Frequently Asked Questions

Since 1996, SafePlace has provided training to service providers across the country about sexual assault, domestic violence and caregiver abuse against people with disabilities. Below are answers to some of the most frequently asked questions about serving abuse survivors who have disabilities.

An abuse survivor with a cognitive disability has been referred for counseling, but our counselors have no experience in this area. What can we do?

Begin by treating each person according to chronological age, and with respect for life experiences and perspectives. People with cognitive disabilities can receive the same benefits from counseling as any other survivors, but may take longer to process emotions. Be flexible about the number and length of counseling sessions allowed.

Reassure the abuse survivor that she/he did nothing wrong. Avoid asking leading questions, as people with cognitive disabilities may be eager to please and may have been trained to be compliant to authority figures. Consistency and familiar routines (e.g., meeting at the same time on the same day of the week) may be helpful to people with cognitive disabilities. Shorter or more frequent sessions may also be helpful in processing feelings and experiences.

Contact your local developmental disability center for training in providing counseling or services to people with cognitive disabilities. Seek clinical consultation to expand staff's professional competency in working with people with cognitive disabilities.

Can a domestic/sexual violence program require that a survivor with mental illness take medication in order to continue with services?

No. Taking medication cannot be a condition for staying in shelter or receiving other services. Making medication mandatory could be perceived as a violation of the Americans with Disabilities Act (ADA). This requirement could also pose ethical and liability issues, particularly if the agency is not licensed to distribute medications or monitor their use.

Psychotropic medication is not a cure-all, and taking it is a personal choice. When medication is working well, it can help a person cope with and manage mental health or trauma symptoms. However people can choose to experience mental illness symptoms rather than managing side effects (fatigue, weight gain, insomnia, etc.). Some cannot afford medication, or stop because they start to feel better.

Respect their choice, but let the survivor know that program guidelines exist to keep everybody safe. With or without medication, ultimately each person has a responsibility to adhere to program guidelines. Do consider, however, which guidelines can be adapted as reasonable modifications according to the letter and spirit of the ADA.

A lot of survivors we serve use alcohol and drugs, and we have a zero tolerance policy for use. What are some guidelines for working with people who have ongoing substance use issues?

This is a difficult issue for many domestic violence and rape crisis centers. Survivors may use drugs or alcohol, including prescribed or over-the-counter medications, to cope with the experiences of violence in their lives. Some survivors may not be ready to give up this coping method. Conversely, others who are working to stay sober may find it difficult to be around people who use alcohol or other drugs. Safety of all survivors is our paramount concern, and finding a balance for opposing needs can be tricky.

Bear in mind the impact that a zero tolerance policy for use during services often sets up survivors with addiction to fail and return to their abusive situation. When a survivor exhibits signs of substance use upon arrival, a variety of options may include linking the person with a counselor, encouraging the person to remain in their room or a quiet space until sober, or determining if it is necessary to seek immediate medical attention. When in doubt, call 911. Regularly discussing substance use at resident meetings, as drug and alcohol abuse may be prevalent in shelter. These discussions can create an open dialogue.

To provide support for survivors coping with substance addiction:

- Offer support groups for participants with multiple issues, including domestic and sexual violence; substance abuse; mental health; and other issues related to trauma; providing on-site 12-step programs (e.g., Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, etc.).
- Refer survivors to outside 12-step programs, support groups, and treatment programs. Note: Because some abusers may stalk their victims, discuss safety planning with survivors who attend outside groups.
- Provide information about other recovery options, such as gender-specific groups, culturally relevant support groups, or a substance recovery philosophy different from the traditional 12-step model.
- If an individual is exited from services due to substance abuse, do not automatically deny the person re-entry into the program at a later date. Recovery from addiction often takes many attempts before success.

We want to provide community education about personal safety and sexuality to people with disabilities. What resources are available, and how do we start?

Many people with disabilities never receive education on sexuality, relationships, or safety and therefore lack knowledge about their bodies, healthy relationships and how to protect themselves. People with disabilities living in segregated settings and participate in day programs or employment training programs need access to information about personal safety and sexuality.

Ask your local center for independent living to team with you to outreach to people with disabilities. Provide educational workshop on healthy relationships, sexuality, rights to safety, assertiveness, types of abuse and personal safety strategies, including where to find help, who to talk to about abuse and how to say no.

A number of resources are available on personal safety and sexuality education for people with cognitive disabilities. Materials in the SafePlace Disability Services resource lending library are available for loan in person or by mail within the United States.

Sometimes, when I am providing sexual assault hospital support, I hear the law enforcement officer and the sexual assault nurse talk about survivors who have a mental illness diagnosis as if they were not telling the truth, particularly if they are frequent visitors to the emergency room. How can I handle this situation with those service providers and with the survivor?

Let the survivor know that you believe them and that you are there to provide support. If, within your professional role, you can advocate on behalf of a survivor with hospital and law enforcement staff who are being dismissive, do so privately. Be calm and matter of fact, not accusatory.

However, some sexual assault agencies designate a specific staff member to resolve conflicts, and request that volunteers and staff not advocate directly with the Sexual Assault Nurse Examiner (SANE) nurses, hospital staff, and law enforcement. In that case, express your support to the survivor and continue to provide hospital advocacy. Document what was said and talk to the liaison at your agency so that the issue can be addressed.

Sometimes, hospital staff and law enforcement are skeptical because the same person has reported sexual assault before that was not supported by evidence. Because several studies show a high incidence of sexual assault against people with mental illness, remind other service providers that your agency takes each new report of potential rape or assault seriously.

If after repeated hospital visits there is no evidence of sexual assault that supports the survivor's story, consider the possibility that the survivor is remembering or re-experiencing previous assaults and having trouble differentiating between the past and current experiences. Difficulty differentiating from past and current events is not an automatic indicator of a serious mental illness. Many survivors – particularly of childhood sexual abuse, domestic violence or other trauma – experience flashbacks, night terrors and body memories that are often difficult to manage and understand. Ask if the hospital social worker can provide consultation. Let the survivor know about the crisis hotline, counseling and other services available through your rape crisis agency. As with all sexual assault survivors, make sure the person has a safe place to go after leaving the hospital.

How can we make our agency accessible to people who use wheelchairs or other mobility equipment?

Ideally, the entire agency will be accessible to people who use wheelchairs and other mobility supports. If this is not possible – in historic multi-story buildings, for example – make sure that people who use wheelchairs have access to all programs. Have accessible office space available or offer services offsite at an alternate accessible location.

Ask people with various disabilities to tour the facility, with a checklist, and give feedback on its accessibility. The center for independent living in your area may provide this service. Go over that list with staff, and then ask them to come up with their own list of physical barriers in the office, reception, restrooms, offices, counseling and waiting area. Make a plan to address and remove any identified barriers.

The open attitude of rape crisis and domestic violence staff is just as important as wheelchair ramps and accessible restrooms. Pay attention to the messages that the agency gives out to the public through the agency website, materials or press releases. Include pictures of people with disabilities or the wheelchair logo (a universal sign for accessibility) on agency materials.

How can our transitional housing program provide a supportive environment to people with disabilities?

Review your application forms and processes to make sure they are not screening out people with disabilities. Several federal laws prohibit discrimination against people with disabilities in these residential programs.

Be flexible. Provide staff training on disability etiquette and about modifying agency practices to be accessible to people with disabilities. An example of a modification is allowing a resident to have a service animal at the apartment. Because service animals are not pets, landlords and crisis agencies cannot charge an additional

security deposit. Additionally, the person is not required to provide documentation of whether the animal is certified or not.

Be flexible about educational or employment-related goals. More adults with disabilities who have lived in facility settings are moving into the community. A person who has no experience living or working in the community will have quite different goals than someone who has lived alone or held a job, and will usually require a more detailed case management plan.

Although not a full list, below are some additional tips:

- Work with your state vocational rehabilitation agency to help persons with disabilities with job searching, job training, job accommodations and mobility instruction.
- Provide accessible play areas for kids with disabilities in your transitional housing community.
- Increase the sense of community through promoting peer support.
- Have apartments that accommodate a person using a wheelchair (wider doorways, lower counters, open counters under sinks, wheelchair accessible bathroom with grab bars, a raised toilet, levers on sink and shower faucets, etc.).
- Ask survivors with substance abuse issues how staff can best provide support, including information about local resources.
- Be familiar with local public and private accessible transportation options (e.g., para transit services or taxicabs).
- Allow service animals and provide a relief area.
- Offer agency paperwork and materials in alternate formats (Braille, large print, simplified language, audio, video in American Sign Language).
- If needed, assist residents with correspondence, filling out forms or making telephone calls.
- Provide accessible equipment (e.g., flashing and audible fire alarms and doorbells).
- Schedule American Sign Language interpreters when meeting with Deaf clients.
- When developing your annual program budget, allocate line items specifically for accommodations (e.g., interpreters, Braille, adaptive equipment).

We want to serve the Deaf community, but we do not have anybody on staff who knows sign language. What can we do?

Shelter or other crisis services can be very isolating for someone who is deaf. This isolation can feel re-traumatizing or trigger memories of abuse and deaf survivors may choose to leave because of communication barriers. Having a good understanding of Deaf culture and an open attitude is a helpful start to effectively work with Deaf abuse survivors.

A well-qualified interpreter is critical to effective communication unless the person who is deaf specifically requests written communication or lip reading. Crisis agencies are required to provide an interpreter if a person who is deaf requests it, but are not required to do so 24 hours a day. Work with the survivor to pick the most important circumstances for an interpreter (i.e., counseling, assessment, support group, shelter meetings, group social times).

While some Deaf people are fluent in written English, it is generally a second language for people who sign. Most people who are deaf can write at primary level, but effective communication through written language may be extremely limited. Resources for finding interpreting services are your state rehabilitation agency, the Internet, the phone book, or local government and nonprofit agencies that provide services to people who are deaf.

Include costs for interpreting services in your annual agency budget and grant proposals, or hold specific fundraisers to develop a pool of money for this and other accommodations. Get realistic figures when calculating these costs.

Except for very basic information (e.g., dinner is at 6:00), do not use children to interpret. Children may withhold information and the conversation may be traumatic for them to hear. Using children to interpret conversations about sexual assault or domestic violence may be considered child abuse.

Consider outreach efforts into the Deaf community. Build relationships with Deaf community members who can give input on offering “deaf-friendly” services. The Deaf community is tight knit, so if one survivor who is deaf has a negative or isolating experience with your agency, others who need crisis services may be reluctant to approach you. Conversely, if you provide supportive services for one survivor who is deaf, you may receive a number of referrals.

Further tips:

- Plan staff training on deaf culture and sensitivity.
- Hire staff that are deaf and fluent in ASL.
- In shelter, have available adaptive equipment, such as a TTY, videophone, flashing lights to signal a fire and television with closed captioning.