. Even the people with disabilities in the Berkeley area who were not students began to come to PDSP for services. In 1970 Ed went to U.C., Riverside to direct the Handicapped Opportunity Program for Education (HOPE). In 1971 he became Dean of Students and professor of Political Science at Common College in Woodside, near his hometown of Burlingame. By 1971, people with disabilities both students and non-

students, were talking about developing self-help community programs like PDSP for all persons with disabilities. Also that year the Center for Independent Living opened its doors on University Avenue in Berkeley, a year later Ed became its executive director.

In 1975, Ed was appointed director of the State Department of Rehabilitation in California. He used Federal Innovation and Expansion grant funds to start independent living centers throughout California. The idea was so successful that in 1978 a committee of the House of Representatives held hearings to learn about independent living centers and the needs of persons with disabilities. Also that year, Congress passed the Rehabilitation Act of 1978, which opened the way for the development of independent living centers all across the country. (*Adapted From: Reminiscences of Ed Roberts by Joan Leon http://www.edrobertscampus.org/er_03.html*)

Elder Abuse Historical Highlights

1960's: A number of demonstration projects funded by the Administration on Aging to examine the effect of programs on those in need of protective services.

1974: Title XX gave state permission to use Social Services Block Grants funds for adult protection as well as child protection.

1981: All states had an office with responsibility to see that adult protective services were provided to some segment of the population.

1992: 42 states had mandatory reporting (Otto, 2000).

Elder abuse services generally work with persons age 60 and older, some of whom cannot take care of or protect themselves. Often the largest percentage of clients are persons who self-neglect. The role of elder abuse/adult protective services workers is to investigate allegations of abuse and offer services. These services can include case/care management, information and referral, home health, respite care, and counseling. Victims are identified when abuse and neglect is reported. Abusers may be interviewed and services may be provided to them.

Abuse

The nature of the abuse and relationship to victim varies widely. Abuse for elder abuse and adult protective services also includes self neglect. The services provided by these systems include, but are not limited to: investigation, case management, information and referral, home health, respite care, and counseling. Elder abuse and adult protective services workers also may interview and work with perpetrators, often with victim/consumer consent.

- Record keeping: Case file contains detailed information.
- Source of information: Required to investigate and contact collateral sources.
- Staff role: Care/case managers.
- Staff qualifications: Tend to hire trained social workers or other professionals.
- Goal plans: Care plan for safety in the least restrictive environment.

- Referral: Case manager initiated with consumer's consent. Victim may chose from an array of options.
- Model of service provision: Clinical model with consumer participations and right to self determination.

Appendix G: Screening and Assessment Information

Best Practice Recommendations for the Screening and Assessment of Trauma

Ethnic and cultural issues often have a significant impact on experiences of trauma and mental health. Cultural and individual differences influence which experiences may be considered traumatic. For example, ethno cultural status may influence perceptions of individual responsibility, family relationships and social obligations, in ways often widely different than majority U.S. culture, or than is reflected in mainstream medical model psychiatry. For instance, the sense of obligation to the group, particularly the protection of family honor is more important in many cultures than individual self-disclosure, and may lead some trauma survivors to avoid discussing their experiences. Front line workers and human services professionals should be alert to the fact that many refugees and other immigrants may have experienced war, severe forms of torture, systematic rape and other forms of trauma, which are not routinely encountered by service providers.

It is also very common for people from many cultures, including mainstream U.S. society, who have experienced trauma to suffer from somatic complaints and symptoms such as chronic fatigue, stomach pain, headaches, or have sleep related problems. Often they will not identify emotional distress as an issue, either because of perceived shame of being "crazy" or because the culture lacks the words and definitions for most forms of mental illness. Inviting the trauma survivor to tell their story in a way that is respectful of cultural differences can allow the survivor to begin the path of healing.

Screening for a Trauma History:

Front line workers from all major social systems must begin to screen for histories of trauma or current trauma. Screening asks very general questions about one's family history, marital history, whether the individual is a war veteran, has witnessed any natural disasters, or been a witness to war. Front line workers are defined as those who have initial contact with consumers/survivors who are seeking services, including the first possible point of entry into any social system. Examples of social "systems" staff or front line workers are law enforcement officials, jail staff, attorneys, guardian ad litem, etc., who make up the legal system. The medical system can include EMTs, hospital emergency room staff, physical therapists, home health care workers and nurses. Schools are another social system made up of public and private schools, colleges, technical colleges, alternative schools, etc. The human services system is a system of providers from the areas of mental health, AODA, domestic violence, sexual assault, long term care, social services, etc. It is recommended that before implementing guidelines for the screening of trauma, that front line staff have training about the consequences of trauma and awareness of community resources. Front line staff must also feel comfortable when asking screening questions and know how to respond when disclosures are made by survivors/ consumers. Also it should be noted that survivors might not disclose a trauma history when first asked, but only after a trusting relationship is established.

Assessment for a Trauma History:

This section provides recommended best practice interview techniques for use when consumers/survivors ***remember and know*** they have experienced a trauma event such as physical abuse, domestic violence or sexual assault. Agencies and professionals from the human services system are encouraged to include an assessment for current trauma or trauma histories as part of ***all*** standard intake procedures and initial services provision guidelines. The following discussion about interview style and suggestions of strength-based approaches applies to ***all*** providers of services from AODA, mental health, domestic violence, sexual assault, and other ancillary service providers such as inpatient psychiatric settings, social services and crisis intervention.

A. Suggested Interview Techniques - Current Trauma or Trauma History:

Historically many consumers/survivors with current or trauma histories have had little trust in the public mental health system. This lack of trust, in part, stems from the medical model of providing services. The medical model of mental health services until recently has meant that consumers/survivors have had little say in their therapy or kinds of services they receive. This lack of choice and control is similar to the lack of choice and control survivors experienced when traumatized and can feel like re-traumatization by a survivor.

Build trust:

- Offer choice over when and what information is shared or disclosed with the helping professional - reassure the individual that they have control over stopping the questions, such as, "At anytime we can stop or take a break, just let me know."
- Use an introduction statement such as, "Because of the prevalence of violence in our world, some difficult questions may be asked." OR "Because of the prevalence of sexual assault and domestic violence in our world, I've started asking about it routinely."
- Always ask permission to ask questions, such as, "Do you mind if I ask some questions about_____?" OR "Is this a good time to ask questions about_____?"
- At all times the helping professional should explain what happens next

Operate from a strength-based approach:

- Understand and acknowledge the strength and coping strategies necessary for survival from trauma
- Recognize that these strategies are not deficits or pathology or "problem behaviors"
- Do not blame the survivors or judge them
- Use interview techniques and reflective statements that use language of strength such as, "You found the strength to get through that situation" or "that was courageous."
- Use re-framing to reduce shame, normalize coping and provide a framework for building upon strengths. Examples of re-framing statements include: "you were looking for companionship, everyone needs companionship" or "the coping strategies worked well then", or "you showed perseverance."

Asking questions about one's trauma experiences gives permission to the consumer/survivor to talk as well as shows interest and empathy on behalf of the helping professional. In the beginning it is recommended that more general questions be asked, moving to specific questions. The following illustrates examples of questions appropriate for a variety of settings, moving from a general to specific interview format that will solicit information about trauma histories as well as allow the consumer/survivor to begin to tell his/her story.

- => "What brings you to our agency today?" OR "Where would you like to start?"
- => "How can our agency help you?"
- => "I understand that you have some concerns about.....can you tell me about them?"
- => "Is there anything that you think I need to know that I haven't asked you so far?"
- => "Are there any areas you think we need to cover more thoroughly?"
- => "Have you ever had an experience you thought to be traumatic?"
- => "Can you tell me what happened to you?" OR "What did you do to survive or get through....?"
- => "Have you ever had an experience where you thought you might die or be seriously injured?"
- => "Have you ever had an unwanted sexual experience?" "Have you ever been physically hurt by another person?" "Have you ever witnessed or seen someone killed or seriously injured by another?"
- => "As a child or teen did anyone touch you sexually or make you have sex?" "As a child did you see your parents fight, did they hit, push, shove or call names?" "How did you know your parent(s) was angry at you when you were a kid, did they ever hit you, call names. . . etc?"
- => "Every couple has disagreements or fights, what are disagreements and fights like in your household? Do they ever become physical?"
- => "Are you having any extra stress with your spouse (partner, work)?" "Are you ever afraid of your partner, (spouse or someone at work)?" "You mentioned that your partner uses drugs/drinks. What happens when he/she does?" "You mention that your partner has a temper, what happens when he/she gets angry?"
- => "Has your partner (spouse or someone at work) ever hurt you, threatened to hurt you?" "Did someone hit you?" "Was it your spouse (partner)?"
- => "I'm concerned that what you have told me so far may have been caused by someone hurting you. Has someone hurt you?" "Many persons who come to this agency tell me that someone close to them has hurt them. Could this be happening to you?"
- => "Have you ever been in a situation similar or like this one?"

It is important when asking the above questions, to *avoid an atmosphere of cross-examination and emotional flooding* of the survivor. The goal is to allow the consumer/survivor to initiate a narrative disclosure of trauma, at a comfortable and safe pace. During the unfolding narrative, the interviewer asks key questions and makes reflective statements to clarify and support the disclosure. By using re-framing and strength-based techniques the helping professional establishes trust and connects with the consumer/survivor.

Signs of emotional "flooding" must be respected and checked out with the survivor. Emotional flooding may result in consumers/survivors withdrawing or failing to attend sessions, increased feelings of hopelessness or increased trauma responses such as nightmares, self-injury, etc.

Most helping professionals, at some point in their work will make judgments about the authenticity of a survivor's report of abuse. There are no valid or tested guidelines that help judge the credibility of trauma stories. Credibility decisions may in fact predispose professionals to certain disbeliefs that will interfere in the helping relationship. For example, the professional who does not believe in dissociative identity disorder (DID) will not listen to his/her clients concerns about hearing voices or may misdiagnose the client, leading to further re-traumatization. Professionals who have strong beliefs or find they do not believe trauma stories should refrain from providing trauma work and refer the individual on to another helper.

B. Special Considerations When Assessing for a Trauma History: People with Disabilities and Older Adults

It has been estimated that 83% of women with a disability will be sexually assaulted in their lifetime (Stimpson, L. and Best, M. (1991) *Courage Above All: Sexual Assault Against Women with Disabilities*. Toronto: DisAbled Women's Network). Older adults are also assaulted at alarming rates. Even though abuse is so prevalent for these populations many in society do not believe that it occurs because of cultural stereotypes of what a typical sexual assault or physically abused victim looks like. As a result, very few of these people receive any type of victim services, and are often left alone to deal with the trauma of the assault. The few that make it into the system are often re-traumatized by people who do not believe them and treat them as if they are lesser than human.

Many service providers are afraid of working with people with disabilities because of possible communication differences. Many do not take the time to learn about what a person's needs might be, or they make unfair assumptions. Many people with disabilities feel that victim services are not accessible to them, even if they meet government standards for physical accessibility, because of attitudes and perceptions that the staff might hold. This further isolates the person and often causes them a lot of additional trauma. In addition this lack of support creates an environment in which perpetrators are not held accountable, allowing them to continue to assault other people with disabilities that they perceive to be "easy targets".

Cognitive Disabilities

- For many individuals with disabilities, providing trauma services will be no different than with a client without disabilities, however, many disabled survivors may be nonverbal, or may use a different form of communication.
- Be respectful and patient. It may take more time than for other survivors with whom you work.
- Many individuals with cognitive disabilities might be very concrete in their thinking. Phrase questions and statements in such a way to avoid ambiguity or confusion. Try to avoid idioms, clichés, or expressions. Avoid using technical terms.

- Don't speak too fast.
- Try to determine the relationship between the suspected abuser and the victim. Because many people with disabilities are dependent on others for their care, you will need to know what the relationship means to the victim in terms of practical and emotional issues.
- Especially for people with cognitive disabilities, 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 with all levels of ability can be lead by particular actions of another person.
- If a person you are talking with has trouble focusing or staying on track, help them to do so by rephrasing questions and providing structure to the subject you are discussing. Be repetitious. Ask questions in a different way.
- If the person is having trouble remembering dates or times try using memory cues. For example ask them what was on TV, if the assault happened near their bedtime, or if it occurred near a holiday
- Listen to all information and believe what you are told. Make every effort to get accurate information from the person with a disability before relying on information from others. What she/he is telling you may seem factually incorrect, but it is possible she/he has interpreted the words differently.
- As in the general population, false disclosures are rare. People with disabilities sometimes retract a story of abuse due to fear, confusion, or pressure.
- Some people with developmental disabilities are unable to communicate through oral language, yet possess receptive language and other ways of communicating which may include body movements, sounds, communication boards, augmentive communication devices, drawing, and anatomically correct dolls or pictures.

Physical and/or Sensory Disabilities

Mobility impairment:

- Do not assist with pushing a wheelchair without permission
- Position yourself in front of the person, facing the person at eye level. Do not lean or put your feet on the wheelchair.

Visually Impairment:

- Repeat your name and introduce others by name and title each time you initiate contact until he/she is familiar with your voice(s).
- If the person uses a dog to assist them, do not pet the animal without the person's permission.
- Describe the layout of the room as well as all procedures in detail before they occur.
- Assist with completing any intake or treatment forms only after you have read them aloud to the survivor in their entirety. Have forms and resources available in accessible formats such as large print, Braille, or on audiotape.

- Do not attempt to physically lead the person without asking first; allow the individual to hold your arm and control his/her movements. If you are assisting an individual in seating, place the person's hand on the back or arm of the chair and allow them to sit by themselves.

Deaf or hard of hearing:

- Provide a safe, trusted and qualified interpreter.
- Approach a person who is deaf or hard of hearing from the front or signal your entry to the room.
- Find out right away how the person best communicates (e.g. speech/lip reading, writing, sign language and an interpreter.)
- Look directly at the person while speaking
- If you suspect the person has a hearing loss, ask her if she has a hearing aid or to let you know if she cannot hear you clearly.
- When working with someone who is hard of hearing do not shout. Speak at your normal volume unless the person asks you to talk louder - - hearing aids make sound louder not clearer.
- Make sure you gain the attention of an individual who is deaf or hard of hearing (i.e. by placing your hand lightly on the person's shoulder) before beginning to talk. Identify who you are and make sure that you look directly at the person as you speak.
- To make it easier for the individual to lip read, face the light, speak clearly in a normal tone, keep your hands away from your face and use short simple sentences.
- If you do not know sign language, use paper and pencil. You should not be embarrassed to use this method because getting the message across is more important than the medium used. If there is an interpreter present be sure to talk directly to the person and not to the interpreter.

Psychiatric Disabilities

- Treat a survivor with psychiatric disabilities like anyone else.
- Ask the person about what treatment options work best for them. Find out about preferences for types of medications or therapy. Find out if she/he prefers a specific staff person or a staff person of a specific gender. Find out what has or has not worked for the person in the past.
- Find out what types of things upset them, such as being restrained against their will or being touched without her/his permission. Find out what works best to calm them down in the event that they become upset. For example playing certain music or writing in a journal might help.
- A flashback is an intrusive powerful reliving of past traumatic events. If, during a session, a person has a flashback, try to use grounding techniques to bring the person back: you might say to the person in a clear tone "Can you open your eyes? It is safe here." It may help to give the person a pillow to hold. In general, do not touch the person. The person may know what helps, so it may be useful to ask the person what works best.

- Failure of some service providers to understand the connection between a survivor's symptoms and trauma history frequently leads to actions that re-traumatize the person. For example, failure to acknowledge the abuse perpetuates the secrecy and lack of validation experienced by the individual; locking a person in seclusion may replicate experiences of being isolated and helpless; stripping a patient may trigger flashbacks of sexual assaults; misinterpreting cutting behavior as suicide attempts or "attention-seeking behavior" discredits the person and what he/she is feeling.

Older Adults

- Older adults are a very heterogeneous population. Most are healthy, live on their own, and take care of themselves. Others may have disabilities or aging infirmities and live in a facility setting.
- Variation between ability levels can be vast. Older adults can be of any gender, ethnicity, religion, sexual orientation, class, and ability level.
- Elder survivors may be embarrassed to talk about sexual assault or domestic violence. They may not recount everything that was done. Also, sex was something that was not often talked about when they were growing up, so they may not want to tell you all the details. Remember that and respect their decision.
- In addition to the trauma of being abused, an older victim/survivor often experiences an increased awareness of her/his physical vulnerability; her/his reduced resilience, her/his old age, and the eminence of death. The person may need to deal with these issues in addition to the trauma.
- Some older adults are adult survivors of childhood sexual assault/abuse. Because of isolation many survivors feel their first opportunity to talk about their experience may occur as they start to put their lives in balance during their final years. This may possibly be triggered by the death of the perpetrator.
- The victim/survivor may be afraid of being placed in a nursing home or experiencing the public shame when a family member is a perpetrator or batterer. This may cause the victim/survivor to refrain from seeking help or reporting the abuse.
- Some older adults prefer to be referred to by Mr., Mrs., or Ms. This is a form of respect for many elders and they may be insulted if you call them by their first name.
- Some older adults may not be comfortable with the use of words such as abuse, rape, or battery to describe their assault because of the stigma associated with these things by others and generational differences. Instead ask questions like "has anyone ever touched you in a way that made you feel uncomfortable?" "Has anyone ever hurt you by hitting, pushing or slapping you?"

C. People who are Lesbian, Gay, Bisexual or Transgendered (LGBT):

Survivors who are lesbian, gay, bisexual, or transgendered should be treated in the same way as any other person receiving trauma services. It is important to use respectful and inclusive language at all times, and not make assumptions about a person's sexual orientation or the gender of perpetrators. One should be aware that it could be very difficult for some people to talk about

their abuse experiences, especially if they have not publicly disclosed her/his sexual orientation. Also, some people who are LGBT may have little or no support systems in place due to the stigma associated with her/his sexual orientation. This can increase isolation and cause further trauma after an assault.

- Make sure forms use gender-neutral words when asking about parent and partner information. (parent/parent instead of mother/father; partner, etc.)
- Use inclusive language (Cook-Daniels, 1998).
- Use whatever term a person uses to refer to someone that they are in a relationship with.
- If a person is transgendered use whatever name/pronoun the person uses, regardless of the person's legal identity and/or physical characteristics. (Cook- Daniels, 1998)
- Make sure that the survivor is being treated by someone who will treat him/her fairly and respectfully, regardless of his or her sexual orientation.
- Don't assume that the person who assaulted someone is a member of the opposite sex.
- The survivor may feel shame or struggle with issues surrounding sexual orientation if they were assaulted by someone other than his/her gender or sexual preference.
- Both gay and heterosexual men are at high risk for depression and suicidal behavior after being sexually assaulted.
- For gay men, lesbians, people who are bisexual or transgendered, fear of disclosure is frequently a major issue, even for people who are open about their sexual orientation or identity.
- Even if the assault was not a "hate crime", often it feels as though it is and results in increased anxiety, deep personal doubt, negative self-image, and depression. (Miller, 1997).
- Some survivors, especially adolescents who are LGBT, may live in communities or families where their sexual orientation is not accepted. This lack of a support network, including a lack of connections in the gay and lesbian community, might increase an individual's isolation and fear after a sexual assault.
- Be aware of the lack of legal protections same sex couples have. The person may not have rights to children, savings, and property if these are in their partner's name. (Cook-Daniels, 1998)

D. Refugee and Immigrant Women:

Refugees and immigrants, who have come to the U.S. from other countries at war, or from places with oppressive governments, are often survivors of extreme trauma. These people may have experienced or witnessed systematic rape and other physical violence as a means of power and control over the people of a country the goal being to crush their dignity and spirit. Refugees and immigrants may continue to live each day in fear, even if they are now living away from the violence. They may also experience further trauma and isolation due to the stigma associated with being victims of sexual assault or physical violence, which may be taboo in their culture. Refugees and immigrants may have trouble working with service providers who speak a different language, or whom are unfamiliar with their culture and their struggles. Extra efforts should be made to be culturally sensitive and to keep from re-traumatizing the survivor.

- If a female comes from a culture that blames the victim for rape or does not consider her marriageable once raped, she may deny that the sexual assault occurred.
- If married, fear of the husband blaming her and/or rejecting her may prevent her from disclosing the rape.
- For individuals who are refugees or immigrants, cultural difference, fear of law enforcement and/or deportation (if they immigrated illegally), and language barriers can increase vulnerability.
- You may need to provide resources in a different language or have an interpreter present.
- The effects of trauma on people who witnessed or were victims of war and torture are often more severe. (Lennon, 2002)
- Ordinary experiences which remind individuals of past trauma, such as waiting in line or being asked questions can cause a person to relive their traumatic experience. (Lennon, 2002)
- Some people who have survived the horrors of war and torture often experience survival guilt.
- Mental health professionals working with refugee/ immigrant populations should have a basic cultural understanding of the population they are working with.
- Rape is often used as a political tool. Be aware of the severe trauma that is often present because of systematic abuse. Gang rapes by military personnel and other political people are often used as tools of war.
- Some refugee/immigrant women may have been kidnapped and forced to marry against their will.

E. Male Survivors/Consumers:

Research findings consistently state that boys and girls experience sexual abuse differently.

Specific research findings that effect boys/men are:

- Male victims are more often sexually abused by same sex perpetrators than females. (Finkelhor, 1984; Fritz, Stoll, & Wagner, 1981; Risin & Koss, 1987)
- Boys are more frequently the victims of extrafamilial abusers. Boys are at greater risk of being sexually abused by teachers, priests, babysitters and coaches. (Finkelhor, 1984; Fritz, Stoll & Wagner 1981 Pierce &Pierce, 1985; Risin & Koss, 1987; VanderMay, 1988).
- Boys who are sexually abused are also more likely to be physically abused than girls. (Dixon, Arnold & Calestro, 1978; Finkelhor,1984; VanderMay, 1988).
- If a male victim, who is a juvenile, discloses abuse, his abuse is more likely to be reported to law enforcement rather than to a child protection agency. (Finkelhor, 1984; Pierce & pierce, 1985; Vander May, 1988).
- After disclosure male victims are less likely to receive supportive services or counseling than female victims. (Vander May, 1988).

Most of the above research findings are at least 12-15 years old, and even though we know today that one in six boys will be sexually abused before the age of 18, treatment resources and up to

date research is lacking. Many communities and treatment providers still have difficulty acknowledging male victimization as well as providing resources for healing to male survivors. This lack of resources and awareness increases isolation and secrecy for male survivors. Some assumptions about male survivors which lead to under-reporting include boys and men are reluctant to identify themselves as victims due to masculine role pressure, confusion about what is sexual assault, and fears of being gay or having a bisexual orientation.

Victims/survivors perceptions of their sexual abuse will be determined by many factors, including: cultural beliefs, society's messages about gender, and age of the victim. Society and cultural beliefs often give boys/men and girls/women clear messages about how they are suppose to act, respond, and feel. For example, traditional Caucasian societal messages tell boys/men that they are not suppose to need assistance or feel intense emotions, but rather they are to be protectors, sexual initiators and providers. Therefore, when boys/men are sexually abused they often experience intense shame and greater isolation than female survivors, and confusion with male gender identity.

Boys/men often have greater difficulty disclosing sexual abuse, and more difficulty in therapy using the therapeutic relationship to connect with feelings of sadness and loss. Some additional possible assessment questions for use with men when you suspect sexual abuse are:

- =>Please describe sexual experiences you have had in your life, even though you may not at the time of the experience saw it as sexual (for example, being told sexual information or things, being shown pornographic pictures, discovering masturbation with someone, being touched by someone in a sexual way.)
- => Please tell me about all confusing experiences you have had that others might consider sexual.
- => Please tell me about any sexual experiences you had before the age of 18.

In spite of the differences between male and female gender perceptions of abuse and the consequences of abuse, many more similarities exist in the healing and recovery from abuse. Being knowledgeable about prevalence, impact and the issues involving both female and male survivors is necessary for developing respectful, safe and trusting relationships that empower boys/men and girls/women in their healing journeys.

State of Maine
Department of Behavioral and Development Services (BDS)
Trauma Assessment for BDS Facilities/Staff

This form serves as a guide to taking trauma history. It is recommended for use as part of the intake assessment. After clinical review, this information should be incorporated into treatment plans, with client participation. It should be used in conjunction with the Personal Safety Form.

- 1) Sometimes, people have been hurt or frightened by others in the past. Some have lived through terrible experiences such as abuse, rape, combat, or injuries. If we know about these experiences, we may be better able to help you. Are you willing to answer a few questions to understand more about your personal experience with such things? Yes _____ No _____

(If the client is unwilling or uncertain whether to proceed, please gently explore the basis for his or her refusal and attempt to address any concerns about the process.)

- 2) Have you ever been physically hurt or threatened by another? (e.g., hit, punched, slapped, kicked, strangled, burned, threatened with object or weapon, etc.?) Yes _____ No _____

(If yes, in the past? _____ Is it still going on? _____ Are you able to say by whom? _____)

Someone known to you or a stranger? _____

Details _____

- 3) Do you have a history of unwanted sexual contact by another? (e.g. unwanted kissing, hugging, touching, nudity, attempted intercourse?) Yes _____ No _____

(If yes, in the past? _____ Is it still going on? _____ Are you able to say by whom? _____)

Details _____

- 4) Have you ever been raped, or had sex against your will? Yes _____ No _____

(If yes, in the past? _____ Is it still going on? _____ Are you able to say by whom? _____)

Details _____

5) Have you lived through a disaster (like a flood, tornado, or plane crash)? Yes _____ No _____

If yes, please give age and circumstances:

6) Are you a combat veteran, lived through war as a civilian in another country, or experienced an act of terrorism? Yes _____ No _____

If yes, please describe

7) Have you been in a severe accident, or been close to death from any cause?
Yes _____ No _____

If yes, please describe

8) Have you witnessed death or violence or the threat of death or violence to someone else?
Yes _____ No _____

If yes, please describe

9) Have you been the victim of a crime? Yes _____ No _____

If yes, please describe

10) Have you ever experienced seclusion or physical or chemical restraint in a hospital, institution, or other setting? Yes _____ No _____

If yes, please describe

- 11) If yes to any of the above, have you experienced any emotional, psychological or physical problems (e.g. flashbacks, nightmares, lost time, insomnia, numbness, confusion, memory loss, self injury, extreme fearfulness or terror, etc.) which may be related to the events?

Yes _____ No _____

Is this happening currently?

Yes _____ No _____

- 12) Were these questions upsetting to you?

Yes _____ No _____

Would you like to talk with someone else?

Yes _____ No _____

- 13) If you find yourself thinking more about these issues later, how will you let someone know?

(Suggestions of possible ways)

Please incorporate the information in the trauma assessment
into the treatment plan for this client.

