

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



A project of the

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

WV S.A.F.E. Partners:

- West Virginia Foundation for Rape Information and Services (WVFRIS)**
- West Virginia Department of Health and Human Resources (WVDHHR)**
- Northern West Virginia Center for Independent Living (NWWCIL)**

Fall 2010

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

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

Forward

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

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

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

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

Acknowledgements

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

Project Partners and Primary Authors

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

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

Special thanks go to *Amy Loder* (Office on Violence Against Women); *Michelle Wakeley*, *Nikki Godfrey*, *Betty Irvin*, *Whitney Boutelle*, and *Emma Wright* (contributing authors); *Susie Layne*, *Wade Samples*, *Marion Vessels*, *Mark Derry*, *Teresa Tarr* and *Suzanne Messenger* (technical assistance with legal and policy components), West Virginia Foundation for Rape Information and Services staff and *Kathy Littel* (proofreading); *Carol Grimes* of Grimes Grafix (graphic designer) and to all of the survivors of sexual violence and women with disabilities who helped guide this work—both through this project and in creating the professional history of the individuals cited on this page. This toolkit is dedicated to ensuring that your shared experiences will help make for a better service delivery system for others.

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WV S.A.F.E. Training and Collaboration Toolkit— Serving Sexual Violence Victims with Disabilities⁴

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

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

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

Toolkit Features

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

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

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

NOTE:

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

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

Background: Toolkit Development

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

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

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

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

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

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

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

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Toolkit Organization

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

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

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

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

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

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

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

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

- Agencies that interact with sexual violence victims and persons with disabilities typically refer to the individuals they serve as “clients,” “consumers” and/or “victims.” For convenience, “victims” and “clients” are primarily used.
- The terms “sexual violence” and “sexual assault” generally will be used to encompass sexual assault, sexual abuse and other forms of sexual violence.

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

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

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

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

³Adapted from University of California Berkley.

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

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

⁶Although males and females are both victimized by sexual violence, most reported and unreported cases are females (C. Rennison, *Rape and sexual assault: Reporting to police and medical attention, 1992–2000* (Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2002), 1, <http://bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=92>; and P.Tjaden & N.Thoennes, *Prevalence, incidence and consequences of violence against women: Findings from the National Violence Against Women Survey* (Washington, DC: National Institute of Justice, Office of Justice Programs, U.S. Department of Justice, 1998), 2–4, <http://www.ojp.usdoj.gov/nij/publications/welcome.htm>. Regarding sex offenders, males make up the vast majority, but females also

commit sexual crimes. In 1994, less than 1 percent of all incarcerated rape and sexual assault offenders were female (L. Greenfeld, *Sex offenses and offenders: An analysis of data on rape and sexual assault*, U.S. Department of Justice, Bureau of Justice Statistics (Washington, DC: 1997). As cited in R. Freeman-Longo, *Myths and facts about sex offenders* (Center for Sex Offender Management, 2000), <http://www.csom.org/pubs>.

Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors

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

Key Points

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

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

Purpose

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

SEXUAL VIOLENCE 101

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

Objectives

Those completing this module will be able to:

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

Part I: CORE KNOWLEDGE **What does vulnerability to sexual victimization mean?**

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

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

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

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

- The 2007 National Crime Victimization Survey for the first time detailed crimes specifically against persons with disabilities. The survey found that persons with a disability had an age-adjusted rate⁶ of victimization that was more than twice the rate of persons without a disability.⁷
- One study estimated that approximately 49 percent of people with developmental disabilities who are victims of sexual violence will experience 10 or more abusive incidents.⁸

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

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

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

What do we know about the reporting of sexual victimization?

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

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

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

SEXUAL VIOLENCE 101

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

Commonly Cited Risk Factors for Sexual Victimization of Persons with Disabilities¹⁸

Negative public attitudes toward persons with disabilities—While social and legal reform since the 1960s has improved public attitudes towards individuals with disabilities, this population still faces considerable prejudice and discrimination. Society still has a tendency to devalue and dehumanize people with disabilities and suppress their voices. Some people believe that people with disabilities receive unnecessary “special” treatment, such as favored parking spaces and priority in affirmative action hiring, while ignoring how such treatment enables persons with disabilities to remain independent. (See *Disabilities 101. Self-Advocacy and Victims with Disabilities*.)

Too frequently considered physically weak, emotionally unstable and/or intellectually incompetent, persons with disabilities may be viewed by perpetrators as easy targets for victimization. Perpetrators may trust that first responders won't believe these victims or know how to help them. Perpetrators may also think it unlikely that a conviction would be pursued, especially if it might disrupt an agency's current practices (e.g., cause an investigation of a nursing home staff person at a time when staffing is already limited), challenge an agency's policies (e.g., not screening home health care workers), or require an agency to make costly changes in its policies or practices.

Social isolation—Sexual assaults most often occur in the homes of victims or perpetrators. The assaults usually are at times when victims are isolated from other people, particularly if the family culture is heavily self-reliant and closed. Persons with certain disabilities often may be socially isolated, with limited access to outside communications and interactions.

Lack of accessible transportation—One reason people become socially isolated is the lack of accessible transportation. Many communities do not have public transportation or transportation with a chair lift. Even if transportation options are available, they may be difficult to access.

Reliance of people with disabilities on others for care—Individuals with disabilities sometimes depend on others for assistance with their personal needs. This reliance on others may increase their vulnerability and exposure to sexual violence. One study found that, *for victims with disabilities, 33 percent of their abusers were acquaintances, 33 percent were natural or foster family members, and 25 percent were caregivers or service providers.*¹⁹ Many also may lack control of their personal affairs, which can contribute to learned helplessness.

Communication barriers—A person with a disability that creates communication challenges may have difficulty reporting sexual victimization. Lack of an interpreter or assistive technology, difficulty articulating thoughts or having a limited vocabulary can all contribute to an individual's inability to disclose sexual victimization. (See *Disabilities 101. Accommodating Persons with Disabilities*.)

Learned compliance of people with disabilities—Persons with disabilities, particularly in group homes or institutional settings, are often taught to be compliant, passive and quiet to meet the expectations of a “good” resident/client. Inherently, many persons with developmental disabilities or mental retardation are very trusting, desire to please others and seek acceptance—factors that can increase their risk for sexual victimization.

Lack of knowledge about healthy intimate relationships—If persons with disabilities have not experienced healthy intimate relationships, they may be unclear about the differences between healthy relationships and sexual exploitation. Some individuals with disabilities may also lack knowledge about their

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

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

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

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

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

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

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

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

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

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FYI When reviewing the above list with victims, emphasize **it is not a specific disability that creates the risk, but the situation that the person with a disability is in that creates the risk.**

Unfortunately, someone with a disability is more likely to be in a situation where they have limited finances/resources, are isolated, have a caregiver who wasn't screened, etc.

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

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

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

Examples of Barriers that May Perpetuate Risk and Prevent Reporting

Accessibility for persons with disabilities—for example:

- Reliance on caregiver to access resources/services
- Lack of transportation/lack of access to transportation
- Communication challenges
- Lack of physical accessibility of services

Situational factors—for example:

- Programmatic barriers (lack of needed services, lack of information about available services, negative attitudes of agency staff towards people with disabilities, etc.)
- Financial dependency or reliance on caregiver for access to finances

Fear—for example:

- Fear of perceived consequences (retaliation by offender, loss of caregiver, loss of independence, etc.)
- Fear because of negative past experience
- Fear of not being believed

Educational/socialization factors—for example:

- Manipulated to feel blame
- Lack of knowledge regarding sexuality
- Lack of knowledge regarding rights
- Socialized to be compliant
- History of being protected by others inhibits accessing resources for protection
- Inhibited from being self-directed

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

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

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

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

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

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

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

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


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

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

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

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

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



Test Your Knowledge

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

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

Part 2: DISCUSSION

Projected Time for Discussion

2 hours

Purpose and Outcomes

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

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

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

Preparation

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

Suggested Activities and Questions

1. **Invite participants to identify the discussion ground rules to promote open communication.** Utilize the following principles: (10 minutes)
 - An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
 - Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
 - Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.
- 2.a. **Utilizing the list of barriers to reporting in Part 1: Core Knowledge, review each item and ask each participant to identify if it would be a barrier for a victim with a disability seeking services from their specific agency.** (For example, if a victim with a physical disability had a caregiver who was the offender and the victim contacted your agency for help, would you have the capacity to fully serve her?²⁷ What if she lacked transportation? What if she needed an interpreter?) Identify whether each barrier is a result of the disability (which cannot be changed) or the lack of accessible services. (15 minutes)
- 2.b. **As a group, brainstorm possible ways to overcome any identified barriers.** (Up to 30 minutes)
- 3.a. Make sure each participant has a copy of *Abuse of People with Developmental Disabilities by a Caregiver*. These power and control wheels address various types of intimidation and abuse that a victim of sexual violence may experience. **As a group, review each of the eight categories on the wheels and identify where victims with developmental disabilities who are experiencing that type of mistreatment by their caregivers could easily access services in your community.** Then expand your assessment to include victims with various types of disabilities (physical, sensory and cognitive).

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

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

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

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

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

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

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

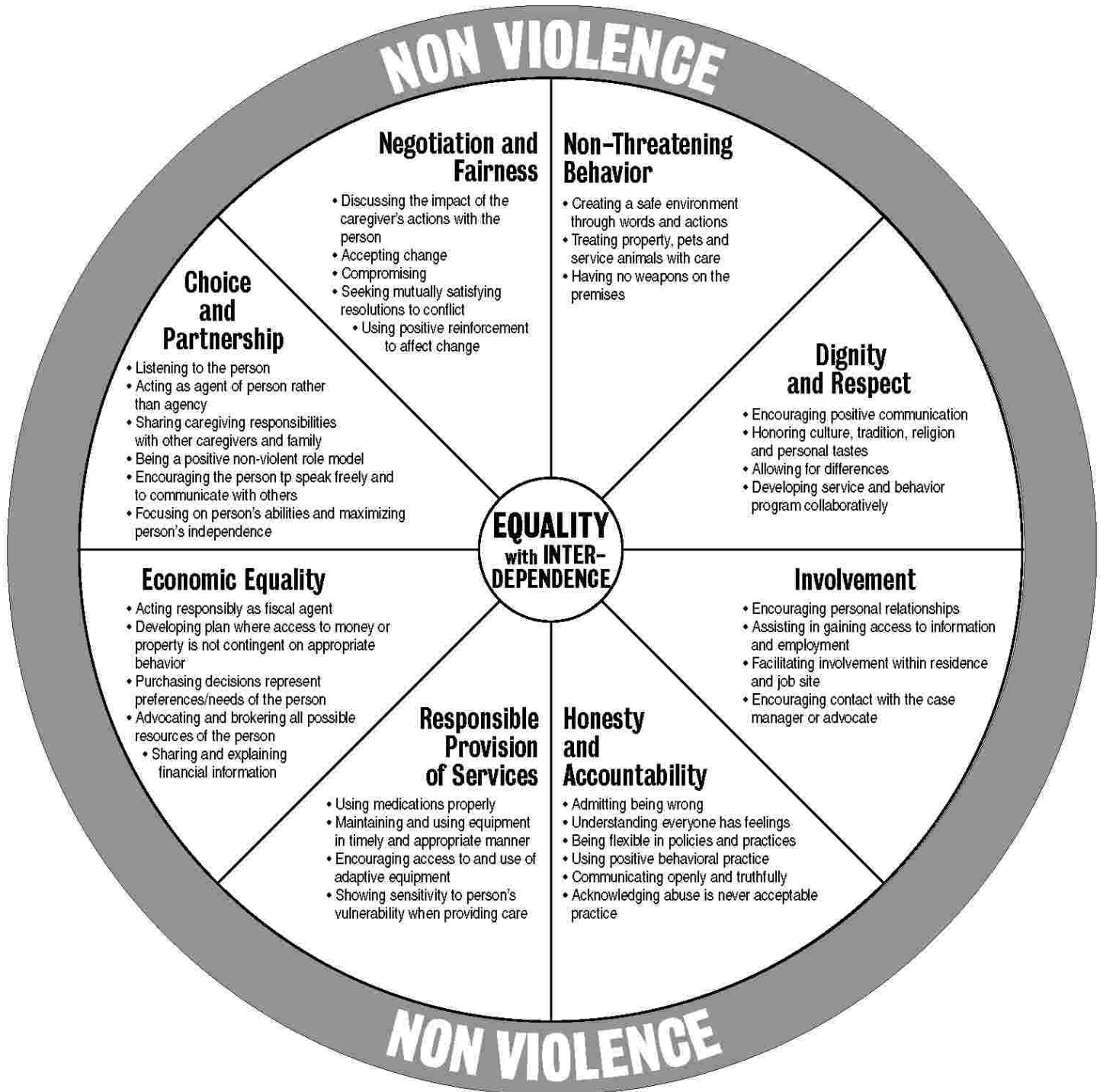
Funding was provided by Grant No. 2006-FW-AX-K001 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this module are those of the authors and do not necessarily reflect the views of the U.S. Department of Justice,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

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

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

- ³Partnering agencies refer to the persons they serve as “clients,” “consumers” and “victims.” For convenience, the term “victims” is primarily used in this module. Also note that the terms “sexual violence” and “sexual assault” generally are used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.
- ⁴For an overview of their more comprehensive research, see N. Groth & H.J. Birnbaum, *Men who rape: The psychology of the offender* (Da Capo Press, 2001).
- ⁵Tjaden & Thoennes.
- ⁶Age-adjusted rates are used in this report to “account for variations in age and risk of victimization among those with and without disabilities.” M. Rand & E. Harrell, *Crime against people with disabilities* (Bureau of Justice Statistics Special Report, Office of Justice Programs, U.S. Department of Justice, 2009), 2, <http://bjs.ojp.usdoj.gov/>. For more explanation, see the report.
- ⁷See Rand & Harrell.
- ⁸D. Valenti-Heim & L. Schwartz, *The sexual abuse interview for those with developmental disabilities* (1995).
- ⁹West Virginia Bureau for Public Health, Health Statistics Center.
- ¹⁰www.census.gov.
- ¹¹M. Rand, *Criminal victimization 2008, Bureau of Justice Statistics Bulletin* (2009), <http://bjsdata.ojp.gov/content/pub/pdf/cv08.pdf>.
- ¹²D. Kilpatrick, C. Edmonds & A. Seymour, *Rape in America: A report to the nation* (Arlington, VA: National Crime Victims Center, 1992).
- ¹³D. Kilpatrick & B. Saunders, *National survey of adolescents in the United States* (Ann Arbor, MI: Inter-University Consortium for Political and Social Research, 1995), <http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/02833>.
- ¹⁴D. Kilpatrick, *Rape and sexual assault* (National Violence Against Women Prevention Research Center, 2000).
- ¹⁵D. Valenti-Heim & L. Schwartz, *The sexual abuse interview for those with developmental disabilities* (Santa Barbara, CA: James Stanfield Company, 1995).
- ¹⁶D. Sobsey & C. Vamhagen, *Sexual abuse, assault and exploitation of people with disabilities: A study of victims* (Ottawa: Health and Welfare Canada, 1988).
- ¹⁷M. Mandel, *A survey on the prevalence of sexual assault among people with disabilities in the Tucson area* (unpublished raw data) (Tucson, AZ: Southern Arizona Center Against Sexual Assault, 2005). As cited in Office for Victims of Crime, *Promising practices in serving victims with disabilities* (Washington, D.C.: Office of Justice Programs, U.S. Department of Justice) http://www.ovc.gov/publications/infores/ServingVictimsWithDisabilities_bulletin/crime.html.
- ¹⁸M. Ticol, *Violence and people with disabilities: A review of the literature* (Ontario: L’Institut Roehrer, National Clearinghouse on Family Violence, Family Violence Prevention Unit, Health Canada, 1994), <http://www.phac-aspc.gc.ca/ncfv-cnivf/publications/fvdisabliterature-eng.php>; and Day One: The Sexual Assault and Trauma Resource Center, Rhode Island Coalition Against Domestic Violence and PAL: An Advocacy Organization for Families and People with Disabilities, *Is your agency prepared to ACT? Conversation modules to explore the intersection of violence and disability* (Advocacy Collaboration Training Initiative, 2004).
- ¹⁹D. Sobsey, *Sexual offenses and disabled victims: Research and practical implications*, *Visa Vis*, 6(4) (1988).
- ²⁰I. Johnson & R. Sigler, *Forced sexual intercourse among intimates*, *Journal of Interpersonal Violence*, 15(1) (2000).
- ²¹M. Young, M. Nosek, C. Howland, G. Chanpong & D. Rintala, *Prevalence of abuse of women with physical disabilities*, *Archives of Physical Medicine and Rehabilitation*, 78 (suppl) (1997), s34-s38.
- ²²L. Stimpson & M. Best, *Courage above all: Sexual assault against women with disabilities* (Toronto: DisAbled Women’s Network, 1991).
- ²³Statistics Canada, Centre for Justice Statistics, 1994, as cited in *Harm’s Way: The many faces of violence and abuse against persons with disabilities* (Ontario: L’Institut Roehrer, 1995).
- ²⁴K. Muenzenmaier, I. Meyer, E. Struening & J. Ferber, *Childhood abuse and neglect among women outpatients with chronic mental illness*, *Hospital Community Psychiatry*, 44(7) (1993), 666-670.
- ²⁵A. Abbey, *Alcohol and sexual violence perpetration* (National Online Resource Center on Violence Against Women 2008), www.vawnet.org.
- ²⁶Used with permission from Wisconsin Coalition Against Domestic Violence, available through <http://www.ncall.us/resources.html#NCALLPUBS>.
- ²⁷Although males and females are both victims of sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User’s Guide* for a full citation). Therefore, in this module, victims/clients are often referred to as female.

Abuse of People with Developmental Disabilities by Caregivers



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

Abuse of People with Developmental Disabilities by a Caregiver



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Indicators of Sexual Violence

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

Key Points

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

B2. Indicators of Sexual Violence

Purpose

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

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

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Objectives

Those who complete this module will be able to:

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

Part I: CORE KNOWLEDGE **What is the impact of sexual violence?**

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

PHYSICAL INDICATORS OF SEXUAL ASSAULT

Will most sexual assault victims have physical injuries?

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

Who is most likely to sustain physical injuries?

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

What are the most common physical injuries?

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

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

BEHAVIORAL INDICATORS OF SEXUAL ASSAULT

What are behavioral indicators of sexual assault?

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

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

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

Self-Harming Behaviors

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

Changes in Social Interactions/Behaviors

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

Individual Behavioral Changes

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

EMOTIONAL INDICATORS OF SEXUAL ASSAULT

What are indicators of emotional trauma from a sexual assault?

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

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

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

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

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

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

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



Test Your Knowledge

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

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

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

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

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

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

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

West Virginia Laws on Sexual Assault and Abuse

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

Key Points

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

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

B3. West Virginia Laws on Sexual Assault and Abuse

Purpose

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

SEXUAL VIOLENCE 101

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

Objectives

Those who complete this module will be able to:

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

Preparation

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

Part I: CORE KNOWLEDGE

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

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

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

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

Definition of Terms: WV Sexual Abuse and Sexual Assault Laws

Drawn from WVC§61-8B

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

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

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

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

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

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

1. A man slipped a drug into your drink without your knowledge, you passed out, and he had sexual contact with you without your consent. Which crime do you think has been committed?
2. If someone has sexual contact with a person with a cognitive disability who does not have the capacity to give consent, what crime do you think has been committed?
- 3a. If a 17-year-old male has sexual intercourse with an 11-year-old girl who uses a wheelchair, what crime do you think has been committed?
- 3b. Does the fact that the girl uses a wheelchair affect this classification?

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

How are suspects charged with sexual assault or sexual abuse?

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

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

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

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

What evidence is needed to support these charges?

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

Evidence on the victims' bodies can be collected whether or not the crime is reported.

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

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

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

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

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



Test Your Knowledge

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

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

Part 2: DISCUSSION

Projected Time for Discussion

1.75 hours

Planning

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

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

Suggested Activities and Questions

1. **Invite participants to identify the discussion ground rules to promote open communication.** Utilize the following principles: (10 minutes)
 - An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
 - Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
 - Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.
2. **Briefly summarize state law regarding sexual assault, sexual abuse, statute of limitations and mandatory reporting** and discuss any questions. (5 minutes)
3. In either a small or large group setting, **ask participants to review the following scenarios and consider the questions** that follow. (15 minutes)

Scenario 1

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

Scenario 2

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

Scenario 3

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

Scenario 4

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

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

- a. For each scenario, is the act considered a crime in West Virginia? Why or why not? If it is a criminal act, what is the violation/degree?
- b. What factors made it difficult to decide upon criminality/violation/degree?
- c. What additional information might service providers need to make a determination?

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- d. What can staff/volunteers working with victims with disabilities do if they need clarity on how the law might apply to a case? What resources are available?
4. **Ask participants to discuss possible reactions of victims** who find out the act committed against them is not considered a crime in West Virginia or that no charges will be made due to insufficient evidence. Are there reactions that may be specific to persons with disabilities? Discuss how service providers/partnering agencies can respond to these victims in a supportive way. (10 minutes)
5. **Invite participants to share their general experiences of interacting with victims of sexual violence, especially those with disabilities.** To whom did the victims disclose? Did they report, have evidence collected and have subsequent criminal justice involvement? What were the outcomes? Did they seek support services? What services would have been helpful to them? (10 minutes)
6. Most victims do not report their assaults to authorities; many never tell anyone. **If your agency serves persons who may be sexual violence victims who may not have disclosed, in what ways can your agency provide them with information regarding their rights?** (10 minutes)
7. **What training might staff at your agency need to be able to provide support and referral services?** (For assistance in meeting your training needs, visit www.fris.org.) (5 minutes)
8. **Closing.** Ask participants to write down how the information gained from this discussion will promote change in policies, practices or training programs in each of their agencies and their next steps in the process of initiating that change. Then facilitate a large group discussion on this topic. (10 minutes)

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

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

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

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

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

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

Sexual Harassment

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

Key Points

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

B4. Sexual Harassment

Purpose

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

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

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

Objectives

Those completing this module will be able to:

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

Preparation

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

Part I: CORE KNOWLEDGE What is sexual harassment?

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

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

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

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

What are the two basic forms of sexual harassment?

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

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

What are common reactions to being sexually harassed?

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

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

What are ways to support victims of sexual harassment?

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

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



There are no mandatory reporting requirements for sexual harassment in West Virginia. However, certain professionals⁷ are required to report to the West

Sexual harassment is never the victim's fault.

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

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

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

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

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

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

For victims of sexual harassment, what laws apply?

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

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

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

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

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

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

- Schools; and
- Colleges.

What can victims do if they are sexually harassed?

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

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

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

What are the steps to report sexual harassment?

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

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

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

Where can a complaint be filed?

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

West Virginia Human Rights Commission (for qualifying workplaces and schools): 304-558-2616 or 888-676-5546, <http://www.wvf.state.wv.us/wvhrc/>.

State of West Virginia Equal Employment Opportunity Office (for state employees): 304-558-0400, <http://www.eeo.wv.gov>.

U.S. Equal Employment Opportunity Commission (EEOC) (for qualifying workplaces): 800-669-4000 or 800-669-6820 (TTY), <http://www.eeoc.gov/>.

U.S. Department of Education, Office of Civil Rights (for schools and colleges that receive federal financial assistance): 800-421-3481, <http://www2.ed.gov/about/offices/list/ocr/index.html>.

How do victims file a complaint?

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



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

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

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


When can a complaint be filed?

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

What happens after the complaint is filed?

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

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

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

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

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

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

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

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

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

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

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

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

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



Test Your Knowledge

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

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

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Part 2: DISCUSSION

Projected Time
2.75 hours

Purpose and Outcomes

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

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

Preparation

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

Suggested Activities and Questions

1. **Invite participants to identify/review discussion ground rules to promote open communication.** Utilize the following principles: (10 minutes)
 - An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
 - Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
 - Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.
2. **Ask a representative from each agency to summarize the written policies on sexual harassment at their workplace.** Do the policies include only sexual harassment of employees, or does it also have a process for addressing sexual harassment of clients by agency staff? (15 minutes)
3. **Facilitate a group discussion.** (15 minutes)

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- a. How often does your agency have clients who disclose sexual harassment (frequently, occasionally, rarely or never)? Does your staff receive training on working with victims of sexual harassment?
 - b. If your agency rarely or never receives these disclosures, consider why (noting sexual harassment is a fairly common occurrence). Consider the barriers for your clients in reporting sexual harassment (e.g., they don't label what they are experiencing as sexual harassment, they don't know help is available or where to go to get assistance, they don't view your agency as one that can provide guidance on this topic, or they fear the ramifications of disclosing).
 - c. What would help your staff/co-workers be better positioned to help clients label what they are experiencing as sexual harassment and what support can you provide if clients do disclose?
 - d. What local resources might be helpful to a person who discloses to you they are being sexually harassed?
- 4. Ask participants to review the following scenarios and consider the questions that follow.** (These are the same scenarios in *Part I: Core Knowledge*.)¹⁸ (45 minutes)

Scenario 1

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

Scenario 2

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

Scenario 3

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

- a. For each scenario above, which type of sexual harassment is described and what recourses are available? (Answers are available in *Part I: Core Knowledge*).
- b. Describe how you think Emily and Jennifer might react to the sexual harassment they are experiencing. How could it impact their daily lives?
- c. What support could your agency provide for the victims?
- d. Do you think these types of scenarios occur often? If so, what are possible contributing factors in our culture?
- e. Do you think these types of scenarios occur often to persons with disabilities? If so, what do you think could make this population targeted by harassers?
- f. In Jennifer's situation where remarks are made at lunch, what could bystanders (e.g., others who may also be in the lunchroom) do to provide support to Jennifer? What could they be doing that intentionally or unintentionally provides support to Joe?
- g. What are ways your agencies might raise the awareness of your client population about what sexual harassment is and what to do if they experience this form of harassment?

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

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

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

a. Is Lydia being sexually harassed?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Guidelines To Determine If Your Behavior Or Comments Are Harassing

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

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

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

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

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

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

⁴FRIS, *Sexual harassment brochure*, <http://www.fris.org/>.

⁵FRIS, *Sexual harassment*.

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

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

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

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

¹⁰Section adapted from FRIS, Sexual harassment.

¹¹Sexual Harassment Support.

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

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

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

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

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

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

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

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

Mandatory Reporting

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

Key Points

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

B5. Mandatory Reporting

Purpose

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

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

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

Objectives

Those who complete this module will be able to:

- Discuss state mandated provisions for mandatory reporting and identify who are considered mandatory reporters of abuse, neglect or an emergency situation³ involving individuals the state refers to as “incapacitated adults;”
- Determine if they are mandatory reporters and how to make a report;
- Understand the process for submitting their agency’s West Virginia APS mandatory reporting form;
- Discuss policies and practices regarding mandatory reporting of different partnering agencies; and
- Discuss ethical issues related to mandatory reporting and the consequences of non-compliance for mandatory reporters.

Part I: CORE KNOWLEDGE

What is a mandatory reporter?

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

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

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

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

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

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

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

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

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

What are the procedures for making a mandated report?

Reports of abuse or neglect involving an adult who is incapacitated should be made directly to the local DHHR/APS¹³ or the 24-hour hotline that is provided for this purpose—800-352-6513 (use the hotline especially after regular business hours).

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

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

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

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

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


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

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

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

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

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

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



Test Your Knowledge

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

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

4. What information is needed to make a report? See pages B5.3–B5.4.
5. What obligations do reporters have once a verbal report is filed? See page B5.4.

Part 2: DISCUSSION

Projected Time for Discussion

1.25 hours

Purpose and Outcomes

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

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

Planning

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

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: (10 minutes)
 - An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics.
 - Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.

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- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.
2. **Ask a representative from each partnering agency to share the policies, reporting forms and training materials** they brought to the meeting and summarize their contents. (10 minutes)
 3. **As a large group, discuss the following questions:** (45 minutes)
 - a. Why is there a need for mandatory reporting?
 - b. Who are mandatory reporters in West Virginia? Do you identify yourself as a mandatory reporter? What are you mandated to report? What discomfort do you feel, if any, associated with being a mandatory reporter?
 - c. Do procedures for reporting suspected abuse or neglect of an adult who is incapacitated differ across agencies? If yes, how?
 - d. What are the timelines for reporting?
 - e. How can agencies insure that all staff members and volunteers are responding appropriately to reporting mandates?
 - f. What strengths and weaknesses exist in the current service delivery systems regarding mandatory reporting that may affect victims of sexual violence?
 - g. What are the some of the ethical issues surrounding mandatory reporting? What are the potential implications or unintended consequences for reporting suspected incidences of sexual violence?
 - h. What policy and/or practice changes can be made within each partnering agency to maximize compliance with this law? What specific steps need to be taken to facilitate those changes?
 4. **Closing.** Ask each participant to write down how the information gained from this module discussion will:
 - Change the way they interact with individual clients;
 - Change the way they partner with other agencies to assist clients; and
 - Promote change in their agency's policies, practices or training programs.

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

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

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

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

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

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

Reporter Information:

Name: _____ (Preferred) _____ Date this report completed: _____
Address: _____ Telephone #: _____
Title/Relationship to Victim: _____
Are you a Mandatory Reporter? Yes _____ No _____

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

Name: _____ Age/Date of Birth: _____
Address: _____
Current Location & Directions: _____
Facility Name: _____ Type of Facility: _____ Describe
physical/cognitive/emotional functioning of the alleged victim: _____
Substitute Decision Maker (Type, Name and Address): _____

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

Name: _____ Title/Relationship to Victim: _____
Address: _____ Telephone #: _____
Describe action(s) taken to prevent further abuse/neglect: _____
 (Mark if additional pages attached)

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

Date of Incident: _____ Time of Incident: _____
Where incident occurred: _____
Describe Incident/Injuries: _____

(Mark if additional pages attached)

Was treatment outside facility required? Yes _____ No _____ If yes, provider of treatment: _____
Why is the adult unable to protect her/himself? _____
How long has the problem existed? _____
Is anyone else aware of the incident? If yes, list the name(s) & relationship to alleged victim: _____
Are there witnesses to the incident? If yes, list the name(s) & relationship to alleged victim: _____
Additional Comments: _____

A copy of this report must be filed with the following parties by the person completing the form (within 48 hours).

1. Original to: Adult Protective Services Unit - local Department of Health and Human Resources
2. Copy to:
 - Office of Health Facilities Licensure & Certification (if alleged victim is resident of a nursing home or residential facility)
 - State or regional Long-term Care Ombudsman (if alleged victim is resident of a nursing home or residential facility)
 - Facility administrator (if alleged victim is resident of a nursing home or residential facility)** [see instructions on back]
 - Local law enforcement agency (when applicable - e.g. violent crime, domestic violence, serious injury, death)
 - Local prosecuting attorney (when applicable - e.g. violent crime, domestic violence, serious injury, death)
 - Local coroner or medical examiner (in case of a death)

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Instructions for Completing the WVDHHR APS Mandatory Reporting Form

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

WHO/WHEN TO COMPLETE:

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

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

REQUIRED FILING:

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

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

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

Effective Date:

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

To request additional copies of this form:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Confidentiality

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

Key Points

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

B6. Confidentiality

Purpose

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

Objectives

Those completing this module will be able to:

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

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Part I: CORE KNOWLEDGE **What is confidentiality?**

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

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

Why is confidentiality important to victims of sexual assault?

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

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

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

Are there confidentiality concerns for specific populations?

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

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

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

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

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

What is privileged communication?

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

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

Do mandatory reporters have privileged communication?

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

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

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

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

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

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

Specifically, a written release should indicate:

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

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

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

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

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

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

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

FYI Talk with your supervisor to determine if your agency receives funding under the Violence Against Women Act. Obtain a copy of your agency's client release of information form and review it for compliance purposes.

Are written releases of information necessary for multidisciplinary teams that review client cases?

Each worker on the team must follow their agency's policy for confidentiality and the release of *identifying* information. If, for example, you wanted to discuss a specific client's case at a multidisciplinary meeting in order to improve the service delivery system, that client would need to sign a release of information form for that specific meeting for each person participating in the discussion.

Non-personal identifying information can be released as long as you can ensure that, once all of the aggregate data is compiled, the victim cannot be identified. For example, if at a team meeting you discussed the importance of having a private waiting area at the hospital for victims because of feedback you have received, that feedback probably could not be traced back to a specific victim. However, if you said that a victim that you worked with

last month told you that the hospital had difficulty obtaining an interpreter for her and she had to wait in the general waiting room with her seven children, there would be the potential that others in your meeting could trace that situation back to a specific client. That would be a breach of confidentiality.

What are the mandatory reporting requirements related to releasing information?

West Virginia law determines who is required to report suspected cases of abuse, neglect or an emergency situation involving adults who are incapacitated and minors. It also defines the criteria for those categories. (See *Sexual Violence 101. Mandatory Reporting.*)


- Mandatory reporters in cases of suspected mistreatment of adults who are incapacitated include medical, dental and mental health professionals, Christian Science practitioners, religious healers, social service workers, law enforcement officers, humane officers, state or regional ombudsmen, or any employee of a nursing home or other residential facility.⁷
- In cases of the mistreatment of a minor, mandatory reporters include medical, dental or mental health professionals, religious healers and members of the clergy, Christian Science practitioners, social service workers, school teachers and other school personnel, child care or foster care workers, humane officers, emergency medical services personnel, peace officers or law enforcement officials, circuit court judges and family court judges, employees of the Division of Juvenile Services and magistrates.⁸

Even if your position does not fall into one of these mandatory reporter categories, you should always consider the safety of any victim in an emergency situation and the need to report if there is a threat of imminent harm to them or a third party.

If you are a mandatory reporter, you do not need a release of information from the victim. However, if your agency receives Violence Against Women Act funds, you are required to make a reasonable attempt to notify the victim of the report. If it would be dangerous to do so, it could be reasonable not to inform the victim. Best practice would be to support the victim in making a self-report. Not only can self-reporting begin the process to help the victim regain control in her life, but the likelihood of holding an offender accountable may increase if the victim is willing to be involved in the investigative process.

What should you do if a release of information is court-ordered?

It is important for you to talk with your supervisor and discuss your agency's procedures if a victim's records are subpoenaed. In West Virginia, certain entities and professions have privileged communication. For example, sexual assault advocates do not have privileged communication (as of the time of this writing, 8/2010), but advocates working within domestic violence shelters and dual programs do. That privilege is "qualified" and in some cases the records may be subject to *in camera* review by the court (meaning the judge will review the information in question in her/his private chambers without a jury and come to a decision about its release). Therefore, if a client's case record is subpoenaed, a determination must be made as to if or how the information should be provided. This determination should be made with your supervisor in conjunction with the local court.

 If you will not be completing *Part 2: Discussion* in this module with your partnering community agencies, it may be useful to review the discussion questions with your supervisor to ensure your understanding of your agency's policies and procedures regarding confidentiality.

What about the confidentiality of victims' medical records?

Most sexual assault victims with disabilities will have had prior interactions with health care professionals. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) established laws protecting the privacy of certain

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health information. HIPAA, among other provisions, limits the release of medical information, gives patients the right to a copy of their own health records, allows patients to learn what information was disclosed and how their information may be used, and essentially gives patients more control over their health information. HIPAA covers the dissemination of medical information, both written and oral. If, in your work with sexual violence victims with disabilities, you will have access to or become knowledgeable of a victim's medical information, you should learn more about how HIPAA regulations protect the confidentiality of certain health information. Additional information on HIPAA and protected health information can be found at www.cdc.gov.

Where can I find more information on confidentiality issues?

The Victim Rights Law Center (VRLC) created a resource, *Beyond the Criminal Justice System: Using the Law to Help Restore the Lives of Sexual Assault Victims, A Practical Guide for Attorneys and Advocates*, to assist in meeting the legal needs of sexual assault victims. Two chapters will assist you in examining the issues of confidentiality and informed consent. Chapter 3, "Privacy: a Pre-Eminent Concern for Sexual Assault Victims," includes sections on victim credibility, unexpected consequences of an authorized release, the difference between confidentiality and privilege, victims' privacy concerns, and special vulnerabilities—mental health and mandatory reporting. Chapter 12, "Representing Sexual Assault Victims with Disabilities," provides additional information, including initial considerations when working with victims with disabilities, privacy issues, ensuring privacy and informed consent when there are multiple service providers, maintaining confidentiality, and HIPAA issues. Contact VRLC through <http://www.victimrights.org/> to find out how to obtain this resource.



Test Your Knowledge

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

1. What does it mean for a service provider to maintain client confidentiality? See page B6.2.
2. What are reasons that confidentiality may be important to victims of sexual assault? See page B6.2.
3. What confidentiality concerns are specific to victims who are considered by state law to be incapacitated and victims living in rural communities? See pages B6.2–B6.3.
4. What is privileged communication? See page B6.3.
5. What situations warrant a release of client information? See page B6.3.
6. What should be included in a written release of information? See pages B6.3–B6.4.
7. What if the client is a minor or an adult who is considered by state law to be incapacitated and cannot give consent to release information? See page B6.5.
8. What should service providers do if a release of victim information is court-ordered? See page B6.5.
9. How does the Health Insurance Portability and Accountability Act (HIPAA) impact the confidentiality of a victim's medical records? See pages B6.5–B6.6.

Part 2: DISCUSSION

Projected Time for Discussion

2 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* in this module to their collaborative work with sexual violence victims with disabilities. The discussion could be incorporated into forums such as agency staff meetings, orientations and continuing education programs, as well as multi-agency meetings or trainings. Anticipated discussion outcomes include an increased understanding of confidentiality barriers and challenges experienced by victims with disabilities and victims in rural areas; identification of ways to enhance confidentiality through agency policies and procedures; and increased knowledge of confidentiality and mandatory reporting requirements that impact victim safety.

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

Preparation

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator for the discussion. The facilitator should be familiar with confidentiality issues as they relate to victims of sexual violence.
- Select a note taker.
- Prior to the meeting, participants and the facilitator should review and bring to the meeting a copy of the *Sample Release of Information Form* included in this module.
- Participants should review and bring to the meeting copies of the confidentiality policy and release of information form used by their respective agencies.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.



NOTE: This toolkit was developed to assist communities in addressing gaps in services to sexual assault victims with disabilities. It is anticipated that in discussing the issue of confidentiality, agencies may find that their policies and forms may need to be revised. Partners are encouraged to engage in an open discussion in an effort to develop procedures that best meet the needs of victims and adhere to existing laws.

Suggested Activities and Questions

1. Invite participants to identify discussion ground rules to promote open communication.

Utilize the following principles: (10 minutes)

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

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- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.
2. **Ask a representative from each partnering agency to share their agency's confidentiality policy and practices** and whether or not agency staff are mandatory reporters and/or have privileged communication. (10 minutes)

3. **Discuss the following questions:** (up to 35 minutes)

- a. Why is confidentiality a concern for:
 - Victims of sexual violence?
 - Victims of sexual violence with disabilities?
 - Victims of sexual violence in rural areas?

Discuss these questions separately, as it is important to note that special concerns exist for each one. The depth of your discussion will impact your level of understanding of the reluctance of victims to disclose and the challenges you face as service providers in bridging those challenges.

- b. What are some potential unintended consequences related to client confidentiality and providing services to victims with disabilities who do not have the capacity to consent to sexual intercourse?
- c. Are there ways that services can be provided to victims with disabilities without resulting in the unintended consequences?

4. **Ask a representative from each partnering agency to share their agency's release of information form.** Ask the group to review the *Sample Release of Information Form* provided with this module. Then **discuss the following questions:** (up to 35 minutes)

- a. Inherent in signing a release of information form should be that individuals understand what they are giving permission to and recognize the intended and potential unintended consequences of releasing information. This is "informed consent." What challenges do service providers face when obtaining informed consent with victims with different types of cognitive disabilities?
- b. How is consent obtained when the victim has a guardian? What if the guardian is the suspected offender?
- c. What procedures do your agencies have in place for training staff on the issues of informed consent, consent through guardians, and consent when the guardian is the offender?
- d. What components of the *Sample Release of Information Form* provide specific protection for victims with disabilities?

5. **Ask participants to review the following scenarios individually and then as a large group discuss the questions posed in each scenario:** (20 minutes)

Scenario 1

You are assisting 24-year-old Jason in filing a Crime Victims Compensation Fund claim for injuries sustained in a sexual assault. You need the medical expenses from his doctor to complete the form. Jason does not seem to have the capacity to understand the purpose of the Crime Victims Compensation Fund. You are concerned that his lack of understanding

prevents him from giving his informed consent to release the medical information to you. He is, however, willing to sign the release of information form. What do you do?

Scenario 2

Ann is blind and lives alone in a rural community. She was sexually assaulted by her family physician during her annual physical exam yesterday and now has extreme pain when urinating. The physician is well known and loved in the community. Ann wants to report the assault, but fears her credibility and reputation will be challenged—both at the local hospital and throughout the criminal justice system. How can you, as a local service provider, help her?

Answers:

Scenario 1: According to West Virginia law, unless a court has determined that Jason is not able to make health care decisions on his own behalf, he is considered competent to sign the form. Therefore, you should accept that he can consent and proceed with the request for the release of information. You should make every effort, in multiple meetings, to explain in basic language to Jason the purpose of the form and the Fund. You should also keep him informed on the progress of the request for the release. (See *Disabilities 101. Guardianship and Conservatorship.*)

Scenario 2: While validating Ann's concerns regarding reporting the assault, you can stress that it is critical to address her immediate medical needs. To avoid people who might know her in her community, you could discuss the possibility of going to a hospital in a neighboring county for care (including addressing how she will get to/from the hospital and any available accommodations). You can also tell her that, in West Virginia, she can have a forensic medical examination conducted and a sex crime kit collected (typically within 96 hours of a sexual assault) without immediately reporting the incident to law enforcement (as long as she is not incapacitated). Evidence collected can be stored for up to 18 months, giving her more time to decide about whether to report to law enforcement and to build a support network. (After that 18 month period, she can still report, but evidence that was collected through the forensic medical exam will have been destroyed.) Additionally, you can help her explore other options, such as reporting the assault to the state medical licensing board. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault and Abuse, Sexual Violence 101. Mandatory Reporting, Sexual Violence 101. Sexual Assault Forensic Medical Examination and Disabilities 101. Accommodating Persons with Disabilities.*)

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

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

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

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

Sample Release of Information Form

Created by Julie Field, J.D., Consultant

[APPROPRIATE AGENCY LETTERHEAD]

READ FIRST: Before you decide whether or not to let [Program/Agency Name] share some of your confidential information with another agency or person, an advocate at [Program/Agency Name] will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want [Program/Agency Name] to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom and

I understand that [Program/Agency Name] has an obligation to keep my personal information, identifying information and my records confidential. I also understand that I can choose to allow [Program/Agency Name] to release some of my personal information to certain individuals or agencies.

I, _____, authorize [Program/Agency Name] to share the following specific information with: (name below)

Who I want to have my information:	Name: Specific Office at Agency: Phone Number:
---	--

The information may be shared: in person by phone by fax by mail by e-mail

I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

What info about me will be shared:	(List as specifically as possible, for example: name, dates of service, any documents).
Why I want my info shared: (purpose)	(List as specifically as possible, for example: to receive benefits).

Please note: There is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by [Program/Agency Name].

I understand:

That I do not have to sign a release form. I do not have to allow [Program/Agency Name] to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like [Program/Agency Name] to release information about me in the future, I will need to sign another written, time-limited release.

That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from [Program/Agency Name].

That [Program/Agency Name] and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

Expiration should meet the needs of the victim, which is typically no more than 15 to 30 days, but may be shorter or longer.

This release expires on Date: _____ Time: _____

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signed: _____ **Date:** _____ **Witness:** _____

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)	
I confirm that this release is still valid and I would like to extend the release until (New Date) _____ (New Time) _____	
Signed: _____	Date: _____
Witness: _____	

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

²As per WVC§9-6-11.

³As per WVC§9-6-9, “incapacitated adult” means any person who by reason of physical, mental or other infirmity is unable to independently carry out the daily activities of life necessary to sustaining life and reasonable health. For an online reference to the state code, see <http://www.legis.state.wv.us/WVCODE/Code.cfm>. Note the occasional use of legal terms in this module that deviate from “person first” language (which places the focus on the person, not the disability). While these legal terms would not be our choice of language, they currently define the law and influence charging decisions nonetheless. First responders are urged to avoid use of terms such as “incapacitated adult” in their interactions with victims, as their use could increase a victim’s reluctance to seek assistance with safety, healing and justice. (See *Disabilities 101. Person First Language*.)

⁴Victim Rights Law Center, *Beyond the criminal justice system: Using the law to help restore the lives of sexual assault victims* (Boston, MA and Portland, OR: 2007). This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested that you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

⁵Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User’s Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

⁶WVC§49-7-27: A child over the age of sixteen may petition a court to be declared emancipated. The parents or custodians shall be made respondents and, in addition to personal service thereon, there shall be publication as a Class II legal advertisement in compliance with the provisions of article three (3), chapter 59 of this code. Upon a showing that such child can provide for his physical and financial well-being and has the ability to make decisions for himself, the court may, for good cause shown, declare the child emancipated. The child shall thereafter have full capacity to contract in his own right and the parents or custodians shall have no right to the custody and control of such child or duty to provide the child with care and financial support. A child over the age of 16 years who marries shall be emancipated by operation of law. An emancipated child shall have all of the privileges, rights and duties of an adult, including the right of contract, except that such child shall remain a child as defined for the purposes of articles five (5) and five-a (5a.) of this chapter.

⁷See WVC§9-6-9.

⁸From the West Virginia DHHR website on reporting child abuse and neglect, http://www.wvdhhr.org/bcf/children_adult/cps/report.asp. Also see WVC§49-6A-2.

West Virginia Crime Victims Compensation Fund

This module offers information on what expenses are eligible for compensation through the West Virginia Crime Victims Compensation Fund, the basic process for filing a claim for compensation, and where to refer victims for assistance in filing a claim.¹

Key Points

- The West Virginia Crime Victims Compensation Fund provides compensation to victims of crime who have suffered personal injury and have incurred out-of-pocket losses as a result of a criminal act.
- West Virginia residents are eligible to file a claim with the Crime Victims Compensation Fund if they are: victims of a crime that caused personal injury and out-of-pocket losses; dependents of a deceased victim of a crime; victims of terrorism overseas; or victims of crime in another state that does not have a compensation program. To be eligible, the crime must be reported to law enforcement within 72 hours (with possible exceptions). The victim must document expenses from the injury inflicted by the crime and fully cooperate with law enforcement. A claim must be filed within two years.
- To file a claim, an application must be completed and submitted to the Crime Victims Compensation Fund. There is no fee to file and an attorney is not required. Victim advocates at rape crisis centers are trained to assist victims in filing claims.
- Once a claim has been filed, a claim investigator reviews the case, creates a Finding of Fact and Recommendation (FFR) and sends a copy to the victim. The victim may file a response to the FFR within 30 days. A judge then reviews the FFR, all case documents and the victim's response, if any, and makes a decision. A copy of the decision is sent to the victim. If the victim or claim investigator disagrees with the decision, they have 30 days to file an appeal. The case will then be transferred to another judge and the victim has 21 days to request a hearing. At the hearing, the victim and other parties may have the opportunity to testify and initial findings are discussed. The court then determines if there is sufficient evidence to award the victim benefits or if the claim will be denied.
- Sexual assault victims can have a forensic medical exam conducted without immediately reporting the crime to law enforcement. If they choose not to report, they are not eligible for compensation through the Crime Victims Compensation Fund. Because there is no statute of limitations on sexual assault, they can later report the crime to law enforcement. If they then file a claim and a judge finds that the victim can provide good cause as to why there was a delay in reporting past the 72 hour eligibility time period, the claim could be approved. The determination is left to the discretion of the judge under the parameters of the state statute.

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B7. West Virginia Crime Victims Compensation Fund

Purpose

In addition to physical injury and trauma, sexual victimization can result in both out-of-pocket expenses and loss of income. If the crime is reported to law enforcement, victims may be eligible for compensation for those expenses through the West Virginia Crime Victims Compensation Fund. In the event that a client discloses victimization, service providers need to have a basic understanding of what expenses are eligible for compensation through the Crime Victims Compensation Fund, the basic process for filing a claim for compensation, and where to refer the victim for assistance in filing a claim.² This knowledge will enable service providers to better assist victims in accessing all possible resources to support them in the recovery process.

Objectives

Those who complete this module will be able to:

- Explain the purpose of the West Virginia Crime Victims Compensation Fund;
- Understand how a claim is processed; and
- Provide information to victims on the Crime Victims Compensation Fund.

Preparation

Download a copy of the Crime Victims Compensation Fund Application Form through <http://www.legis.state.wv.us/joint/victims/main.cfm>.³

CORE KNOWLEDGE

What is the West Virginia Crime Victims Compensation Act?

The Crime Victims Compensation Act was created in 1981 and enacted on January 1, 1982 (WVC§14-2A). Its purpose was to establish “a fund which pays certain compensation and medical benefits to innocent victims of crime.”

What is the West Virginia Crime Victims Compensation Fund?

The West Virginia Crime Victims Compensation Fund is a program administered by the state’s Court of Claims. The program is funded through court fees collected from persons who have been convicted of or plead guilty to a misdemeanor or felony (with the exception of non-moving traffic violations). The program receives \$50 per felony, \$8 per misdemeanor, \$10 for other offenses, 20 percent of assessed fines in drunk-driving cases and 60 percent of the state’s annual Victims of Crime Act grant. The Crime Victims Compensation Fund provides compensation to innocent victims of crime who have *suffered personal injury and who have incurred out-of-pocket losses as a result of a criminal act.*

Who is eligible?

- A WV resident who is an innocent victim of a crime that caused personal injury and out-of-pocket losses
- A dependent of a deceased victim of a crime
- A WV resident who is a victim of terrorism overseas
- A resident of WV who was a victim of a crime in another state that does not have a compensation program

Who is not eligible?

- Persons who commit a crime
- Persons who are injured while they are incarcerated
- Persons who do not cooperate with law enforcement or claim investigators from the Crime Victims Compensation Fund

What is required?

- The crime must have been reported to law enforcement within 72 hours.
- The victim must have documented expenses from the personal injury inflicted by the crime.
- The victim must fully cooperate with law enforcement officials.
- A claim must be filed with the WV Crime Victims Compensation Fund within 2 years. Exceptions:
 - o If the victim is a child, the child has until her 20th birthday to file a claim.
 - o Extended time for filing may be granted if there is “good cause” for filing after the specified time frames.

What are the benefits?

The West Virginia Crime Victims Compensation Fund is a “payer of last resort,” which means it can be accessed once all other resources have been exhausted. Other sources that victims may access include: private insurance (medical, optical and dental), employee sick and annual leave benefits, unemployment benefits, court ordered restitutions, life insurance over \$25,000, auto insurance, public program benefits and civil lawsuit recoveries. The Crime Victims Compensation Fund does not cover personal property (except medically necessary items such as eyeglasses and hearing aids) and lost wages for individuals other than the victim. Each claim is handled on a case-by-case basis. If a victim’s expenses are paid by the Crime Victims Compensation Fund and the victim later receives compensation from another source, the victim is responsible for notifying the Crime Victims Compensation Fund and may be obligated to repay amounts for which it was later determined she was not eligible.

Maximum awards:

- \$25,000 in personal injury cases
- \$50,000 in death cases, which includes \$7,000 for funeral/burial
- \$100,000 in permanent disability cases (in addition to the \$25,000)

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Compensable expenses:

- Medical expenses
- Mental health counseling
- Mental health counseling for secondary victims up to \$1,000
- Lost earnings
- Funeral/burial costs up to \$7,000
- Relocation up to \$1,000
- Travel to a medical treatment facility, to attend criminal proceedings or to return a minor from out-of-state or out-of-country
- Crime-scene cleanup (landlords)
- Rehabilitation
- Attorney fees (public defender rates)
- Replacement services, to do what victims would normally do themselves but no longer can because of the crime. (Examples: A victim owned a store and worked 60 hours per week. Due to his injury, he cannot work and has to hire someone to complete the work he did in those 60 hours. The Crime Victims Compensation Fund could pay for his replacement. If a victim was not able to care for herself because of a crime-related injury, the Crime Victims Compensation Fund could pay the costs of an in-home nurse. Services can be paid until the maximum dollar amount set for this category is reached.)



Test Your Knowledge on Crime Victims Compensation Fund Eligibility

1. A 23-year-old woman with no health insurance was sexually assaulted in her home. She is receiving therapy and was prescribed an antidepressant medication for PTSD (post-traumatic stress disorder). Could she be eligible for benefits to cover the costs of therapy and medication?
2. A 50-year-old woman who is legally blind was sexually assaulted and, as a result, her eyeglasses were broken. Her vision insurance will only cover 50 percent of the total cost to replace her eyeglasses. Could she be eligible for benefits?
3. If a 5-year-old was present when his mother was raped and he is now suffering from anxiety due to the traumatic incident, could he be eligible for mental health benefits?

Answers: “Yes” to all. However, these cases are dependent upon the crime having been reported to law enforcement and eligibility status subject to individual case findings by the Crime Victims Compensation Fund.

How do you file a claim?

There is no fee to file a claim and an attorney is not required. Victim advocates at rape crisis centers are trained to assist victims in filing claims. However, if a victim seeks the services of an attorney *and the claim is approved*, reasonable attorney fees can be paid by the Crime Victims Compensation Fund.

If a victim is uncertain about the eligibility of any aspect of a claim, additional information may be obtained by calling the West Virginia Crime Victims Compensation Fund. An application can be downloaded through

<http://www.legis.state.wv.us/joint/victims/main.cfm> or is available at the local prosecuting attorney's office. Below is the related contact information:

WV Crime Victims Compensation Fund
1900 Kanawha Blvd. East, Room W-334, Charleston, WV 26305-0610
Phone: 304-347-4850, 877-562-6878 (in state)
Email: ctclaims@mail.wvnet.edu

How is the claim processed?

Once a claim has been filed, the Crime Victims Compensation Fund assigns a claim investigator to review the case. Based on the information gathered during the investigation, the claim investigator files a "Finding of Fact and Recommendation," or FFR, and a copy is sent to the victim. The victim may file a response to the FFR within 30 days. One of the state's three Court of Claims' judges then will review the FFR, all file documents, and the victim's response, if any. The judge will then make a decision and a copy of the order will be sent to the victim. If the victim or claim investigator disagrees with the decision rendered by the judge from the Court of Claims, they have 30 days to file an appeal. The case will then be transferred to another judge and the victim has 21 days to request a hearing. When scheduling a hearing date, the judge will make every effort to accommodate the victim by choosing a location that is local and convenient. At the hearing, the victim and other parties may have the opportunity to testify and the initial findings will be discussed. The court will determine if there is sufficient evidence to award the victim benefits or if the claim will be denied.

Are there special eligibility concerns for sexual assault victims?

Sexual assault victims can face unique circumstances regarding eligibility for the Crime Victims Compensation Fund. They can have a forensic medical exam conducted without reporting the crime to law enforcement. *Having a forensic medical exam conducted does not establish that a crime occurred.* Therefore a victim may not be eligible for compensation through the Crime Victims Compensation Fund unless the crime is reported to law enforcement. However, since there is no statute of limitations regarding sexual assault, a victim could later report the crime to law enforcement. *If the Court of Claims' judge finds that the victim can provide good cause as to why there was a delay in reporting the crime past the 72 hour eligibility time period, the claim could be approved.* The determination is left to the discretion of the judge under the parameters of the state statute. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault and Abuse* and *Sexual Violence 101. Sexual Assault Forensic Medical Examination*.)



Test Your Knowledge

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

1. What agency administers the West Virginia Crime Victims Compensation Fund? How is it funded? See page B7.2.
2. What are the eligibility criteria to file a claim with the Fund? See page B7.2.
3. How many years after the crime occurred can a claim be filed? See page B7.3.
4. What expenses are eligible for reimbursement? What are the maximum awards? See pages B7.3–B7.4.
5. Is there a fee to file a claim? See page B7.4.
6. Who can assist victims in filing claims? Is an attorney needed to file? See page B7.4.

7. Once a claim is filed, what is the process for making a decision? What happens if the victim or claim investigator disagrees with the decision? See *page B7.5*.
8. Are there exceptions for sexual assault victims to the standard time period in which crimes must be reported to be eligible for compensation? See *page B7.5*.

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²Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see endnotes in the *Toolkit User’s Guide* for a full citation). Therefore, in this module, victims may be referred to as female and examples provided often have female victims.

³Note that online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

Understanding and Addressing Emotional Trauma

This module offers basic information on emotional trauma and on supporting victims of sexual violence in healing from trauma. It recognizes that victims with disabilities may face additional environmental and/or attitudinal barriers that impede their healing and encourages service providers to work with victims to eliminate such barriers.¹

Key Points

- A traumatic event is one in which an individual experiences, witnesses or is confronted with actual or threatened death, serious injury or a threat to their physical wellbeing.² Emotional trauma—caused by events such as sexual and physical violence, emotional abuse or neglect, natural disasters, serious accidents and acts of war and terrorism—can shatter an individual’s sense of security. However, any situation that leaves a person overwhelmed, frightened and feeling alone can be traumatic.³ It is not the objective facts that determine whether an event is traumatic, but a person’s subjective emotional experience of the event.⁴
- The following are examples of factors that may influence whether a person’s reactions to a stressful event are traumatic:⁵ severity and frequency of the event; personal history; individual coping skills, values and beliefs; and the level of support from family, friends and/or professionals.
- Traumatic reactions may include physical, emotional and cognitive symptoms. Additional symptoms—intrusive re-experiencing of the trauma, emotional numbing and avoidance, and arousal (e.g., hyper-vigilance and overreactions)—are key indicators of post-traumatic stress disorder (PTSD). PTSD symptoms specific to survivors of sexual violence are also known as rape trauma syndrome. The long-term impact of emotional trauma can affect both victims (emotionally, physically and psychologically) and their relationships with others.⁶
- Service providers can help victims understand how sexual violence can cause traumatic reactions and how trauma can affect them. To provide this help, providers can do the following: ask victims for guidance in identifying their reactions and what assistance they want; discuss with victims what accommodations and resources they may need; affirm that it is possible to heal; explain the services offered through their local rape crisis center; explain that mental health treatment for trauma is often critical to recovery, what it involves and how to obtain it; and offer crisis intervention to victims who are in crisis (or immediately refer them to professionals who can).

B8. Understanding and Addressing Emotional Trauma

Purpose

Sexual violence victims’ needs are often impacted by their traumatic reactions to the violence perpetrated against them. This module contains basic information to build service providers’ general understanding of emotional trauma. It also includes ways to support victims in healing from the trauma of sexual violence.

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As discussed in the *Disabilities 101* modules, victims with disabilities may have to contend with environmental and/or attitudinal barriers when seeking support to heal from the trauma of sexual violence. For example, persons with disabilities that impact their mobility may have trouble accessing services unless accommodations are available. Persons with disabilities that affect speech may have difficulty finding someone who has the skills and patience to help them convey what they are experiencing and help them cope with the trauma. (See *Disabilities 101. Tips for Communicating with Persons with Disabilities*.) Persons with mental illnesses and developmental disabilities who disclose sexual violence may find their account of what happened discredited or questioned by others. (See *Disabilities 101. Working with Victims with Mental Illnesses*.) It is critical that service providers identify barriers that can impede healing from emotional trauma and then work with victims to eliminate those barriers.

Objectives

Those completing this module will be able to:

- Understand emotional trauma and its causes;
- Discuss symptoms of emotional trauma, including those associated with post-traumatic stress reactions;
- Define rape trauma syndrome; and
- Discuss how service providers can assist sexual violence victims in healing from emotional trauma.

CORE KNOWLEDGE

What is emotional trauma and what causes it?

A traumatic event is one in which an individual experiences, witnesses or is confronted with actual or threatened death, serious injury or a threat to the physical wellbeing of oneself or others.⁷ Events long-recognized as potentially traumatic include sexual and physical violence, emotional abuse or neglect, natural disasters, serious accidents and acts of war and terrorism.⁸ Emotional trauma caused by such events can shatter an individual's sense of security. However, any situation that leaves a person intensely overwhelmed, frightened and feeling alone can be traumatic.⁹ It is not the objective facts that determine whether an event is traumatic, but a person's subjective emotional experience of the event.¹⁰

This module focuses on emotional trauma caused by sexual violence. It recognizes that the trauma victims of sexual violence face may be impacted by other life circumstances (e.g., if a victim with a disability had recently lost a parent and was moved to a residential facility) or by the lack of support to heal from the trauma.

FYI People can feel emotionally stressed for any number of reasons—work pressures, relationship problems, financial worries, etc. A person's nervous system is deregulated for relatively short periods of time due to stress, but then it reverts to a normal state of equilibrium.¹¹ For people who are traumatized, reverting to “normalcy” can take much longer and the outcomes can have far greater impact on their ability to function on a daily basis.^{12,13}

Why can sexual violence cause trauma for one victim and not another?

The following factors may influence whether victims' reactions to sexual violence are traumatic and the extent of the trauma they experience:¹⁴

- Severity and frequency of the victimization;
- Personal history (e.g., prior victimizations, their age at the time of the violence, their relationship with the offender, etc.);

- Added meaning the victimization may represent for individuals (e.g., a survivor of childhood sexual abuse may interpret a rape as an adult as proof that she will never escape sexual violence);¹⁵
- Individual coping skills, values and beliefs; and
- Reactions and support from family, friends and/or professionals.

What are symptoms of emotional trauma?

(See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors* and *Sexual Violence 101. Indicators of Sexual Violence* for common indicators of victims' reactions to sexual violence. See *Disabilities 101. Working with Victims with Mental Illnesses* for further descriptions of symptoms of psychological conditions.)

A traumatized person may experience one or more of the following symptoms:¹⁶

- **Physical:** Eating and sleep disturbances, sexual dysfunction, low energy and chronic, unexplained pain.
- **Emotional:** Depression; spontaneous crying; feelings of despair and hopelessness; anxiety and panic attacks; fearfulness; compulsive and obsessive behaviors; feelings of being out of control, irritable, angry and resentful; emotional numbness; and withdrawal from normal routines and relationships.
- **Cognitive:** Memory lapses, especially about the traumatic event; difficulty in making decisions; decreased ability to concentrate; hyperactivity; and impulsivity.

FYI First responders and service providers need to know that trauma can affect memory. Therefore, a change in a victim's account of what happened should not immediately be perceived that she is lying. Instead, it should be understood in the context of the impact of trauma.

The additional symptoms listed below are linked with severe traumatic events, including sexual violence:¹⁷

- **Re-experiencing the trauma:** Intrusive thoughts, flashbacks or nightmares and a sudden flood of emotions or images related to the traumatic event. Intrusive symptoms sometimes cause people to lose touch with the "here and now" and react in ways that they did when the trauma originally occurred.¹⁸ For example, many years later a victim of child sexual abuse may hide in a closet when feeling threatened, even if the perceived threat is not abuse-related.¹⁹ Trauma can be triggered by unique circumstances, such as walking through a department store and smelling cologne that the offender wore during the assault or hearing a song in an elevator that happened to be on the radio during the rape. Such circumstances, which the victim cannot control, can make healing difficult.
- **Emotional numbing and avoidance:** Amnesia; avoidance of situations that resemble the initial event; detachment to avoid painful emotions and feeling overwhelmed; and an altered sense of time. Frequently, people use drugs or alcohol to avoid trauma-related feelings and memories.²⁰
- **Arousal:** Hyper-vigilance; jumpiness and an extreme sense of being "on guard;" overreactions, including sudden, unprovoked anger; general anxiety; insomnia; and obsession with death.

Intrusive re-experiencing, avoidance and arousal are key indicators of post-traumatic stress disorder (PTSD). PTSD is associated with high rates of medical and mental health service use and is possibly the highest per-capita cost of any psychological condition.²¹

FYI Nearly one-third of rape victims develop PTSD during their lifetimes.²²

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FYI Because symptoms of PTSD can appear immediately or long after the traumatic event, people don't always connect the way they are feeling now with that event. Also, those with PTSD may avoid diagnosis and treatment or be misdiagnosed (e.g., with common co-occurring psychological conditions, such as depression, substance abuse and bipolar illness, or with physical ailments such as headaches, chest pains and digestive or gynecological problems).²³

Rape Trauma Syndrome

Information drawn from <http://www.rainn.org/>

PTSD symptoms specific to survivors of sexual violence are also known as rape trauma syndrome. These symptoms have been categorized into three phases, based on the work of Ann Wolbert Burgess and Lynda Lytle Holmstrom (Rape Trauma Syndrome, *American Journal of Psychiatry*, 131 (1974), 981-86.):

- **Acute phase:** Occurs immediately after the assault and usually lasts a few days to several weeks. Common reactions include being openly emotional, being controlled/without emotion and experiencing shocked disbelief/disorientation.
- **Outward adjustment phase:** Individual resumes what appears to be her "normal" life, but inside is suffering from considerable turmoil. Primary coping techniques utilized include: minimization (pretends that "everything is fine" or that "it could have been worse"); dramatization (cannot stop talking about the assault—it dominates her life and identity); suppression (refuses to discuss or acts as if it did not happen); explanation (analyzes what happened); and flight (tries to escape the pain by moving, changing jobs, changing appearance, changing relationships, etc.).
- **Resolution phase:** The assault is no longer the central focus of the individual's life. The survivor may recognize that while she will never forget the assault, the pain and negative impact usually lessen over time.

Note that survivors don't necessarily progress through the phases of rape trauma syndrome in a sequential manner.

What are the possible effects of emotional trauma?

If not addressed, emotional trauma can create lasting difficulties in a person's life.²⁴ Some specific effects could include: substance abuse; compulsive behavioral patterns; self-destructive and impulsive behavior; uncontrollable reactive thoughts; inability to make healthy professional or lifestyle choices; dissociative symptoms; feeling permanently damaged; a loss of previously sustained beliefs; and feelings of ineffectiveness, shame, despair and hopelessness.²⁵ Unresolved emotional trauma can also impact interpersonal interactions, contributing to sexual problems, the inability to maintain close relationships or choose appropriate friends and partners, social withdrawal, and feelings of being constantly threatened and hostile towards others.²⁶

Emotional Trauma and Persons with Mental Illnesses

Some trauma symptoms (compulsive or self-destructive behavior, uncontrollable thoughts, depression, etc.) are also symptoms of mental illnesses. Service providers must be knowledgeable about trauma to be able to differentiate between symptoms of trauma versus mental illnesses and to respond appropriately.

Trauma can exacerbate symptoms for persons who have mental illnesses. For example, a victim with paranoia may understandably be more afraid to stay by herself after an assault. Someone who was depressed prior to a rape may have increased difficulties in healing from the trauma. Mental illnesses and trauma both need to be central considerations in safety planning and providing support services. (See *Disabilities 101: Working with Victims with Mental Illnesses*.)

How can service providers assist survivors of sexual violence in overcoming traumatic reactions?

Unfortunately, people who have survived sexual violence cannot erase it from their lives. Yet it is important for them to know that they can cope with and overcome its traumatic effects. In *The Courage to Heal*, Ellen Bass and Laura Davis offer this hopeful message to childhood sexual abuse survivors, which is applicable for all sexual violence victims:²⁷

“It is possible to heal. It is even possible to thrive. Thriving means more than just an alleviation of symptoms, more than band-aids, more than functioning adequately. Thriving means enjoying a feeling of wholeness, satisfaction in your life and work, genuine love and trust in your relationships, pleasure in your body.”

No matter how committed a victim is to healing and thriving, however, these tasks are difficult to accomplish in isolation.²⁸ Several considerations are offered below for service providers who assist victims in taking their first steps towards recovery.

- Help victims understand how sexual violence can cause traumatic reactions and how trauma can affect them. For example, many victims have feelings of “going crazy” after an assault; those feelings need to be examined in the context of their response to trauma.
- Ask victims for guidance in identifying their reactions to the sexual violence and what assistance they would like. Explain that not every victim of sexual violence experiences trauma. Each victim who is traumatized has a unique combination of reactions, and their reactions may be impacted by other life circumstances.
- Affirm with victims who are experiencing trauma that while it may not feel like they will ever overcome the emotional devastation caused by the violence, it is possible to heal.
- Encourage victims to seek support from their families and friends and to tap into resources in their communities for support and for treatment of trauma. Ideally, victims will utilize a combination of resources to help them work through their pain and to achieve healing.²⁹
- Explain to victims that mental health treatment for trauma may be available and involves managing symptoms and working through the trauma. Be clear that treatment strategies can vary, depending on factors such as the source and nature of the trauma, the age of the victim at the time of the traumatic event, and other circumstances related to the event.³⁰ Let them know that counseling is often an important part of recovery for trauma survivors and medications may be used to help reduce some of the related symptoms.³¹
- Explain to victims the services offered through their local rape crisis center. These centers typically offer a 24-hour crisis phone line, various support groups, one-on-one support and advocacy. Advocates can aid victims in determining steps they would like to take to move towards healing, based on their needs and wishes. Advocates can also provide information and referrals to a wide range of resources, including counselors at their rape crisis centers and mental health treatment providers who may have experience working with victims of sexual assault.

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- In addition to encouraging victims to obtain referrals through the rape crisis center, they can also go to Mental Health America's factsheet on finding treatment through <http://www.mentalhealthamerica.net/> and check with their community-based mental health agency for the services it offers or referrals to private providers. Another resource for finding private mental health providers is Psychology Today's Online Therapy Directory through <http://www.psychologytoday.com/> (search by city/zip code). This publication is produced by the National Mental Health Association. (Also see resources listed in *Disabilities 101: Working with Victims with Mental Illnesses*.)
- Provide crisis intervention to victims who are in crisis (or immediately refer them to professionals who can). In addition to the local rape crisis center's 24-hour hotline, the National Suicide Prevention Lifeline is available 24 hours a day at 800-273-TALK (8255). Calls are routed to the nearest crisis center in its network. For information, go to <http://www.suicidepreventionlifeline.org/>. There may be additional resources for crisis intervention in your community. (See *Sexual Violence 101: Crisis Intervention*.)
- Explain that if a service provider cannot accommodate the needs of victims with disabilities or does not have information on accommodations offered by other providers, local disability service agencies may be able to offer assistance and/or appropriate referrals (e.g., providing victims who are deaf/hard of hearing with a listing of certified interpreters and tips for exercising their rights to request this service from a provider).

FYI The National Mental Health Information Center at <http://mentalhealth.samhsa.gov/topics/> offers a wealth of information on trauma topics. Sidran Institute's Risking Connections program at <http://www.riskingconnection.com> also offers a list of related resources.

Vicarious Trauma

Persons who are exposed to the trauma of others can share some of the same symptoms. This “vicarious trauma” or “compassion fatigue” can result in many physical and emotional symptoms, including guilt, exhaustion and insomnia. Service providers need to learn to care for their own emotional needs as they work to assist victims. Creating a balance between work and relaxation, talking to a supervisor about disturbing cases, and making self-care a priority can help reduce vicarious trauma.

Applying the Knowledge

Consider the following case scenario in the context of what you have learned through this module. What are the issues for service providers to address and how might they initially support the victim in dealing with her traumatic reactions to her recent sexual assault?

Anna is a 55-year-old woman with cerebral palsy who resides in an assisted living facility. She calls your agency and explains that a male stranger entered her room that afternoon, shut the door, sexually assaulted her and then fled. She disclosed the attack to a nurse at the facility, who in turn contacted law enforcement as well as facility administrators and security. Law enforcement is enroute to the facility. Anna tells you that she doesn't think she will be comfortable or feel safe living in the facility in the future. She feels totally vulnerable to “creeps like the guy who assaulted her” who see her as easy prey—she uses a wheelchair and has a limited range of motion in her upper and lower body. She tells you that the assault has brought up memories of sexual abuse she experienced as a child that was perpetrated by a family acquaintance. At that time, she told her father about the abuse and was immediately protected. This time, however, she is afraid because she doesn't know who will protect her. (Her father passed away 10 years ago.) She feels that she can't trust anyone. Anna rarely sees her mother, due to her mother's poor health and limited physical mobility.

Immediate issues for service providers to consider:

- Clearly, Anna has been traumatized by the recent sexual assault. She is panicked about her safety. She is extremely on guard and distrusting. Unpleasant memories of an earlier assault have resurfaced, but she remembers being protected from further abuse by her father. She wishes that she had her father's support to deal with the current situation and to keep her safe.
- Service providers can initially assist Anna in dealing with her growing anxiety and fear by offering crisis intervention and help in planning for her immediate safety and well-being. Safety planning must take into account her limited mobility. It should also consider security measures available at the facility (security guards and cameras as well as staff monitoring of patient rooms) and the potential need for placement in another facility. Whether her mother has a role in her decision making will also impact planning. (See *Sexual Violence 101. Crisis Intervention, Sexual Violence 101. Safety Planning and Disabilities 101. Guardianship and Conservatorship.*)
- Anna can be reassured that her heightened feelings of anxiety are normal after experiencing the trauma of sexual assault. Service providers can encourage her to address the emotional trauma, just as she would be encouraged to seek treatment for physical injuries after the assault.
- Service providers can discuss with Anna what assistance they can provide for her, other community resources for victims of sexual violence and accommodations for people with disabilities (e.g., transportation to and from services when needed). They can aid her in identifying her immediate service and accommodations needs and in requesting these services and available accommodations. (See *Collaboration 101. Creating a Community Resource List and Disabilities 101. Accommodating Persons with Disabilities.*) In particular, they can mention that the rape crisis center offers accompaniment for victims when they report to law enforcement, seek forensic medical care, go to court, etc. They can ask her if she is interested in these services. (If she is interested, they can offer to connect her with the services). Service providers can also offer referrals to mental health providers who treat trauma related to sexual violence, as well as help her explore other sources of support, including her family, friends and other community professionals.



Test Your Knowledge

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

1. What causes emotional trauma? What experiences are commonly recognized as being potentially traumatic? See page B8.2.
2. What are examples of barriers that could impede healing from trauma for sexual assault victims with disabilities? See page B8.2.
3. What factors might influence whether a person's reaction to a stressful event is traumatic? See pages B8.2–B8.3.
4. What are symptoms of emotional trauma? See page B8.3.
5. What additional symptoms are key indicators of post-traumatic stress disorder (PTSD)? See page B8.4.
6. What are the three phases of rape trauma syndrome? See page B8.4.
7. What are some of the potential long-term effects of emotional trauma? See page B8.4.
8. How can service providers help sexual violence victims take their first steps towards recovery from trauma? See pages B8.5–B8.6.

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

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

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

²American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, 4th ed. (Washington, DC: 2000). As cited in Witness Justice, Trauma—*The common denominator* (Frederick, MD), through <http://mentalhealth.samhsa.gov/nctic/trauma.asp>. This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

³M. Smith & J. Segal, *Healing emotional and psychological trauma: Symptoms, treatment and recovery*, HELPGUIDE.org (last modified 2008), through <http://helpguide.org>.

⁴Smith & Segal.

⁵Santa Barbara Graduate Institute Center for Clinical Studies and Research and LA County Early Intervention and Identification Group, *Emotional and psychological trauma: Causes and effects, symptoms and treatment* (Healing Resources.info, reprinted from Helpguide.org, 2005), through <http://www.healingresources.info>.

⁶Paragraph from Santa Barbara Graduate Institute et al.

⁷American Psychiatric Association.

⁸Santa Barbara Graduate Institute et al.; and Center for Addiction and Mental Health, *Understanding psychological trauma* (Ontario, Canada, 2010), through <http://www.camh.net>.

⁹Smith & Segal.

¹⁰Smith & Segal.

¹¹Drawn from Santa Barbara Graduate Institute et al.

¹²Drawn from Santa Barbara Graduate Institute et al.

¹³Also see Witness Justice for a description of “the science of trauma.”

¹⁴This sentence and following bullets drawn from Santa Barbara Graduate Institute et al.

¹⁵Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see endnote in the *Toolkit User’s Guide* for a full citation). Therefore, in this module, victims/clients are often referred to as female.

¹⁶Bullets from Santa Barbara Graduate Institute et al.

¹⁷Symptoms listed, except where noted, from Santa Barbara Graduate Institute et al.

¹⁸Sidran Institute, *What is post-traumatic stress disorder?* (2000), through <http://www.sidran.org>. Through the same website, also see E. Giller, *What is psychological trauma?* (Workshop presentation at the Annual Conference of the Maryland Mental Hygiene Administration, 1999).

¹⁹Sidran Institute.

²⁰Sidran Institute.

²¹Sidran Institute.

²²*Rape in America: A Report to the Nation* (Arlington, VA: National Center for Victims of Crime and Crime Victims Research and Treatment Center, 1992).

²³Paragraph from Sidran Institute.

²⁴Center for Addiction and Mental Health.

²⁵Santa Barbara Graduate Institute et al.

²⁶Santa Barbara Graduate Institute et al.

²⁷E. Bass & L. Davis, *The Courage to Heal*, 20 (New York: Harper & Row Publishers, Inc., 1988).

²⁸Bass & Davis.

²⁹Bass & Davis.

³⁰For an explanation of a range of treatment strategies and resources, see Smith & Segal; and Santa Barbara Graduate Institute et al.

³¹Paragraph from Sidran Institute.

Crisis Intervention

This module is designed to assist service providers in developing a basic understanding of crisis intervention; identifying common reactions and coping mechanisms of sexual violence victims; and learning responses to effectively assist victims in crisis.¹

Key Points

- Through crisis intervention, service providers can provide a safe environment where individuals can express their feelings and develop healthy coping strategies to deal with their traumatic reactions to sexual violence. When providing crisis intervention, service providers can: support victims and help them meet their needs; stabilize their reactions to the trauma; help them prioritize and plan to resolve their concerns; and provide informational and referral services.
- Basic crisis intervention responses are the same regardless of whether or not a victim has a disability. Each victim's specific needs should be taken into account as they may influence communication methods, accommodations, mandatory reporting, confidentiality, informational and referral resources, and options identified to help them cope with the crisis.
- There is no wrong or right way for a victim to react to the trauma of sexual violence. Examples of common victim responses include anxiety or fear; depression; shock; disorientation; intrusive memories and flashbacks; hyperarousal;² anger; self-blame and shame; avoidance of memories; suicidal thoughts; withdrawal; emotional numbness; negative beliefs about self, family, friends and the future; problems with relationships; sleep disturbances and nightmares; physical health symptoms and problematic coping behaviors.
- Specific recommendations for service providers when responding to a victim in crisis include the following: Remain calm and help calm the victim. Make sure the victim is safe. Determine if the victim needs any accommodations. Address the victim's medical concerns, urging her to seek any needed care following the sexual assault. Discuss reporting options. Address specific concerns of the victim, helping to prioritize the concerns in terms of urgency. Tell the victim what your agency can and cannot do for her. Disclose any mandatory reporting requirements. Provide the victim with contact information for the local rape crisis center, explain services offered and, with her permission, connect her with a victim advocate.³ Strive to display acceptance, empathy and support for the victim.

B9. Crisis Intervention

Purpose

What do service providers do if a client they are working with, who has disclosed sexual victimization, is in crisis? The initial support and reaction that victims receive after a disclosure of sexual assault can profoundly impact their own reactions to their victimization and their recovery. While rape crisis center advocates are specifically trained to provide crisis intervention to victims of sexual violence, other service providers are not. For example, service providers in agencies serving persons with disabilities may interact with clients who, for the first time,

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disclose sexual victimization. They must then provide basic crisis intervention if it is needed. Therefore, it is critical that service providers are informed and competent in their initial responses, as well as able to quickly connect victims to rape crisis centers for additional crisis intervention and ongoing support.

This module is designed to assist service providers in developing a basic understanding of crisis intervention; identifying common reactions and coping mechanisms of sexual violence victims; and learning specific supportive responses to effectively assist victims in crisis. (For a more in-depth examination of indicators of sexual violence and trauma that victims may experience, see *Sexual Violence 101. Indicators of Sexual Violence* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma*.)

Objectives

Those completing this module will be able to:

- Define crisis intervention;
- Identify possible responses to the trauma of sexual violence; and
- Understand appropriate intervention responses to victims in crisis to facilitate post-trauma healing.

Part I: CORE KNOWLEDGE **What is a “crisis” for sexual assault victims?**

Merriam-Webster’s dictionary defines crisis as... *an unstable or crucial time or state of affairs in which a decisive change is impending; especially one with the distinct possibility of a highly undesirable outcome.*⁴ In the case of a sexual assault, crisis sometimes is narrowly defined as 72 hours after the traumatic event.⁵ However, since the impact of sexual assault often lasts for years, and since most victims never report the violence or seek help, many factors can re-introduce the trauma of the assault for a victim. For example, hearing a song in an elevator can trigger memories of an assault if that same song was on the radio at the time of the rape. Knowing that an offender is going to be released from prison after 25 years can cause a resurgence of fear and other emotions. Unresolved trauma in unreported cases can result in similar emotional responses. For example, having to attend class on a daily basis with the offender or having weekly Sunday meals with an offending relative can prevent the victim from overcoming the feelings of stress, fear and helplessness often associated with a crisis. Therefore, this module recognizes that many incidences over time can trigger crisis responses, rather than viewing a crisis as occurring only within a predetermined time frame after a sexual assault. It also acknowledges that crisis responses can impact the physical, mental, emotional/psychological and spiritual health of the victim.

What is crisis intervention?

Intervention simply means to *mediate, get involved or intercede.*⁶ Crisis intervention attempts to stabilize the reactions to an immediate problem. Sometimes referred to as “emotional first aid” designed to “stop the emotional bleeding;” management, not resolution, is the goal.

What is the role of service providers in providing crisis intervention?

Through crisis intervention, service providers can provide a safe environment where a victim can express her feelings and develop healthy coping strategies to deal with her traumatic reactions to sexual violence. In general, when providing crisis intervention to a sexual assault victim, service providers can support the victim and help her meet her identified needs; stabilize her reactions to the trauma; help her prioritize and plan to resolve her concerns; and provide informational and referral services (including connecting her with the local rape crisis center).

To offer crisis intervention, service providers must be knowledgeable about sexual victimization, the laws and potential resources. (See the *Sexual Violence 101* modules.)

How do victims of sexual violence react in a crisis?

Just as each person reacts differently to stress, each person also reacts differently to trauma. (See *Sexual Violence 101. Understanding and Addressing Trauma*.) It is critical that a service provider not judge a victim based on her response to the sexual violence (e.g., assume she is unaffected by the rape if she is calm and seems in control of her emotions). A victim's response can begin with avoidance or denial (e.g., "If I don't think about it I won't have to deal with it" or "It wasn't rape"). A common reaction is shock. Some victims become hysterical. Others may be unable to cry. These are all natural responses after a crisis. Feelings slowly surface as a victim finds the strength to deal with the reality of the assault.

Many victims are angry if their offender is someone they know. They may feel betrayed. They may feel anger at their family or friends for not protecting them. They may be angry with themselves for being vulnerable. Victims may blame themselves. They may think: "If I hadn't worn that dress..." or "If I hadn't hired that caregiver..." or "If I hadn't been drinking..." or "If I hadn't gone to that particular party..." These feelings of self-blame are often the reasons that victims do not report, so it is important for service providers to challenge these beliefs. (See page B9-7.) The offender is always responsible for the sexual violence, not the victim.

Other victims may be afraid. Fear is a common reaction if the offender is a stranger or if the offender is someone known to the victim and has threatened further harm if she reports the assault.

For many reasons, a victim may have difficulty labeling an attack as sexual assault. For example, she may have had previous consensual contact with the offender (e.g., kissing or dancing). She may have voluntarily consumed alcohol or drugs prior to the assault. She may not remember the attack or only have vague memories of it (e.g., because she was drugged by the offender). She may not have physically fought back or tried to get away. She may not have been physically injured. If she is in a relationship with the offender, she may justify sexual violence as "just rough sex." She may not be able to understand or want to believe that an authority figure (e.g., a teacher or clergy) sexually abused her (e.g., possibly because they "are in love" and she "enjoyed it"). Again, it is important for service providers to challenge these reasons, educate victims about what constitutes sexual violence and stress that the victim's behavior did not cause the violence.

There are many possible victim responses to sexual violence. They include:

- Depression
- Shock, disorientation and difficulty concentrating
- Unwanted and/or intrusive memories and flashbacks
- Hyperarousal (constantly alert, on the lookout, etc.)
- Anger
- Self-blame/guilt and shame
- Avoidance of memories/reminders
- Suicidal thoughts
- Withdrawal, shutting down/emotional numbness
- Negative beliefs about self, family, friends and the future
- Problems with other relationships
- Sleep disturbances/nightmares
- Physical health symptoms (stomach aches, migraines, etc.)
- Problematic coping behaviors (avoidance, denial, etc.)

(Also see *Sexual Violence 101. Indicators of Sexual Violence* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma*.)

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Is crisis intervention for sexual violence victims who have disabilities different from crisis intervention for those without disabilities?

No, basic crisis intervention strategies should be used regardless of whether or not a victim has a disability. Additionally, each victim's needs should be taken into account as they may influence communication methods, accommodations, mandatory reporting, confidentiality, informational and referral resources, and options identified to help cope with the crisis. Consider:

- A crisis may exacerbate pre-existing conditions related to a person's disability. For example, if the person has a disability that affects her speech, a crisis may cause this disability to be more evident and make communication difficult.
- Disabilities that affect thought processes may be directly influenced by a crisis. For example, a person with a cognitive disability who has difficulty finding words to communicate effectively may find that a crisis renders her at a complete loss for words.
- A disability may be a factor in escaping the crisis. For example, a victim may feel unsafe in her home, but be unable to flee due to a physical disability.

To learn about a victim's circumstances, service providers need to:

1. **Listen** to what she says about herself (e.g., I had a stroke a few years ago that left me with memory loss).
2. **Ask questions** (e.g., What, if any, accommodations do you need to access services?).
3. **Observe verbal/nonverbal cues** (comments such as "It's not worth living like this" [said in a flat tone of voice] or "He's not here but I feel him burning me" [said in a trembling voice followed by hysterical crying]); slurred or stuttering speech; dazed appearance; and visible accommodations (e.g., presence of a service animal or use of a wheelchair).

Respect a victim's decisions about disclosing details of her situation—she may feel that some information is not pertinent for service providers to know (her disabilities, age, if there is a guardian, marital status, sexual preference, employment history, substance use, criminal record, etc.). She may not be cognizant of what information is relevant—gentle probing by service providers may help obtain a better picture of her circumstances. For example, a client tells a service provider that last week five boys from her church decided to "fall in love with her." She is now very upset that they are saying mean things about her and don't "love her" anymore. The service provider may ask open ended questions to learn/confirm she has Down syndrome and that the boys gang raped her.

FYI In working with any victim, it is good practice to ask **"Is there anything I should know that will enable me to better assist you?"** This one question can help identify the services that a victim needs and wants.

(Also see the *Disabilities 101* modules, particularly *Tips for Communicating with Persons with Disabilities* and *Accommodating Persons with Disabilities*.)

How should service providers respond to a victim who is in crisis?

To immediately respond to a victim who is in crisis, service providers should:

- **Remain calm and help calm the victim.** Although it is difficult to do so if the victim is hysterical, try to calm her so she can make rational, informed decisions. (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma*.)

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- **Make sure the victim is safe.** If she is not, encourage her to take the necessary steps to enhance her safety. If there is imminent danger, seek emergency assistance according to the policies of your agency. (See *Sexual Violence 101. Safety Planning.*)
- **Determine if the victim needs any accommodations,** such as an American Sign Language (ASL) or language interpreter, materials in an alternate format and/or assistive technology such as a communication device. If requested by the victim, help secure/coordinate needed accommodations. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- **Address the victim's medical concerns.** If the assault just occurred and the victim has been physically injured, urge her to seek medical assistance. Sometimes injuries are not visible, so encourage her to seek treatment if she is unsure. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
- **Discuss options for reporting.** Explain that, in West Virginia, she can decide whether or not to report a sexual assault to law enforcement, unless the situation meets the criteria for mandatory reporting requirements.⁷ A West Virginia resident over the age of 18 is presumed to be competent unless a court determines otherwise. If someone is declared legally incompetent, they are considered a protected person and a court will appoint a guardian and/or conservator. (See *Sexual Violence 101. Mandatory Reporting* and *Disabilities 101. Guardianship and Conservatorship.*)
- **Address the specific concerns of the victim.** To provide effective crisis intervention, a service provider may be asked to answer specific questions and address specific concerns of the victim. Below are examples of possible issues, along with the titles of other modules where further information can be found.
 - Is what happened to me illegal? (See *Sexual Violence 101. Sexual Assault and Abuse Laws* and *Sexual Violence 101. Sexual Harassment.*)
 - I can't afford to go to the hospital or pay for medical treatment. Can someone pay for it? (See *Sexual Violence 101. West Virginia Crime Victims Compensation Fund.*)
 - I'm afraid I'll get pregnant or HIV because of the rape. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
 - What do I do to preserve evidence of the assault? (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
 - What's going to happen if I go to the hospital? (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
 - Why did the law enforcement officer I spoke with tell me not to eat, drink, go to the bathroom or change my clothes until after I am examined at the hospital? (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
 - I'm afraid he'll come back. (See *Sexual Violence 101. Safety Planning.*)
 - I don't feel safe in my home anymore. I'm also afraid for my children's safety. (See *Sexual Violence 101. Safety Planning.*)
 - I'm worried about telling my parents or partner about the assault (See *Sexual Violence 101. Safety Planning* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

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Service providers can help calm a victim by reassuring her that they will assist her in addressing all of her needs (in collaboration with others, particularly the local rape crisis center) and **then help her prioritize her concerns in terms of urgency.**

- **Provide the victim with the contact information for the local rape crisis center** for additional crisis intervention services, hospital accompaniment and follow-up support. If the victim agrees and agency policies permit, the service provider can immediately connect her with a local advocate (e.g., by calling the local rape crisis center directly or through the national 24-hour sexual assault hotline at 1-800-656-HOPE).

FYI Service providers should be knowledgeable about the services of the local rape crisis center to be able to effectively assist victims. (The *West Virginia Protocol for Responding to Victims of Sexual Assault*, available through www.fris.org, provides an overview and checklist on the role of the advocate and the services provided by a rape crisis center.) For example:


- o What are the scope and limitations of services offered? (e.g., Does the agency provide transportation for victims? Do advocates provide victim accompaniment during the forensic medical examination? Are counseling services and support groups available through the center? Are legal services offered?)
 - o Are there age limits for the victims served? Are services provided to family members and significant others of victims?
 - o How are services accessed? Are they free?
 - o What specific resources exist within the rape crisis center for serving victims with disabilities? (E.g., Is there a list of interpreters? What other accommodations are offered? Does the center collaborate with other agencies to secure needed accommodations?) (See *Disabilities 101: Accommodating Persons with Disabilities*.)
 - o What informational materials are available for victims? Is the information available in alternate formats (e.g., large print, Braille, etc.)?
- **As soon as possible in their interactions with the victim, service providers should tell her what they can and cannot do for her.** They should inform her about reporting requirements—for example, if they are a mandated reporter to Child Protective Services (CPS) and/or Adult Protective Services (APS). They should let the victim know they are there to help and to support her decisions. They should also know their own limitations. If service providers are uncomfortable or overwhelmed, they should ask their supervisors for assistance and/or consult with the local rape crisis center.

Throughout their interactions, service providers should display acceptance, empathy and support for the victim.

- **Acceptance** can be conveyed verbally (e.g., comments such as “I believe you” or “It’s not your fault”) or demonstrated non-verbally (e.g., listening, maintaining eye contact, etc.).
- **Empathy** can also be demonstrated verbally (e.g., “I’m so sorry this happened to you” or “You must have been terrified”) or non-verbally (e.g., helping find clothing for her to wear home from the hospital if her clothes are kept for evidence or by providing tissues if she is crying).
- **Support** can be shown in many ways. For example, service providers can:
 - o Reassure the victim she took the right action by asking for help and that you are glad she told you.

- *Remind the victim that any response to the trauma of sexual victimization is normal and valid.* Service providers can reassure her that many victims experience similar reactions—and these feelings will not last forever. Providing this information soon after the assault may reduce or prevent depression, post-traumatic stress disorder (PTSD) and anxiety by preventing the development of potentially damaging negative thoughts.⁸ (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)
- *Challenge self-blaming comments.* For example, if a victim is blaming herself because she went to a fraternity party, service providers can try to refocus her attention on her survival and coping skills. Service providers can reassure her by saying “Had you known you would be raped, you wouldn’t have gone to the party.” Self-blame tends to increase if drugs or alcohol were involved. Service providers can reassure her that her willingness to go to the party or to drink did not mean she consented to sex.
- *Let the victim know about the recovery process.* Service providers can help her understand that emotional healing is as important as physical healing. They can assess her social support systems, discuss any need for additional assistance—medical, legal, emotional and spiritual—and then make referrals as appropriate to her situation and choices. It is helpful to be knowledgeable of available community services. (See *Collaboration 101. Creating a Community Resource List.* Also see the resources available through the state sexual assault coalition website at www.fris.org.)
- *Anticipate that the victim will have additional questions and concerns after a period of time.* Knowledge is power and information may help her regain control. Service providers can encourage the victim to seek further assistance from the local rape crisis center and other community resources.

Whatever the situation, the overriding way to be supportive of victims is to listen and believe them. The healing power of just those two components—listening and believing—is extraordinary.

 Service providers who work with sexual violence victims, regardless of their field of work or agency affiliation, can experience vicarious trauma after providing crisis intervention. They should make sure that they practice self-care, as they can best help others when they take good care of themselves.



Test Your Knowledge

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

1. What are examples of situations that might trigger a crisis for a sexual assault victim? See page B9.2.
2. What is the purpose of crisis intervention in general? As specifically related to sexual assault victims? See page B9.2.
3. What reactions to sexual violence are “normal” for victims? See page B9.3.
4. Does the crisis response vary if the victim has a disability? See page B9.4.
5. What specific actions can service providers take when responding to a victim who is in crisis? See pages B9.4–B9.6.
6. What are ways that service providers can convey acceptance, empathy and support for a victim? See pages B9.6–B9.7.

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Part 2: DISCUSSION

Projected Time for Discussion

2 hours

Purpose and Outcomes

This section is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their actual work with sexual violence victims. These role-play activities could be incorporated into forums such as agency staff meetings as well as volunteer meetings or trainings. Anticipated discussion outcomes include an increased understanding of service providers' roles in crisis intervention when serving sexual assault victims and the opportunity to practice crisis intervention skills using case scenarios.

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

Key Points for the Group to Consider

All skills take practice to perfect and it is preferable not to practice crisis intervention skills with a victim in crisis! One of the best ways to practice intervention skills is to role play different scenarios that a service provider might experience. Although role playing can seem awkward for some, consider that it is an opportunity to “do no harm” during the learning process. It enables service providers to identify areas in which they need additional information and practice without impacting a victim's healing process. If all group members agree to approach the activities as a learning process with the goal to help each other, then the commitment to investing some thought and creativity into the roles will add more reality to the experience.

Planning

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator. The facilitator should be familiar with crisis intervention, victims' responses, and role-playing.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, blank attendance sheet, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

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

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the scenarios. In general, there are no right or wrong responses, only different approaches.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among the participants and ultimately may shut down dialogue. The purpose of the role play scenarios is to provide the opportunity to practice new skills and obtain constructive feedback.

- 2. Explain/demonstrate role-play activities.** Spend a few minutes discussing the concept of role-plays and their purpose in developing intervention skills. Some group members may have never had the experience of role-playing. Talk about the value in using individual creativity in building upon the roles outlined in the scenarios. If requested, have the facilitator demonstrate by role-playing the first scenario with a more experienced member of the group serving in the role of the victim (as directed in Activity 3). Following the demonstration, discuss the pertinent questions listed in Activity 4.
- 3. Facilitate role-playing.** (See *Role-Play Scenarios* below. Keep in mind that in scenarios 1–5, the victims could have a disability even if one is not noted.)

Separate participants into pairs or small groups (the facilitator needs to determine how the group will be divided). Ideally, participants should be divided into groups of two, with each member of the pair rotating between playing the role of the service provider and the role of the victim. (Adapt the gender of the victim in each role-play to match the gender of the persons participating.) After two to three role-plays, new pairs should be formed. Continue the process with the next set of role-plays. Follow each role-play with a discussion as directed in Activity 4. (Allow 5 minutes for each role-play, for a total of 30 minutes.)

For individuals who are reading these scenarios without the benefit of a role-playing partner, write down an outline of how you would respond as the service provider in each scenario. After writing down your responses, look at the end of this module for some suggested responses to consider for each scenario.

Scenario 1

A woman calls who was sexually assaulted earlier in the evening. She wants help and wants to report the crime. What do you do? Would your response change if she discloses she is blind?

Scenario 2

You receive an email from a 14-year-old girl who was raped two days ago at a party. She is extremely scared that she is pregnant and wants emergency contraception. She hasn't told anyone and, although she is close to her mother, she is afraid that her mother will not believe her and will be angry because she was drinking. She does not want to make a report to law enforcement. How do you explain mandatory reporting laws (if applicable)? How do you help make it safe for her to get services? Would your response change if she discloses she is deaf?

Scenario 3

A caller who was sexually assaulted the night before is concerned about AIDS. She would like to have a medical exam but is unsure about reporting the assault to law enforcement. She's heard that there's a drug to prevent AIDS. Is there? If so, she has no money. Can you help her? If you do not have all the information she is requesting, what do you do? Would your response change if she discloses she has a mental illness and "tends to obsess about things?"

Scenario 4

A 19-year-old college freshman had too much to drink 10 days ago at a campus party, was gang raped and never reported the incident because she was afraid of being charged with underage drinking. She kept her clothes and did not wash them. The guys are now bragging on campus. She is angry and wants the offenders to be held accountable. What are her options? Would your response change if she discloses she has a cognitive disability which makes communication difficult? (She does not have a guardian.)

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Scenario 5

A caller was raped a number of weeks ago by his male date. He has an extensive history of being abused and wants to talk about the painful details of the assault. What do you do? Would your response change if he discloses that he has had depression periodically for 10 years?

Scenario 6

A 24-year-old woman who appears to have Down syndrome stops by your table at the mall health fair. In the course of her general conversation, she tells you about the bus driver at her group home. Females in the home call him “Uncle Bob,” and he brings them candy. He often touches her “private area.” She is afraid he will stop giving her candy if she says she doesn’t want him to touch her there anymore. She says it’s really good candy. What do you do?

4. **As a large group, facilitate a review and discussion on each scenario.** Use the questions below, as well as the suggested action steps, to help guide the discussions. (10 minutes per scenario, for a total of 60 minutes)
- After each role-play, have one or two pairs present their intervention responses and actions to the large group. Discuss whether their actions were appropriate. The facilitator should summarize the ideas on how to respond to the situation and re-instruct on specific best practices as necessary.
 - What key facts in the scenario impacted your response? Did your response change when you knew the victim had a disability? (Note that basic crisis intervention strategies and goals are consistent across victim populations, but that responses may be influenced by factors such as age, cultural beliefs and values, type of sexual violence, disabilities, etc.)
 - What laws or specific resources did you need knowledge of to be able to help the victim?
 - What aspects of this scenario made it uncomfortable for you to assist the victim?

Suggested action steps for each scenario:

Scenario 1—suggested actions and issues to consider

This scenario requires basic crisis intervention. Determine her age and if she has the capacity to make her own decisions. Assess her injuries and safety. Find out her needs. Briefly explain any available services and her options regarding the forensic medical exam and reporting. If she chooses to have a forensic medical exam, discuss transportation to an appropriate facility. Advise her to not wash, change clothes, urinate, defecate, smoke, drink, eat, brush her hair or teeth or rinse her mouth and to bring the clothes she was wearing when assaulted (or a change of clothes if she is still wearing the clothes she wore during the assault). Identify if there is someone she trusts who can support her. Provide unconditional support. Activate advocacy, medical, law enforcement and other relevant first responders as she directs. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

If the victim discloses that she is blind, discuss accommodations she may need to access services (material in an alternate format, help in filling out forms, use of a service animal, etc.). (See *Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 2—suggested actions and issues to consider

Service providers are often unclear about mandatory reporting laws. (See *Sexual Violence 101. Mandatory Reporting.*) Review them thoroughly and discuss with your supervisor. Most service providers have mandatory reporting requirements. How can you serve this victim once you know her age? How would that change if you know her

age, but do not know her name or phone number? *Can* you provide services without obtaining identifying information from the victim? How would the age of the offender impact your response? What is the time period for taking emergency contraception? Where can it be purchased, and what are the related age limitations? In such calls it is critical to create safety for the caller, identify her concerns and explore what options are available to her. Always recognize your limitations and refer for services when necessary.

Any victim communicating through an unsecured technological device (including email, cell phone or texting) should be advised that confidentiality issues are present and should utilize more secure methods of communicating.

If the victim discloses that she is deaf, she may have access to a text telephone (TTY) or Telecommunications Relay Services (TRS). The service provider would need to be familiar with communicating via these devices. Discuss accommodations she may need to access services (e.g., ASL interpreter). (Also see *Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 3—suggested actions and issues to consider

Under West Virginia law, victims can have a forensic medical exam conducted within 96 hours of a sexual assault. Exams can be conducted without reporting the assault to law enforcement (with the exception of cases requiring mandatory reports). The collected sex crimes kit will be sent and stored at Marshall University Forensic Science Center for up to 18 months. During that time, the victim can choose to report. Unless service providers are medical professionals, they are unqualified to give medical advice. In general, prophylactic/preventive treatment is available in most communities if started within 72 hours of exposure. The treatment's side effects can be difficult to tolerate. The known risk of contracting HIV from one unprotected sexual encounter is slight. Encourage the victim to go to or contact the hospital to receive detailed information on HIV prophylactic treatment from medical professionals as well as other services (if she chooses), such as a forensic medical exam, advocacy and an opportunity to report the crime. HIV treatment could possibly be paid out of the West Virginia Crime Victims Compensation Fund; however to access those funds, the rape would have to be reported to law enforcement. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination* and *Sexual Violence 101. West Virginia Crime Victims Compensation Fund.*)

If the victim discloses that she has a mental illness and “tends to obsess,” it may be useful to again stress that it is unlikely she has been exposed to HIV, but that it is important to quickly address her concerns with a health professional and decide whether she is a candidate for prophylactic treatment. Discuss accommodations she may need to access services (e.g., transportation if she doesn't drive, accompaniment, etc.). (See *Disabilities 101. Working with Victims with Mental Illnesses* and *Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 4—suggested actions and issues to consider

This is a good example of a case that has several additional variables. First, the victim could conceivably be charged with underage drinking; it is helpful to know your local prosecutor's position on that issue. In most cases, forensic medical exams are conducted up to 96 hours following a rape. However, each case needs to be considered separately. If she was gang raped, there may have been significant tearing and bruising, which still could be visible and documented. The fact that she did not wash her clothes could provide the necessary DNA evidence. DNA, if not destroyed, can remain indefinitely. You would want to review the options with the victim. Those options would also include any appropriate reporting and disciplinary actions available through the local college. Utilize the services of the local rape crisis center for additional support and information. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

If the victim discloses having a cognitive disability that makes it difficult to communicate, discuss accommodations she may need (e.g., the method in which you communicate with her, assistance in filling out forms, etc.). (See

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Disabilities 101. Tips for Communicating with Persons with Disabilities and Disabilities 101. Accommodating Persons with Disabilities.)

Scenario 5—suggested actions and issues to consider

Crisis intervention is a normalizing process that strives to return victims to pre-crisis levels of functioning. Having callers remain in an extreme emotional state or repeatedly revisit a traumatic event can be counterproductive. For some victims, the process of telling and re-telling the story can be therapeutic. Focus on what the caller needs right now. If he has never talked about the assault, then support him in disclosing and listen. If he has focused only on the assault since the rape and seems fixated on the attack, continue to listen but recognize that he may need additional interventions. Review his safety plan. Help him return to the present moment, find out how he helped himself feel better in the past, identify his support systems and make a self-care plan for the next few days. Possibly refer him for ongoing counseling. (See *Sexual Violence 101. Safety Planning.*)

If the victim discloses that he has a history of depression, talk with him about accommodations he may need (assistance in reaching out to other service providers, financial aid for counseling, etc.). Also, discuss how the most recent victimization may exacerbate his depression, as well as trigger unwanted thoughts about any past victimization. If he is open to it, talk with him about what he usually does to cope with depression, if there is anyone supporting him in dealing with it, and if so, encourage him to connect with them for additional support. (See *Disabilities 101. Working with Victims with Mental Illnesses and Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 6—suggested actions and issues to consider

This scenario presents several complicating factors: Is this a case of sexual abuse by an authority figure? Is the victim's capacity to consent to these sexual acts an issue? Are you a mandated reporter? While the victim may not be in crisis, since she views the sexual act as a means to an end (candy) rather than abusive, you need to take the suspected abuse seriously. Find a private place to talk with her. Validate her decision to tell you about the situation and explain that help is available. You should disclose that you are a mandated reporter (if you are). Explain in language she can understand that if she tells you that someone is harming her, you must tell someone on her behalf. Remember that your role is not to investigate the abuse, but to provide support and report any suspected abuse of those who cannot speak for themselves. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault and Abuse and Sexual Violence 101. Mandatory Reporting.*)

Ask her for the information you need to make a report to APS, such as her contact information and any specifics about what occurred (when, where, etc.). Ask if there is someone that helps her make decisions (the term "guardian" may have no relevance to her). If so, ask for contact information for that person and for the group home. (See *Sexual Violence 101. Confidentiality and Disabilities 101. Guardianship and Conservatorship.*)

FYI To close this activity, stress to participants that **when providing crisis intervention services, it is important to remain in the role of providing support for the victim.** Once people disclose victimization, in addition to dealing with the trauma of the assault, they usually begin wrestling with whether they took the right action by telling you about it. **Your reaction is critical to their healing process. Focus on their immediate needs by providing the support and information they need.**

5. **Closing.** Ask participants to write down any questions they have or additional information they need based on the role-play activities. Discuss their plans for getting the information they need to better provide crisis intervention services. (10 minutes)

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

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

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

²Symptoms that stem from high levels of anxiety, such as: “Having a difficult time falling or staying asleep; feeling more irritable or having outbursts of anger; having difficulty concentrating; feeling constantly on guard or like danger is lurking around every corner; and being jumpy or easily startled.” (M. Tull, *About.com* Health’s disease and conditions: PTSD (*hyperarousal*) (2009), <http://ptsd.about.com/od/glossary/g/hyperarousaldef.htm>.) Note this and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

³Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User’s Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

⁴Merriam-Webster Dictionary (accessed October 23, 2009), www.merriam-webster.com.

⁵L. Ledray & S. Moscinski, *Advocate/counselor training, Training manual* (Washington, DC: Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice), 104.

⁶www.merriam-webster.com (accessed October 23, 2009).

⁷Legislative Bill HB08-1217 (Division of Criminal Justice, 2008)(accessed October 23, 2009), http://dcj.state.co.us/OVP/Documents/Forensic%20Exams/Information_for_Medical_Facilitiesweb.pdf.

⁸Ledray & Moscinski.

Safety Planning

This module offers basic information for service providers on safety planning with clients who disclose sexual victimization. It includes considerations when clients have disabilities.¹

Key Points

- Safety planning is a thoughtful, deliberate process in which a helper and a victim together create a plan to enhance safety for the victim. Each victim's circumstances, safety needs and concerns are unique.²
- **The following are steps for safety planning with a victim in crisis:**
 - Ask the victim the reason she is calling/requesting help.
 - Ask if she has immediate or pending safety concerns for herself or her family.
 - Ask her if you can help in developing a plan of action to address her immediate safety needs. The plan should identify: specific steps the victim can take to address her immediate safety concerns; supportive persons in her life who can help with safety and their roles in the process; specific safety strategies that may prove difficult to achieve and accommodations needed to reduce or eliminate these barriers; any essential items the victim needs if she has to flee her current location; and referrals to community resources to meet her urgent needs.
 - Encourage the victim to follow up to let you know how she is doing and/or to develop a longer-term plan for safety and other assistance (unless the victim is referred to another agency for long-term planning).
- **The following are steps for safety planning when the victim has time to prepare:**
 - Build rapport with and listen to the victim.
 - Help the victim identify fears, obstacles, threats and barriers to her safety, health and well-being.
 - Ask the victim what she needs to do to be safe. Subsequently, help her develop a plan for safety in multiple situations, as appropriate to her circumstances and safety goals. Consider strategies to prevent future incidents of harm by others; strategies to facilitate protection and seeking help during a potentially unsafe interaction; strategies to obtain emotional support; plans for acquiring any necessary accommodations; and referral services that offer additional assistance the victim may need to promote her safety, health and well-being. Offer her safety planning materials in an alternate format as necessary.
 - If needed, practice and repeatedly discuss the safety plan until the victim feels comfortable with it. Encourage the victim to periodically review/update the plan as her situation changes.

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B10. Safety Planning

Purpose

This module provides a reference for service providers in safety planning with sexual violence victims. It has four main components: introduction, safety planning for victims in crisis, general safety planning for victims who are not in crisis and safety issues for persons with specific disabilities. These topics are in one module so you can compare strategies across different types of situations and types of disabilities. Due to the length of the module, consider reviewing the module in two or three sessions.

Objectives

Those who complete this module will be able to:

- Understand the basic components of safety planning and its importance for sexual violence victims; and
- Gain knowledge about safety concerns of victims of sexual violence with disabilities and how to help them plan for their safety.

Preparation

- Review agency forms, policies and procedures on safety planning with clients.

Part I: CORE KNOWLEDGE

Why is it critical to address the safety needs of sexual violence victims?

Sexual violence can shatter many victims' feelings of safety.³ Victims may not feel physically safe for months or years after an assault.⁴ If victims have or worry about ongoing contact with their perpetrators, their post-assault fears and hyper-vigilance may be especially acute.⁵ Victims may develop an elevated general fear after an assault (of men, crowds, being alone, being out at night, etc.). They may face threats to their health, such as contracting a sexually transmitted infection or HIV/AIDS. The emotional distress they experience can also increase their risk of self-inflicted harm. (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma*.)

Victims may be unable or unwilling to seek assistance to enhance their safety for many reasons. They may be afraid that their perpetrators will retaliate or they may be immobilized by the emotional reactions or fears caused by the assault.⁶ Victims with disabilities may face additional barriers to safety, due to challenges presented by their individual circumstances. For example, a victim may be physically dependent on an abusive caregiver and unable to seek help because the perpetrator isolates her from others and she lacks the social supports, financial means or transportation needed to escape. A victim with clinical depression may sink into a deeper depression and think about ending her life.⁷ (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors* and *Sexual Violence 101. Indicators of Sexual Violence*.)

Victims' feelings of security and control in their lives can be enhanced when service providers provide an opportunity to discuss their safety concerns and ways to reduce their risk of further harm. They can help victims with disabilities examine if and how their disabilities impact safety and identify accommodations that may be useful in overcoming barriers to safety. Recognizing that victims' situations and safety concerns may change over time (e.g., if their level of functioning/mobility changes or if they start having flashbacks years after the assault), safety planning should be an ongoing process rather than a one-time event. It is critical that service providers also realize that victims with disabilities may worry that a disclosure of sexual assault may lead to a loss of independence. Therefore, they should support victims in making their own choices about their safety, to the

extent possible, instead of deciding what is best for them.⁸ (See *Disabilities 101. Self-Advocacy with Victims with Disabilities*.)

What does safety mean to sexual violence victims?

Safety can have different meanings to individuals in the aftermath of being sexually victimized. For example, it can include safety from:

- *Continued physical harm, intimidation and retaliation by their perpetrators* (e.g., immediately following the violence; if they live with their perpetrator; if the perpetrator is someone the victim is likely to see in the community; if the perpetrator is arrested and then released on bail; during an investigation and prosecution; after the perpetrator is released from prison; etc.). Victims may be concerned for themselves as well as for the safety of their family, friends, pets and service animals. Victims may also fear retaliation from the family or friends of their perpetrator.
- *Other persons, places or things they fear as a result of the sexual violence or existing fears that are exacerbated by the violence* (e.g., if the assault occurred in a parking garage, a victim may have a fear of using a parking garage).
- *Potentially life-altering and fatal health issues resulting from the sexual violence*, such as sexually transmitted infections (STIs), HIV/AIDs, depression and pregnancy.
- *Self-inflicted harm and other self-destructive behaviors in reaction to the emotional distress triggered by the sexual assault* (e.g., suicide attempts, self-mutilation, excessive drinking, drug use, unsafe sexual activity, compulsive overeating or binge eating).

(See *Sexual Violence 101. Understanding and Addressing Emotional Trauma* and *Sexual Violence 101. Crisis Intervention*.)

What is safety planning?

*Safety planning is a thoughtful, deliberate process in which a helper and a victim together create a plan to enhance safety to the extent possible for the victim.*⁹ Given the dangers that victims potentially face, the process of safety planning is critical in helping them identify and address their unique safety needs. However, victims *must also understand that while a safety plan may help them reduce their risk of future harm, it does not guarantee prevention of further victimization*. It is important to emphasize that sexual victimization is never the victim's fault. Providing a consistent message across service delivery systems that sexual victimization is never their fault can help victims reframe their experience and aid in their recovery from the trauma they experienced.

There are two main forms of safety planning for victims discussed in this module: planning when victims are in a crisis; and planning when they have time to prepare. When victims are in crisis and/or experiencing imminent danger, their immediate focus typically is on finding a safe location (e.g., away from the perpetrator, the place where the assault occurred or the situation that is causing them fear) and on seeking support to help them become safer (e.g., law enforcement officers to protect them from the perpetrator, emergency medical services technicians to treat serious injury and/or a crisis counselor to help them deal with their distress). In non-crisis situations, victims have more time to focus on their comprehensive safety needs.

FYI **Safety plans should be based on victims' self-identified needs and goals rather than professionals' opinions or family members' concerns.** To the extent possible, victims should make their own choices about planning for safety. It is understandable that family, friends and others who support victims want them to be safe from harm after a sexual assault. For example, a family member may want an older victim with disabilities placed in a residential facility rather than living in the community on her own. A service provider may feel that a victim with a mental illness who has suicidal thoughts is the "safest" in an

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in-patient psychiatric hospital. Yet these safety “solutions” may represent a loss of independence for victims and may not be their personal choices. *Victim-centered safety plans, on the other hand, can help restore power and control to victims as they make decisions about their safety.* For example, the older victim may ultimately choose to remain living in the community, but with a caregiver and enhanced security measures. The victim with a mental illness may decide to address her suicidal feelings through out-patient counseling, contact with supportive friends and use of a 24-hour crisis line.¹⁰ (See *Disabilities 101. Self-Advocacy and Victims with Disabilities, Disabilities 101. Guardianship and Conservatorship* and *Sexual Violence 101. Working with Victims with Mental Illnesses.*)

Which agencies should assist victims with safety planning?

All agencies that interact with sexual violence victims should have the capacity to do basic safety planning with them, both in crisis and non-crisis situations. They should have policies and procedures to facilitate this planning with victims and provide training for staff to implement these policies and procedures. However, all agencies do not need to be experts in safety planning or in implementing safety plans. Rather, each agency should develop relationships with other providers in the community and share resource lists. (See *Collaboration 101. Creating a Community Resource List.*) Staff can then connect victims with more comprehensive assistance to access services, information and accommodations. For example, disability service providers can refer victims to the rape crisis center for detailed information about what to do following a sexual assault.

How can service providers assist victims who are in crisis in planning for their safety?¹¹

If a victim who is in crisis contacts any service agency, the provider should quickly gather information and offer help in planning for her safety. Keep in mind that a victim in crisis often requires immediate assistance to be safe and that the provider’s interaction with her may just be for a matter of minutes, depending upon her circumstances. The provider can encourage the victim, when there is more time, to develop a longer-term safety plan and offer aid in developing that plan (as discussed later in this module). NOTE: There will be some overlap in crisis and longer-term safety planning. (See *Sexual Violence 101. Crisis Intervention.*)



CHECKLIST FOR SAFETY PLANNING WITH A VICTIM IN CRISIS

- **Ask the victim the reason she is calling/requesting help.**
 - Convey that you are glad she called/requested help, you believe her, the violence was not her fault, you are sorry the violence occurred, and you can assist her in getting help.
 - Respect and accommodate the pace of communication and the needs, abilities and experiences of the victim.
- **Ask the victim if she has immediate or pending safety concerns for herself, her family, any pets and/or service animals. Ask her to be specific.**
 - Validate her concerns about safety.
 - In the case of imminent danger, call 911 as per your agency’s policy.
 - If the assault was recent, explain the importance of getting immediate attention for any injuries as well as for the prevention of sexually transmitted infections and pregnancy (if relevant). Help facilitate medical care for the victim as per your agency’s policy. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
 - If relevant, explain to the victim the mandatory reporting requirements, as defined by state law. (See *Sexual Violence 101. Mandatory Reporting.*) Recognize that victims with disabilities may be reluctant to involve law

enforcement or other authorities for a variety of reasons. (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors*.) If a mandatory report is required, encourage the victim to initiate the report and offer assistance in reporting.

- **If she discloses having a disability, ask her to explain any concerns she has related to how the disability may affect her safety.**
 - It may be difficult for her to identify if and how a disability impacts the situation (e.g., because she has not considered this issue before or has trouble comprehending the extent of the danger posed). Provide support as necessary in talking through this issue.
- **Ask the victim if you can help her in developing a plan to address her immediate safety needs** (for her and her dependents, pets and service animals as applicable to the situation). The plan should identify specific tasks, persons and resources that can help meet her needs. These could include:
 - Specific steps the victim can take to address her immediate safety concerns. Offer assistance in brainstorming creative solutions to safety that are within her abilities and resources.¹²
 - Supportive persons whom the victim can turn to for help with safety needs and their potential roles in the process.
 - Specific safety strategies that may prove difficult to achieve and accommodations available to reduce or eliminate any barriers. (See *Disabilities 101. Accommodating Persons with Disabilities*.)
 - Essential items needed, if time and safety allow, when the victim has to flee from her current location (e.g., medications, assistive devices, information about services and financial benefits, key insurance and legal documents, money, caseworker's name and phone number, information about a legal guardian, etc.) and any assistance needed to obtain these items. (See the next section for a more extensive list of items.)
 - Referrals to community resources to meet the victim's urgent needs. As appropriate, ask if you can immediately connect her with agencies to help her deal with the situation (e.g., to the local rape crisis center).
- **Encourage the victim to follow up to let you know how she is doing and to develop a longer-term plan for safety and other assistance** (if the victim is not referred to another agency for long-term planning).

What is involved in longer-term safety planning with victims with disabilities?

If victims are not in crisis, service providers can help them develop a more long-term safety plan. In general, longer-term safety planning involves the steps described below.¹³



CHECKLIST FOR GENERAL SAFETY PLANNING WHEN THERE IS TIME TO PREPARE

- **Build rapport with and listen to the victim.** Respect and accommodate the pace of communication and the needs, abilities and experiences of each victim. Do not underestimate the power of compassionate listening—victims can benefit simply from being heard, believed and supported in their decisions regarding safety.¹⁴ (See *Sexual Violence 101. Crisis Intervention*.)
- **Help the victim identify fears, obstacles, threats and barriers to safety, health and well-being that may be in her life.** Also consider these issues as they apply to her dependents, pets and service animals. (See the next section on issues specific to victims with disabilities.)

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○ **Ask the victim if and how any needs for accommodations might impact her safety and safety planning.** Consider what accommodations might help meet her safety needs. (See *Disabilities 101. Accommodating Persons with Disabilities*. Also see the next section on issues specific to victims with disabilities.)

- Consider support persons who can assist with safety needs and discuss their roles.
- Consider community resources available for safety and possible barriers she may encounter in accessing them. For example, a courthouse that is not physically accessible may permit a protection order court hearing to occur by telephone to accommodate petitioners who use wheelchairs.¹⁵
- If the victim knows her perpetrator, discuss if and how the perpetrator could potentially prevent her from using services and resources. For example, if the victim is deaf, an abusive spouse or caregiver could tell her that 911 will not respond to her TTY calls, or may try to act as an interpreter for her during a hospital visit to control the content of her statements to healthcare providers. Provide the victim with clarifying information and brainstorm options for these situations.¹⁶

○ **Ask the victim what she needs to do to be safe.** The victim is an expert on what safety techniques will work best for her, given her strengths, circumstances and accommodation needs. Most victims will be able to state their preferred methods for accomplishing a task. Rely on the victim's creativity and knowledge, while providing her with information on sexual violence and, if necessary, suggestions for additional methods of reaching the same goals.¹⁷

- Recognize, however, that a victim may have difficulty identifying the possible safety solutions and accommodations she needs (due to a disability, misinformation about available resources, isolation from society, etc.). While service providers cannot know every detail about every type of disability, they must understand the basic functions needed to develop and implement a safety plan, be aware of available safety planning strategies, and explore how a disability might affect those safety planning functions and accommodations.¹⁸
- Help the victim create a safety plan for multiple situations as appropriate to her circumstances and safety concerns and goals. Below are some ideas.¹⁹

○ **Strategies to prevent future incidents of harm by others:**

- Report the violence to law enforcement or other authorities (with the expectation that the perpetrator will be arrested/incarcerated or otherwise remove/restrict access to the victim).
- Minimize financial dependency on one person; include more than one person in financial arrangements (e.g., assisted living staff and a family member or a guardian and a service provider).
- Obtain and understand basic information on sexual violence, personal boundaries, personal safety and community resources.
- Inform caregivers and service providers that any sexual violence will be reported to law enforcement and follow through with reports.
- Reduce isolation through multiple social connections (family, friends, church, neighbors, social networks, etc.).
- Maintain regular conversations with someone other than the caregiver (with a doctor, advocate, family member, Adult Protective Services (APS) worker, clergy, etc.) who can verify personal safety.
- Obtain a restraining/protective order, if eligible.

- Screen personal care attendants before hiring and guardians before appointment.²⁰ (See *Disabilities 101. Guardianship and Conservatorship*.) If the perpetrator is the caregiver, arrange for alternative personal assistance.
- Identify a supportive family member/friend to live with, either temporarily or permanently. Also identify family members, friends and others who can regularly check in to monitor safety.
- If there are children, grandchildren or other dependents, devise a plan of safety for them when with/not with them. Inform schools, day care programs, etc. about who has permission to pick them up and who does not.
- Reduce chances of contact with the perpetrator by moving to another safe, accessible residence or room in a residential facility, transferring to another class/program, changing routines, etc.
- Identify safe communication methods for corresponding and interacting with service providers (ask providers to use plain envelopes, mail information only to locations deemed safe by the victim, make contact only through phone numbers and e-mail addresses deemed safe by the victim, address victim safety getting to and from appointments, etc.).
- Change and add locks and install alarm systems and other home security measures (keep windows shut and locked at all times, increase outside lighting, etc.).
- Change telephone numbers and e-mail addresses. New numbers should be unlisted and unpublished. Screen telephone calls.
- Hide/disarm/remove weapons.
- If vehicles and any adaptations are used, they should be in good working order. Keep the gas tank at least half full so there is always enough gas to leave a situation quickly if necessary.
- Obtain an escort to the car, bus, taxi or other transportation being utilized. Also, a friend and/or family member can be asked to call to check on the victim's safe arrival at a destination at a specified time.
- If the perpetrator is convicted, make victim impact statements during sentencing and parole hearings. These may result in a longer prison sentence and/or special conditions during incarceration and/or probation and parole.

o **Strategies to facilitate protection/seeking help during a potentially unsafe interaction:**

- Ensure access to communication (phone, cell phone, TTY machine, computer/Internet service, etc.) if help is needed.
- Maintain access to assistive mobility devices.
- Identify who can help and have emergency numbers and a phone/other communication devices readily available (e.g., program 911 into a cell phone or activate an alarm button).
- Identify a signal, such as placing a towel in the window or using a code word (e.g., the word “red” could mean “I’m in danger”), which will alert neighbors, family or friends to send help.
- Teach children and other dependents how to contact law enforcement and emergency services.
- Plan routes/destinations to escape a variety of dangerous situations (at home, at work, at school, while

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in transit, in public buildings and places, etc.) and identify/secure accommodations and what assistance is needed. If a service animal is used or there are dependents, the plan should also include how to get them to safety. If leaving during a dangerous situation, plan to drive directly to the police station.

— Gather together:

- Important contact information (law enforcement, APS, rape crisis center, domestic violence agency, home health agencies, caseworkers, disability service providers, friends or past caregivers who might be willing to help with personal care tasks during transitional periods, etc.);
- Important documents, both for the victim and any dependents (protection orders, driver's license and other I.D. cards, birth certificates, social security cards, benefit award letters, proof of disability, work permits, green cards, passports, divorce and custody papers, leases, rental agreement/house deed, car registration/insurance papers, fixed route bus passes, mobility ID cards, special transit ID cards, etc.);
- Spare keys;
- Money, bank books, checkbooks, credit/debit cards, ATM cards, mortgage payment book and public assistance cards;
- Medications and medical documents (insurance papers, Medicaid and Medical Assistance document/cards, medical records, prescriptions, service animal's medical/shot records, etc.);
- Assistive devices and supplies;
- Food and supplies for a service animal; and
- Personal items (address books, pictures, jewelry, clothing, a few toys for small children, items of sentimental value, etc.).

Store these items in an easily accessed/safe location (e.g., at a friend's house) if a quick escape is needed. Remember, however, that no item is as important as the victim's safety.

- If a protection order is in place, carry it at all times and give copies to trustworthy people at places of employment, school and other frequented sites or where protection from the perpetrator is needed.
- During an incident, try to move away from rooms that have any possible weapons, like the kitchen. Seek shelter in a room where a door can be locked and that has a working phone/communication device. Or, if possible, look for an exit, yell for help or try to flee.

o **Strategies for obtaining emotional support:**

- Identify a 24-hour/consistent source of support, crisis intervention and contact as needed.
- Decide who can provide the needed support (e.g., caseworkers, service providers, family and/or friends) to talk about the sexual violence. Spend time with these individuals (in person or through phone/online contact).
- Participate in support groups and counseling.

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- If there is a need to be in communication with the perpetrator, maximize safety in doing so—whether by telephone, writing a letter, e-mail or in the company of a third person. Debrief with a support person after any communication/interaction with the perpetrator.
- Seek assistance with daily functions as needed (e.g., explore childcare options, request time off from work/school or ask for a reduced workload).
- Attend to physical needs and concerns (e.g., if nightmares and difficulty sleeping are issues, talk with a doctor about possible remedies).
- Participate in activities that soothe, calm and lift spirits such as playing with and caring for pets, listening to music, exercising, meditating or praying, reading or listening to inspirational materials, finding a hobby, or attending community activities.
- If there is a concern about self-harm:
 - Remove items that could be used for self-harm;
 - Ask a supportive person to lock up and/or limit the amount of medications easily accessible;
 - In advance, consider what to do to stay safe if suicidal thoughts or thoughts about self-harm occur (e.g., go to a public place or a hospital, visit a friend, journal, call the crisis hotline, etc.).
- **Identification of referral services** that offer additional assistance in promoting safety, health and well-being.
- **If needed, practice and repeatedly discuss the safety plan** with the victim until she feels comfortable with it.
- **Encourage the victim to periodically review and update the safety plan as her situation changes.** Different circumstances may require different safety strategies (e.g., changes in the victim's place of residence, capacity to function or need for assistance). Encourage the victim to inform supportive friends, family and others of changes to the plan.
- **Offer the victim safety planning materials in alternate formats as needed.**

What are specific issues that victims with disabilities face in safety planning, as well as potential solutions?

The charts below offer examples of different safety issues and potential solutions.²¹ These examples are not meant to be an all-inclusive listing of points to consider for safety, as each victim's needs are unique.

Victims with Cognitive Disabilities

Safety issues

- Cognitive disabilities generally fall into the following categories: learning disabilities such as dyslexia, attention deficit hyperactivity disorder (ADHD), brain injuries and genetic diseases such as Down syndrome, autism and dementia.²² People with cognitive disabilities may or may not have issues with language, learning, mobility and capacity for independent living. However, the range of capabilities of people with cognitive disabilities is probably greater than with any other type of disability.²³

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- Some people with cognitive disabilities are overprotected and discouraged from being independent or interacting with others. Often, they are limited to segregated services and programs (e.g., in residential, healthcare, educational and work settings).
- Some individuals with cognitive disabilities are taught to comply with authority at all times and this can impact their ability to identify options for safety. (See *Disabilities 101. Self-Advocacy and Victims with Disabilities.*)

Possible safety solutions

- When safety planning with victims with cognitive disabilities, keep in mind that the plan must match what they can process and retain. For example, a one-step plan to call a friend, family member or case manager may work best for some individuals. Others will be able to process and retain more detailed safety planning information. (See *Disabilities 101. Tips for Communicating with Persons with Disabilities.*)
- Depending upon a victim's needs, frequently review the safety plan. Consider role-playing potential scenarios so the victim can practice the planned response.
- Consider including photographs and phone numbers of trusted persons in the plan.
- If a victim is not able to maintain confidentiality, help arrange for services that do not have to be kept confidential (e.g., shelter or program locations).
- Ask for a guardian to be assigned to victims when appropriate. (See *Disabilities 101. Guardianship and Conservatorship.*)
- In group living situations, develop strategies with nonoffending staff, guardians and family members to allow for monitoring and dual oversight of the victim's safety at all times. Oversight strategies planned to ensure the safety of residents should strive to maintain the independence and autonomy of the victim. (See *Disabilities 101. Self-Advocacy and Victims with Disabilities.*)

Victims with Sensory Disabilities

Hearing

Safety issues

- Not all individuals who are deaf or hard of hearing use sign language or even the same form of sign language. Some may have difficulty reading and understanding complex documents. Ask the person what method of communication is preferred. (See *Disabilities 101. Tips for Communicating with Persons with Disabilities.*)
- It may be difficult for a person who is deaf or hard of hearing to keep the assault hidden from others in the Deaf community. This community is often very cohesive and it is not uncommon for one person's crisis to be common knowledge within days.

Possible safety solutions

- Check with the victim before engaging any specific services for them (e.g., an emergency interpreter service may work with or for the perpetrator).
- You cannot tell the identity of a person talking on the TTY. Perpetrators may pretend to be victims using the TTY to gain information. If this situation is a possibility, set up a code word with the victim (e.g., the name of her cat) to verify with whom you are speaking.

- Save an outgoing message to 911 typed into the TTY memory so that a victim can quickly request an emergency police response. The message should include her address and any existing protection order information.
- Erase the memory on the TTY machine after a confidential conversation. The TTY has a computer chip that retains previous phone calls in its memory. If a victim is leaving the TTY behind, the perpetrator might be able to find out where she went by reading the phone conversation from the TTY memory.
- Perpetrators may damage TTY machines to prevent victims from communicating with others. Note that the West Virginia Division of Rehabilitation Services (www.wvdrs.org or 800-642-8207) provides low interest loans to qualified individuals with disabilities to purchase assistive technology. In addition, the Centers for Independent Living within the state operate a Community Living Services program that also provides funding to individuals with disabilities to purchase assistive devices or pay for home modifications to improve accessibility. See www.mtstcil.org.
- Flashing lights and vibrating pagers can be connected to a motion detector, alarm system, doorbell or other devices to increase a victim's safety.

Vision

Safety issues

- There are several types of vision disabilities, each requiring differing accommodations. People who are legally blind may be able to read large print or move about without mobility aids. They may be able to perceive light and darkness, some color or see nothing at all. Some persons who are blind may read Braille, but the majority of people who are blind do not. Some use service animals, some do not. (See *Disabilities 101. Accommodating Persons with Disabilities*.)
- People with service animals WILL NOT leave their animals; service animals need to be included in any plan to flee a situation.
- Perpetrators may try to use the animals to control victims because of their dependency on the animals.

Possible safety solutions

- Vibrating pagers or fans can be hooked up to a motion detector or alarm system to quietly signal the victim that the alarm has been set off.
- Service dogs can signal to the victim the presence of someone they know well. In a dangerous situation, they can serve as an excuse to get out of the house for a walk.
- Service dogs can be easily trained by a professional to “smile on command.” Smiling dogs look like they are baring their teeth (e.g., getting ready to attack) and could be used as a deterrent.
- If at all possible, victims should not leave service animals behind if they flee. Safety planning should include identifying alternate care for the service animal if needed, bringing food and supplies for the animal, inclusion of the animal's medical/shot records with other necessary papers, etc.
- If you offer to escort a victim somewhere and your offer is accepted, allow the person to hold your arm and direct them rather than pulling them. Let the person control her movements to the extent possible. Verbally describe the area as you travel through it.

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Speech/Communication

Safety issue

- Victims with communication disabilities may have difficulty conveying their needs for assistance in an emergency situation. (See *Disabilities 101.Tips for Communicating with Persons with Disabilities.*)

Possible safety solutions

- With the victim's permission, identify a person who has information about the victim's personal history and sexual violence chronology and is willing to assist in explaining her situation in a crisis.
- Pre-record a message with pertinent information onto a tape recorder and place it near the phone so it that can be played during a 911 call.
- Activate emergency assistance using alarm buttons and bracelets.

Victims with Mobility Disabilities

Safety issues

- There is a wide range of physical abilities among those who use wheelchairs and other assistive devices. Some people do not use wheelchairs exclusively and may also use canes, leg braces or nothing at all for brief periods of time.
- When giving directions to a person, consider the distance, weather conditions and physical obstacles such as stairs, curbs, steep hills and other possible transportation barriers. (See *Disabilities 101.Tips for Communicating with Persons with Disabilities.*)
- Some folding wheelchairs have arm pieces or leg braces that can be removed and potentially used as a weapon.

Possible safety solutions

- When the victim needs immediate help and must use a phone that is monitored or controlled by the perpetrator, it may be helpful to develop a prearranged code word (e.g., the name of her cat) or pre-designated illness (e.g., she can't talk because of a migraine) that communicates to the provider that the victim is in a crisis situation.
- It is important that people with limited mobility stay as close to a pathway to safety as possible. For example, a victim might sleep on the ground floor of a multi-story residence to make escape easier. A cell phone or alarm system could enable her to immediately call for assistance. Safety items should be within the victim's reach. For example, the front door spy hole (also known as a "peep hole") should be at the eye level of the person who will be using it. Phones could be installed both near the victim's bed and where she is during waking hours.
- Many 911 call centers store information in their database that is instantly available on a computer screen to 911 dispatchers. When a person with a disability calls in an emergency, it is possible to retrieve past information that would assist the law enforcement response. As a safety planning strategy, review with the victim the specific disability-related information that would be helpful to provide to the 911 dispatchers in an emergency situation.

- As a safety planning strategy, people who routinely use personal care attendants can learn techniques for screening them during the hiring process and have emergency replacement caregivers available.
- When strategizing with a victim who has an abusive caregiver, discuss alternatives for the personal care tasks (e.g., cooking, house cleaning, shopping, accompaniments, clerical assistance, lifting and transferring, feeding, bathing, bowel and bladder care, and dressing) for which the caregiver is responsible.

Victims with Hidden Disabilities

Safety issues

- Hidden disabilities in this module refer to those disabilities that may not be easily detected by or apparent to others. This category could include disabilities already mentioned, as well as chronic health conditions that can cause disabilities such as HIV/AIDS, seizure disorders, asthma, diabetes, heart disease and substance abuse.
- Some people with disabilities may have difficulty with breathing. Many different substances may be responsible for the constriction of air passages that is symptomatic of asthma. Stress may also be a factor in causing difficulty with breathing.
- People with diabetes who take insulin may be subject to insulin shock brought on by exercise, stress, an overdose of insulin or too little food. Too much sugar in the blood and not enough insulin may result in a diabetic coma.
- An individual's seizure threshold may be influenced by many factors such as emotional upset, bodily discomfort, stress, hunger, fatigue or changes in medication.

Possible safety solutions

- Discuss with the victim her pattern of stress-related illness and any signals that her symptoms may be increasing. Ask her to identify methods she uses to limit the increase of symptoms in stressful situations. Brainstorm additional options.
- Determine where to get information about specific disabilities.

Victims with Mental Illnesses

(See Sexual Violence 101. Working with Victims with Mental Illnesses, Sexual Violence 101. Understanding and Addressing Emotional Trauma and Disabilities 101. Tips for Communicating with Persons with Disabilities.)

Safety issues

- Mental illnesses typically are recurring, ongoing conditions. Societal discrimination is a barrier to accessing services for victims with mental illnesses.
- People with certain mental health diagnoses may develop patterns of relating to others that make relationships

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difficult to initiate and maintain. Community resources available for these individuals may be significantly less accessible for this reason.

- Dissociated or fragmented thoughts and an inability to process information may affect a victim's ability to recognize and avoid danger, as well as possibly impact her credibility from the perspective of the criminal justice system.
- A high percentage of adults diagnosed with serious mental illnesses have histories of childhood abuse. It can be helpful to provide these individuals with basic information regarding flashbacks and memory triggers to traumatic experiences.
- Abusive caregivers/partners may tamper with victims' medications as a control tactic.

Possible safety solutions

- Regardless of whether a mental illness was present before the onset of the sexual violence, sexual victimization can have many emotional and behavioral effects, leading to a trauma-induced diagnosis or the exacerbation of an existing mental illness. Service providers can stress this fact with victims.
- For victims who are distrustful of service programs, providers can help them build their trust by responding empathically to disclosures of sexual violence and initiating discussions about safety. In turn, victims may be willing to share more information that allows providers to learn about their history of victimization, their individual circumstances, their needs and the accommodations required to access services.
- Part of building trust is letting victims know early in your interactions with them the limitations of your services (e.g., your agency provides crisis intervention and support, but not counseling) and the scope of confidentiality your program can maintain (e.g., that you are a mandatory reporter as per state law and 911 will be called in the case of imminent danger). (See *Sexual Violence 101. Mandatory Reporting* and *Sexual Violence 101. Confidentiality*.)
- Collaborate with other local community providers (e.g., a mental health practitioner who understands both sexual violence and disability issues) to brainstorm how to best assist victims in specific cases as needed. Also, offer to connect victims with these providers to expand the resources available to them.
- Many individuals are able to identify their memory triggers and are able and willing to both plan to avoid these situations, as well as to learn how to deal with the flashbacks.
- Support victims by developing creative ways for them to provide personal information and history in a crisis. It is sometimes helpful to identify a person or a system that has information about a victim's personal history and sexual violence chronology and is willing to assist in explaining her situation in a crisis.



Test Your Knowledge

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

1. How can safety planning help victims increase their safety and well-being? See pages B10.2–B10.3.
2. What steps can service providers take to aid sexual violence victims in crisis in planning for their safety and well-being? See pages B10.4–B10.5.
3. What steps can service providers take to assist victims in planning for their safety when there is time to prepare? See pages B10.5–B10.9.
4. What are examples of specific issues that victims with disabilities face in safety planning, as well as potential safety solutions? Please describe for victims with cognitive disabilities, sensory disabilities (hearing, vision and speech), mobility disabilities, hidden disabilities, and mental illnesses. See pages B10.9–B10.14.

Part 2: DISCUSSION

Projected Time for Discussion

2 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their collaborative work with sexual violence victims. The discussion could be incorporated into forums such as agency staff meetings as well as multi-agency meetings or trainings. Anticipated discussion outcomes include an increased understanding of the safety issues faced by sexual violence victims and victims with disabilities, as well as ways to plan to address those issues.

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

Planning

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator. The facilitator should be familiar with safety planning with victims of sexual violence and with victims with disabilities.
- Select a note taker.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion. Each participant should bring to the meeting a copy of their agency's policies, procedures and forms related to safety planning.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, blank attendance sheet, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: (10 minutes)
 - An environment of mutual respect and trust is optimal. Everyone should feel comfortable to express their opinions and feelings on the various topics. There are no right or wrong answers, only different perspectives.

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- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and the expectations for confidentiality in the context of this partnership.

2. **Ask a representative from each partnering agency to share their agency's approach to safety planning with clients and any tools they use** to facilitate this process.

Then, ask participants to discuss the following questions in a large group: (25 minutes)

- a. Are the approaches to safety planning that their agencies use narrower, as broad as or broader than the approaches discussed in the *Part I: Core Knowledge*? Explain.
- b. Do the approaches to safety planning that their agencies use allow for individualized planning and flexibility?²⁴ Explain.
- c. What different issues have agencies addressed when safety planning with clients? For example, abuse by caregivers and victims' concerns about long-term care placement.

3. **Ask participants to read over the following two scenarios and then discuss the questions for each in a large group.** (60 minutes)

Scenario 1

Jessica, a 19-year-old college student, was recently sexually assaulted by another student who is in several of her classes. She calls your agency in crisis and explains that she fears intimidation by the perpetrator and his friends, getting a sexually transmitted infection and becoming pregnant. She is afraid that she will not be able to quickly flee the perpetrator or his friends if he comes after her, due to a vision disability and difficulty walking. She reveals that she has been contemplating suicide due to the intense shame and self-blame she is feeling. She also fears that her parents, who are overprotective to begin with, will want her to quit school and come home so "they can take care of her." She feels that by going home, she will lose her independence after struggling for so long to gain it.

Scenario 1 questions to consider:

- a. What steps can your agency take to respond to the crisis that Jessica is facing and help facilitate her immediate safety?
- b. Jessica follows up the next day, as requested, to let your agency know she is safe. What steps can your agency take at this point to help Jessica develop a longer-term plan for safety?
- c. What other agencies may be able to provide information or assistance to Jessica to help enhance her safety, health and well-being and/or provide accommodations? What steps can your agency suggest to Jessica to connect her with these resources?

Scenario 2

Hank is a 35 year-old man with moderate autism who lives in a residential facility (a group home). Tom, a new staff person at the group home, takes Hank to a physician's office for his annual physical exam. When helping Hank change into a patient dressing gown, Tom fondles Hank's genitals and buttocks and then tells Hank to lay down on the exam table to wait for the doctor. Hank does what Tom says and is too afraid to say anything about the sexual contact. Back at the group home, Hank avoids Tom as much as possible. Hank's brother, who is Hank's guardian, visits a few days later. He notices that Hank is acting more nervous and withdrawn than usual, especially when Tom is around (Tom is the staff person on

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duty during his visit). The brother asks Hank what is going on. Hank just keeps repeating “Tom is a pervert” and says that he doesn’t want to be around him. The brother isn’t sure what to do; he calls your agency for guidance.

Scenario 2 questions to consider:

- a. What steps can your agency take to respond to the brother and help facilitate Hank’s immediate safety?
 - b. Subsequently, what steps can your agency take to help Hank develop a longer-term plan for safety? How can the brother fit into the plan?
 - c. What other agencies may be able to provide information or assistance to Hank to help enhance his safety and well-being and/or provide accommodations?
 - d. What steps can the service provider from your agency suggest to Hank and his brother to connect them with these resources?
4. **As a large group, ask participants to discuss the following questions:**²⁵ (15 minutes)
- a. How do you support clients in making their own choices about safety, even if risk is involved, and balance that with your concerns for their safety? (See *Disabilities 101. Self-Advocacy and Victims with Disabilities.*)
 - b. What are ways service providers exclude victims from their own safety planning? How can agencies strengthen victims’ voices in this process?
5. **Closing.** Ask each participant to write down how the information gained from this discussion will promote change in their agency’s policies, practices or training programs and their next steps in the process of initiating that change. Then facilitate a large group discussion on this topic. (15 minutes)

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

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

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

²Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User’s Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

³Victim Rights Law Center, *Beyond the criminal justice system: Using the law to help restore the lives of sexual assault victims. A practical online training module for attorneys and advocates and other professionals* (Boston, MA and Portland, OR, 2009).

⁴Victim Rights Law Center.

⁵Victim Rights Law Center.

⁶Victim Rights Law Center.

⁷A useful resource in considering safety planning for persons with disabilities is Community Living British Columbia, *Addressing personal vulnerability through planning: A guide to identifying and incorporating intentional safeguards when planning with adults with developmental disabilities and their families* (Canada, 2009).

⁸Drawn from Day One: The Sexual Assault and Trauma Resource Center, Rhode Island Coalition Against Domestic Violence and PAL: An Advocacy Organization for Families and People with Disabilities, *Is your agency prepared to ACT? Conversation modules to explore the intersection of violence and disability* (Advocacy Collaboration Training Initiative, 2004), 37-43.

⁹National Clearinghouse on Abuse in Later Life, *Anticipate: Identifying victim strengths and planning for safety concerns*, Trainers Module (Madison, WI: Wisconsin Coalition Against Domestic Violence, 2003), 7-9, through <http://www.ncall.us/docs/>. This and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested that you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

¹⁰Concept for this paragraph drawn from Day One et al., 39.

¹¹Section adapted from C. Hoog, *Model protocol on safety planning for domestic violence victims with disabilities* (Olympia, WA: Washington State Coalition Against Domestic Violence, 2004).

¹²C. Hoog, *Enough and yet not enough: An educational resource manual on domestic violence advocacy for persons with disabilities in Washington state*, 83-90 (Olympia, WA: Washington State Coalition Against Domestic Violence, 2003), <http://www.mincava.umn.edu/documents/wscdv/wscdv.pdf>.

¹³Adapted from Hoog, *Model protocol*; B. Brandl, C. Dyer, C. Heisler, J. Otto, L. Stiegel and R. Thomas, *Elder abuse detection and intervention*, 205-8 (New York: Springer Publishing Company, 2007); and National Clearinghouse on Abuse in Later Life, *Interactive training exercises on domestic abuse in later life, Safety planning: A guide for individuals with physical disabilities, and Safety planning: How you can help (cognitive disabilities)* (Madison, WI: Wisconsin Coalition Against Domestic Violence), all through <http://www.ncall.us/docs/>.

¹⁴Hoog, *Enough and yet not enough*.

¹⁵Paragraph from Hoog, *Model protocol*.

¹⁶Paragraph from Hoog, *Model protocol*.

¹⁷Paragraph from Hoog, *Model protocol*.

¹⁸Paragraph from Hoog, *Model protocol*.

¹⁹Adapted from National Clearinghouse on Abuse in Later Life, *Anticipate; Safety planning: A guide for individuals with physical disabilities and Safety planning: How you can help (cognitive disabilities)*; and Hoog, *Enough and yet not enough*.

²⁰See C. Hughes, *Stop the violence, break the silence training guide: Building bridges between domestic violence and sexual assault agencies, disability service agencies, people with disabilities, family and caregivers*, 72-4 (Austin, TX: Disability Services ASAP of SafePlace, 2005).

²¹With exceptions as noted, this section excerpted and adapted from Day One et al., 37-43. Originally excerpted and adapted from Hoog, *Model protocol*.

²²Disability definitions, http://studentdisability.wayne.edu/handbook/010_disability_definitions_list_6.05.pdf.

²³While persons with profound cognitive disabilities may need considerable assistance with their daily functioning, individuals with less severe cognitive disabilities have greater levels of functioning, perhaps even to the extent that the disability is not discovered or diagnosed. Adapted from WebAIM—Web Accessibility in Mind, *Cognitive disabilities*, <http://www.webaim.org/articles/cognitive/>.

²⁴Question adapted from Day One et al., 40.

²⁵Questions adapted from Day One et al., 39-41.

Sexual Assault Forensic Medical Examination

This module provides basic information on the sexual assault forensic medical examination and related considerations for victims with disabilities.¹

Key Points

Service providers to whom victims first disclose sexual victimization can help facilitate the forensic medical exam process by following the steps below (after addressing victims' immediate needs for medical treatment, crisis intervention and safety planning).

- Explain to victims (and their caregivers/guardians when appropriate) the need for a forensic medical examination to assess medical needs and collect forensic evidence related to a recent sexual assault.
 - Explain what happens during the exam process, keeping in mind the amount of information that victims want/can handle at this time. Inform them that a victim advocate may be available to be with them during the examination and beyond. Inform them of the medical facility options and their options for transportation to a medical facility. If they have a disability, encourage them to let responders know how to best accommodate their needs.
 - Explain how to help preserve bodily evidence until it can be collected (e.g., do not wash, change clothes, urinate, defecate, smoke, drink, eat, brush hair or teeth, or rinse mouth). Explain that in suspected cases of drug/alcohol facilitated sexual assault, their first available urine should be collected and brought to the medical facility if they cannot wait to urinate until arrival at the facility. Explain that since their clothing may be taken as evidence, they may wish to arrange to have a change of clothes at the medical facility. (NOTE: In some facilities replacement clothing may be available.)
 - Explain who pays for the exam. In WV, the state covers the forensic costs if the exam is conducted within 96 hours of the crime. Victims are responsible for any non-forensic treatment costs.
 - Inform victims of their reporting options. They can have the forensic medical exam conducted within 96 hours of the crime even if they have not decided about reporting the sexual assault to law enforcement. There is no statute of limitations on reporting sexual assault. Collected evidence in a non-report will only be stored for up to 18 months.
- Explain that if the sexual assault was not recent, victims can still access medical care, advocacy and other services. They can report the crime to law enforcement and discuss with responders whether evidence might be available to corroborate their account of the sexual assault.
- Give victims the opportunity to discuss their concerns and ask questions about their health, the exam, reporting, advocacy, etc. Help them identify their options for addressing these concerns.
- Respect victims' decisions related to advocacy services, reporting (except if there is a threat of self-harm, harm to others or a mandatory reporting situation), and the forensic medical exam (the exam should never be done against their will). If victims would like to receive support from advocates, report and/or seek protective services from law enforcement or have the exam done, service providers can connect them with the appropriate responders.

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B11. Sexual Assault Forensic Medical Examination

Purpose

This module offers basic information on the sexual assault forensic medical examination and related considerations when victims have disabilities. When victims initially disclose sexual violence to service providers, it is important that providers are able to generally explain the forensic medical exam process. This explanation can help victims make informed decisions related to the exam. Providers can also link victims with first responders to sexual assault, guide them in preserving evidence and obtaining support to minimize retraumatization and begin the healing process.

This module does not go into depth regarding the clinical or forensic aspects of the examination. For further guidance on the discipline-specific and coordinating roles of first responders in West Virginia before, during and after a sexual assault forensic medical exam, see the *West Virginia Protocol for Responding to Sexual Assault*, available through <http://www.fris.org>. Also see *A National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescent*, available through <http://samfe.dna.gov>.²

Objectives

Those completing this module will be able to:

- Describe the purpose of the sexual assault forensic medical examination, what it entails and who conducts it;
- Discuss who may be involved in the immediate response to sexual assault, their respective roles and the importance of a coordinated response to victims;
- Discuss considerations during the examination for victims with disabilities; and
- Answer related questions that often arise, such as whether the exam can be performed if victims are undecided about reporting the crime, which entities cover the cost of the exam and what happens when disclosures are delayed.

CORE KNOWLEDGE

What is the purpose of a sexual assault forensic medical examination?

Following a sexual assault, victims may require medical attention for their injuries and need to address their health concerns. There may be evidence on their bodies that could be collected and information that needs to be gathered about the assault, if the victim is considering reporting the assault to law enforcement. Since the body is the crime scene, evidence is time-sensitive and may only be present until the victim bathes, washes and/or urinates.

The purpose of the sexual assault forensic medical exam is to assess a victim's health care needs and to collect evidence for potential use during case investigation and prosecution.³ An examination by a health care provider is still recommended even if (1) there are no visible injuries as a result of the assault, (2) the victim does not wish to have evidence collected, or (3) the assault was not recent. In these cases, the victim may have injuries that are not apparent or acute or have related health concerns.⁴

What does the forensic medical examination include?

Specifically, the forensic medical exam includes:

- Support and crisis intervention;

- Information gathering from the victim for the forensic medical history;
- An examination/medical assessment;
- Coordination of treatment of injuries;
- Documentation of biological and physical findings;
- Collection of evidence from the victim's body;
- Information, treatment and/or referrals for sexually transmitted infections, pregnancy and other non-acute medical concerns; and
- Follow-up care as needed to facilitate additional healing, treatment or collection of evidence.⁵

How is the forensic medical exam different from a medical exam?

The biggest difference is that a medical exam is solely for health purposes, while a forensic medical exam is geared to address victims' health concerns related to a sexual assault and to collect and preserve forensic evidence. And while most local health providers are able to provide general medical care, not just anyone can conduct a sexual assault forensic medical exam (as explained below). Sexual assault forensic medical examinations in West Virginia are typically performed at hospital emergency departments rather than other health care sites such as a physician's office, a clinic or campus health center.

Who conducts the forensic medical examination?

The examination is conducted by a health care provider, ideally one who has specialized education and clinical experience in the treatment of sexual assault patients and the collection of forensic evidence.^{6,7} As a part of post-exam duties when the criminal justice system is involved, this health care provider (henceforth referred to as an "examiner") may also be called on to interpret, analyze and present exam findings and provide factual and/or expert opinion related to the examination.⁸

Many health facilities use sexual assault nurse examiners (SANEs) to perform these examinations. SANEs are registered nurses with advanced education and clinical preparation in sexual assault forensic medical examinations. Many SANE programs utilize on-call nurses to provide around-the-clock coverage for one or more health facilities. When a victim of sexual assault seeks help at one of these facilities, the on-call SANE is contacted to perform the examination. The SANE typically begins the examination after the victim has been assessed and treated for serious injuries. Experienced SANEs provide compassionate care, expertise in identifying physical trauma and psychological needs, skill in coordinating care and referrals, and knowledge regarding how to document injuries and other forensic evidence. Thorough evidence

Since the mid-1990s, there has been momentum to improve the quality of the sexual assault forensic medical examination and address problems historically associated with it, such as:

- Long waits in hospital emergency departments for victims to receive care;
- Limited services for victims and a lack of coordination among responders;
- Health care personnel who were not proficient in forensic evidence collection and who were reluctant because of the possibility of being subpoenaed to testify; and
- Lack of information for victims on policies regarding payment for the examination, as well as incorrect hospital billings.

Many resources are now available to help communities ensure that the examination is more effective in facilitating victim healing and case investigation. These include guides to creating standardized protocols, evidence collection kits, training programs for examiners, guides to developing sexual assault response teams (SARTs) and materials for victims describing what to expect during the examination.

Contact the West Virginia Foundation for Rape Information and Services (FRIS) at <http://www.fris.org> to learn about related efforts in West Virginia.

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collection and testimony by SANEs have helped prosecutors obtain increased numbers of guilty pleas from offenders and have increased the number of convictions.⁹

What other responders are involved during the forensic medical exam process? What are their roles?

The term “exam process” is used to describe the coordinated intervention among first responders that occurs before, during and after the forensic medical examination.

In addition to the health care providers who conduct the exam, other local professionals can be involved in response to victims during the exam process. (Their roles are briefly summarized in the chart below). Together, they ensure that victims have access to immediate comprehensive care, work to minimize trauma, encourage the use of community resources, and facilitate case investigation (if a report is made)—all of which may lead to charges against suspects and subsequent prosecution.¹⁰ Ensuring that victims are supported, their needs are met, their questions answered and their concerns addressed can facilitate their healing and may increase their level of comfort and involvement with the criminal justice system.

First Responders Commonly Involved in Sexual Assault Cases

Health care providers initially assess patients for acute medical needs and provide stabilization, treatment and/or consultation. Ideally, SANEs perform the forensic medical exam and post-exam activities as discussed above. Depending on victims’ circumstances and needs, other health care personnel may be involved.

Sexual assault victim advocates may be involved in the initial victim contact (via 24-hour hotline or a face-to-face meeting) to offer victim advocacy, support, crisis intervention (in conjunction with the examiner), and information and referrals before, during and after the exam process. They may facilitate transportation for victims to and from the exam site and provide replacement clothing if needed. They often provide comprehensive, longer-term services designed to aid victims in addressing needs related to the assault, including but not limited to emotional support and legal and medical systems’ advocacy. Advocates can assist victims with disabilities in securing any needed accommodations throughout the service delivery system.

Law enforcement (e.g., 911 dispatchers, patrol officers, officers who process crime scene evidence and investigators) respond to initial complaints, work to enhance victims’ safety and arrange for victims’ transportation to and from the exam site as needed. They interview victims. They ensure that forensic evidence is properly stored and transferred to the crime lab. They investigate cases—interview suspects and witnesses, request lab analyses, review medical/lab reports, prepare and execute search warrants, write reports and present cases to prosecutors.

Prosecutors determine if there is sufficient evidence for prosecution and, if so, prosecute the case. They should be available to consult with first responders as needed. Prosecutors make the final determination whether to proceed with a criminal case. Victims still have the option of seeking criminal charges if additional evidence is later uncovered or in pursuing civil legal remedies.

Forensic scientist/crime lab personnel analyze forensic evidence and provide results of the analyses to investigators/prosecutors. They may also testify in court regarding their analyses results.

Additional professionals or agencies may be involved in immediate interventions and service provision, depending on the case, jurisdictional policies and the victims’ needs.

For example, if victims with disabilities lack the capacity to consent, Adult Protective Services (APS) may be involved. If victims reside in a nursing home facility, and the assault occurred there, facility staff and a long-

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term care ombudsman may be involved. If victims require accommodations beyond what the health facility can provide, disability service agencies may be able to assist in securing accommodations. Mental health providers may be involved in the initial response if a psychological evaluation is needed.

Victims who attend institutions of higher education may have the recourse of seeking disciplinary charges. When that happens, members of the campus judiciary board review the case to decide if the institutional code of conduct has been violated and, if so, to determine sanctions. American Indian tribes may have their own codes related to sexual assault and/or processes through which victims can seek remedies, beyond what is available through state or federal prosecution.

Victims may secure civil attorneys to protect their interests, address concerns that affect their everyday lives and long-term well-being, represent them in civil legal matters and ensure their rights are upheld during the criminal justice process. Civil attorneys sometimes are consulted during the examination process.

Responders in the same service area usually have established methods to facilitate coordination among their agencies to immediately respond in sexual assault cases (e.g., for requesting examiners at health facilities, the use of on-site services of advocates, intervention by law enforcement, consultation with prosecution, etc.). If communities have sexual assault response teams (SARTs), the teams facilitate this coordination. (For more on facilitating coordination among agencies, see the modules in *Collaboration 101*.)

FYI Service providers should know how to quickly connect victims with the appropriate responders in their communities, depending on the identified needs. The local rape crisis center is a good place to start to obtain this information. Of course, if there is a risk of imminent danger to victims or others, first call 911 for emergency assistance. The National Sexual Violence Hotline (1-800-656-HOPE) immediately connects callers with an available local rape crisis hotline. Other useful information for first responders to know:

- Is there a local SART? How is its response activated?
- What area health facilities perform sexual assault forensic medical exams? Is there a SANE program that serves the area and these facilities? What happens if victims present at facilities not equipped to do forensic medical exams?
- Can medical facilities accommodate victims with disabilities (specify the type of disability and accommodation needs)? If not, are there other options to accommodate these victims?
- Are advocates available to provide support and accompaniment before, during and after the examination?
- Do local law enforcement agencies have specially trained investigators that handle sexual assault cases? When do they get involved in cases?

Regardless of their roles, the key principles below should underlie intervention by all responders to sexual assault victims (adapted from *A National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescent*):


- Victim safety and well-being are the paramount goals of response. (See *Sexual Violence 101. Safety Planning*.)
- Victims know far more about themselves and their needs than responders.
- Victims have the right to make their own choices and those choices must be respected. To make these choices, they need information about the resources available, their options, and the expected consequences of choosing one option over another. (See *Disabilities 101. Self-Advocacy and Victims with Disabilities*.)

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- All victims deserve a high-quality forensic medical exam and to be treated with respect and compassion.
- The right to confidentiality must be respected unless victims are a danger to themselves or others or in mandatory reporting situations. (See *Sexual Violence 101. Confidentiality* and *Sexual Violence 101. Mandatory Reporting*.)
- Sexual assaults committed by persons known to victims are as serious a crime as those committed by strangers.

What happens during the forensic medical exam process?

The following is a very brief overview of what happens during the exam process (see the resources listed on B11.2 of this module for more detailed information). When explaining this process to victims, provide them with opportunities to ask questions or raise related concerns. Help them identify their options for getting their questions answered and their concerns addressed.

 Responders should follow jurisdictional and agency policies regarding maintaining their own safety and the safety of others during the forensic medical exam process.

Exam Process Components

Initial contact

A victim's point of entry into the service delivery system often is through initial contact with law enforcement, an advocacy agency or other service organization. A victim may also present at a health facility. First responders play a critical role in:

- Assessing and addressing emergency medical assistance, safety and support needs of the victim;
- Explaining to the victim the importance of medical care and evidence collection;
- Coordinating transportation for the victim to the medical facility;
- Explaining to the victim how to preserve bodily evidence until it can be collected at the exam facility (e.g., do not wash, change clothes, urinate, defecate, smoke, drink, eat, brush hair or teeth, or rinse mouth);
- Explaining in the case of a suspected drug/alcohol facilitated sexual assault, that if the victim cannot wait to urinate until arrival at the medical facility, she should collect/bring a sample to the facility (the sooner a urine specimen is obtained after the assault, the greater the chances of detecting substances that are quickly eliminated from the body¹¹); and
- Explaining to the victim that clothing may be taken as evidence—she may wish to arrange to have a change of clothes at the medical facility. (In some facilities replacement clothing may be available.)

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<p>Triage and intake</p>	<p>Health care providers do the following, based on facility and jurisdictional policies:</p> <ul style="list-style-type: none">• Give sexual assault cases priority medical care;• Respond to acute injury, trauma care and safety needs before evidence is collected;• With victim consent, alert other responders of the need for their services—<ul style="list-style-type: none">◦ An examiner to conduct the forensic medical exam;◦ An advocate to provide support, crisis intervention and advocacy;◦ A law enforcement officer to take a report, offer protection and begin the investigation; and• In a mandatory reporting situation, the assault should be reported to APS or Child Protective Services (CPS) and/or law enforcement. However, the examination cannot be done against the patient’s will. It is also the victim’s choice whether she wants advocacy services.
<p>Forensic medical history</p> <p>As outlined in the WV Sex Crime Collection Kit. Medical facilities that conduct these exams must use this kit or one that contains all of the items in this kit. The forensic medical history is different from the investigative interview conducted by law enforcement if there is a report. The investigative interview often occurs at the medical facility at the conclusion of the examination.</p>	<p>The examiner seeks the following information, based on jurisdictional policies:</p> <ul style="list-style-type: none">• Date and time of the assault/examination;• Offender information (if known);• Assault-related history, including possible involvement of drugs/alcohol;• Post-assault activities of the victim;• Pertinent medical history, including, for women, contraceptive/menstruation information and gynecological history; and• Recent consensual sexual activity.
<p>The examination</p> <p>See the WV Sex Crime Collection Kit.</p>	<p>The examiner does the following, based on jurisdictional policies:</p> <ul style="list-style-type: none">• Conducts the general physical exam;• Conducts the anogenital exam; and• Document findings using written notes, anatomical drawings and/or photography as appropriate.

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<p>Evidence collection</p> <p>See the WV Sex Crime Collection Kit. Many variables affect the relevance of certain types of evidence in a particular case, including whether an assault was committed by a stranger, a known offender who claims no sexual contact with the victim, or a known offender who claims the victim consented to the contact. All evidence available is important, not just DNA evidence.</p>	<p>The examiner collects the following, as relevant to each case and based on jurisdictional policies:</p> <ul style="list-style-type: none">• Clothing evidence;• Debris (e.g., dirt, leaves, fibers, hair, fingernail swabs);• Foreign materials and swabs (e.g., bite marks) from the surface of the body;• Hair combings;• Hair reference samples as needed;• Oral and anogenital swabs and smears;• Known blood or saliva sample or buccal swab for DNA analysis and comparison;• Toxicology samples as needed; and• Documentation of evidence as needed.
<p>Related medical concerns</p> <p>While risk of pregnancy, sexually transmitted infection and HIV/AIDs from a sexual assault is low, these are major concerns for victims.</p>	<p>The examiner does the following, based on facility and jurisdictional policies and as relevant to the victim's age and gender:</p> <ul style="list-style-type: none">• Informs the victim of the risk of pregnancy and sexually transmitted infections, testing for HIV/AIDs, and prophylactic steps to avoid pregnancy and infection;• Provides testing/prophylactic care as needed; and• Provides referrals for related follow-up health services.
<p>Discharge and follow-up instructions</p>	<p>The examiner does the following, based on facility and jurisdictional policies:</p> <ul style="list-style-type: none">• Provides the victim with the opportunity/supplies to wash, change clothes (providing replacement clothing if necessary) and get food/beverages;• Informs the victim about post-exam care (information may include referrals to address health needs related to the assault, discharge instructions, follow-up appointments with the examiner or other health providers, and contact procedures for medical follow-up and documentation of developing/healing injuries and resolution of healing); and• Coordinates with advocates, law enforcement and other involved professionals to discuss other issues with the victim, including safety planning, comfort needs, informational needs, the investigative process, advocacy and counseling options and follow-up contact procedures.

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FYI The forensic medical examination is an invasive and personal procedure. The health care professional conducting the exam should ask the victim if she would like to have an advocate with her, whose only role is to provide support and comfort to the victim.¹² Extreme care should be taken to ensure that someone who may be the perpetrator (family member, caregiver, guardian, etc.) is not in the room. Under no circumstances should law enforcement or other first responders be in the examining room and under no circumstances should anyone other than health care personnel take photographs of victims' genital areas.

What can responders do to make the exam process more comfortable for persons with disabilities?¹³

(See *Disabilities 101. Tips for Communicating with Persons with Disabilities*; *Disabilities 101. Accommodating Persons with Disabilities*; *Disabilities 101. Guardianship and Conservatorship*; *Disabilities 101. Working with Victims with Mental Illnesses* and *Disabilities 101. Self-Advocacy and Victims with Disabilities*. Also see *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors*; *Sexual Violence 101. Mandatory Reporting* and *Sexual Violence 101. Safety Planning*.)

- *Understand that victims may have physical, sensory, cognitive, developmental or mental health disabilities or multiple disabilities.* Make every effort to recognize issues that could potentially arise during the exam process for victims with disabilities (both in general and in relation to their specific disability) and provide reasonable accommodations upon request.
- *Be aware that the risk of criminal victimization, including sexual assault, for people with disabilities is much higher than for people without disabilities.* People with disabilities are often victimized repeatedly by the same offender.¹⁴ Caretakers, family members or acquaintances may be responsible for the sexual assault. In such a case, the offender may be the person transporting the victim to the medical facility. Jurisdictional and medical facilities' policies should be in place to provide guidance on how staff should screen for and handle situations that are potentially threatening to patients or facility personnel.
- *Speak directly to victims,* even when interpreters, intermediaries or guardians are present.
- *Respect victims' wishes to have or not have caregivers, family members or friends present during the exam.* Although these individuals may be accustomed to speaking on behalf of persons with disabilities, it is critical that they do not influence victims' statements during the exam process. If aid is required (e.g., from interpreters), do so only with the victims' consent.
- *Follow medical facility and jurisdictional policy for assessing the ability of adults considered by West Virginia law to be "incapacitated" to consent to the examination, evidence collection and involving protective services.* Keep in mind that the inability to consent could be temporary (e.g., due to substance use, a psychotic episode or onset of an illness such as high fever or a stroke) and victims may at some point be able to make their own decisions. Again, note that guardians could be offenders—if sexual violence by a guardian is suspected, protective services needs to be contacted.
- *Assess victims' needs for assistance during the exam process.* Explain the exam procedures to victims and ask what accommodations they require, if any (e.g., people with certain physical disabilities may need help to get on and off the exam table, may need to be positioned differently for the exam, or may need an alternative to the exam table entirely). Do not assume, however, that they will need special assistance. Also, ask for permission before proceeding to help them (or touch them or their service animals or handle their mobility or communication devices).
- *Ask victims to specify their preferred method of communication. Do not make assumptions.* Preferences and capacity can vary widely. For example, not all individuals who are deaf or hard-of-hearing understand sign language or

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can read lips. Not all blind persons can read Braille. Communication equipment that may be beneficial to victims with sensory and communication disabilities include TTY machines, word boards, speech synthesizers, anatomically correct dolls, materials in alternate formats and access to interpreter services. Responders should familiarize themselves with the basics of communicating with individuals using such devices. Some victims with communication disabilities may prefer communicating through an intermediary who is familiar with their speech patterns.

- *Recognize that individuals may have some type of cognitive disability (for example, an intellectual disability, traumatic brain injury, neurodegenerative condition such as Alzheimer's disease, or stroke). Speak to these individuals in a clear and calm voice and ask very specific and concrete questions. Be exact when explaining what will happen during the exam process and why. Be aware that some victims with cognitive disabilities may be easily distracted and have difficulty focusing. To reduce distractions, conduct the exam in an area that has no bright lights or loud noises. It may also be helpful if examiners and others present in the exam room refrain from wearing jewelry or uniforms with ornamental designs.*
- *Recognize that in cases where victims cannot verbalize what happened to them during the assault, evidence collected during the forensic medical exam may be especially crucial to the investigation.*
- *Keep in mind that victims with disabilities may be reluctant to report the crime or consent to the examination for a variety of reasons, including fear of not being believed, fear of getting in trouble and fear of losing their independence. For example, they may need extended treatment for their injuries. The perpetrator may be their caregiver and the only person they rely on for daily living assistance; reporting the assault may force them into a long-term care facility.*
- *Recognize that it may be the first time victims have an anogenital exam. The procedure should be explained in detail in language they can understand.¹⁵ They may have limited knowledge of reproductive health issues and not be able to describe what happened to them during the sexual assault. They may not know how they feel about the incident or even identify that a crime was committed against them.*
- *Some victims with disabilities may want to talk about their perceptions of the role their disability might have played in making them vulnerable to an assault. Listen to their concerns and what the experience was like for them.¹⁶ Assure them that the assault was not their fault. If needed, encourage discussion in a counseling setting on this issue, as well as on what might help them feel safer in the future.*
- *Recognize that the examination may take longer to perform with victims with certain types of disabilities. Examiners should avoid rushing through the examination—such action not only may distress victims, it can lead to missed evidence and information.*

How long after an assault can the forensic medical exam be conducted and evidence collected?

FYI In general, the West Virginia State Police Forensic Lab indicates that 96 hours post-assault is the outside limit for conducting a forensic medical examination using the state Sex Crime Collection Kit.

Prompt examination following a sexual assault helps to quickly identify victims' medical needs and concerns. Evidence can be lost from the body and clothing through washing hands, bathing, brushing teeth, urinating, etc. Therefore the less time between the assault and the forensic medical exam, the more likely that evidence may be collected. With that said, however, *recognize that evidence may be found on victims' bodies even in cases where the disclosure of a recent sexual assault is delayed.* For example, signs of bruising or vaginal/anal tearing might be present past the 96-hour suggested evidence collection time period. Even when delayed disclosures are made, first responders may encourage victims to seek forensic medical care in some situations. Examiners can obtain

the forensic medical history, examine victims and document findings if victims are willing and evidence is potentially present. The history and documentation of exam findings can aid examiners in addressing any related medical issues and determining if and where there may be evidence to collect. Law enforcement can also interview victims to get an account of the assault, identify potential suspects and witnesses and find out if other evidence might be available (at the crime scene, suspect's home, victim's home, in a vehicle, etc.).

What if a victim is undecided about whether she wants to report the sexual assault? Should she still have forensic evidence collected?

Adult victims of a recent sexual assault can have the forensic medical exam conducted within 96 hours of the assault, whether or not they choose to report to law enforcement. If victims are children or are adults considered by West Virginia law to be “incapacitated,” these crimes will be reported to the West Virginia Department of Health and Human Resources and law enforcement by health care providers. (See *Sexual Violence 101. Mandatory Reporting.*) Kits collected as part of investigations will be sent to the West Virginia State Police Forensic Lab for processing. Kits collected as non-reports are sent to Marshall University Forensic Science Center, where the collected evidence can be stored for up to 18 months, allowing the victim time to make a decision regarding reporting the sexual violence. Should the decision be made to initiate an investigation in a non-reported case, the kit can be retrieved at any time within the 18 months by contacting law enforcement and providing the kit tracking number. There is no statute of limitations on reporting a sexual assault in West Virginia, but there is an 18 month limit on the storage of the Sex Crime Collection Kits.

Who pays for the forensic medical examination?

Victims are often concerned about how the costs of the examination will be covered. The West Virginia Forensic Medical Examination Fund was established by the state legislature (*WVC§61-8B-16*) to pay for “all reasonable and customary costs of a forensic medical examination.” For the medical facility and examiner to be paid for through this fund, the exam must be done within 96 hours of the assault. No payment from the fund is provided for non-forensic procedures or treatment—therefore, victims will most likely be responsible for any medical treatment, either through private pay or private insurance. Victims who report the assault to law enforcement within 72 hours (unless just cause exists) can apply to the West Virginia Crime Victims Compensation Fund for reimbursement of out-of-pocket medical costs. Rape crisis center advocates can assist victims in applying for these funds. (See *Sexual Violence 101. West Virginia Crime Victims Compensation Fund.*)

What are victims' options if the sexual assault was not recent?

Service providers should always validate victims' decisions to seek help to heal regardless of when they disclose sexual violence—whether it is hours, days, months, years or even decades later. If the sexual assault was not recent, victims can still access medical care, advocacy and other services to help them recover. They can report the crime to law enforcement. They can discuss with service providers the possibility of other existing evidence that could corroborate their account of the sexual assault.



Test Your Knowledge

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

1. What is a forensic medical exam? See page B11.2.
2. How does a forensic medical exam differ from a medical exam? See page B11.3.
3. Where does a forensic medical exam typically take place? See page B11.3.

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4. Who conducts a forensic medical exam? See page B11.3.
5. What is a SANE? See page B11.3.
6. What other responders are involved in the forensic medical exam process? What are their roles? See pages B11.4–B11.5.
7. How would you briefly describe components of the forensic medical exam to a victim? See pages B11.6–B11.8.
8. What can responders do to make the forensic medical exam more comfortable for victims with disabilities? See pages B11.9–B11.10.
9. How long after a sexual assault can a forensic medical exam be done? See pages B11.10–B11.11.
10. If victims wish to have the forensic medical exam done but are undecided about reporting to law enforcement, what is the process for storing the kits? See page B11.11.

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

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

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

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

³U.S. Department of Justice, *A national protocol for sexual assault medical forensic examination, adult/adolescent* (Washington, D.C., 2004), 30-2, through <http://samfe.dna.gov>.

⁴The list of problems cited in the text box on this page is from K. Littel, *Implementing SANE programs in rural communities: The West Virginia regional mobile SANE project*, OVC E-Bulletin (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, 2008), http://www.ovc.gov/publications/infores/WVA_Mobile_SANE_guide/welcome.html. Originally drawn from R. Campbell, *The effectiveness of SANE programs*, VAWnet Applied Research Forum (National Online Resource Center on Violence Against Women, 2004), 1; and K. Littel, *SANE programs: Improving the community response to sexual assault victims*, OVC Bulletin (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, 2001), 1–2.

⁵Drawn from U.S. Department of Justice, *A national protocol*, 13.

⁶Drawn from U.S. Department of Justice, *A national protocol*, 24.

⁷Examples of terms used to describe medical professionals who are specially trained and clinically prepared to perform forensic medical examinations include sexual assault nurse examiner (SANE), forensic nurse examiner (FNE), sexual assault forensic examiner (SAFE) and sexual assault examiner (SAE). Drawn from U.S. Department of Justice, *A national protocol*, 53.

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⁸Drawn from U.S. Department of Justice, *A national protocol*, 24.

⁹Paragraph from Littel, *Implementing SANE programs in rural communities: The West Virginia regional mobile SANE project*. Originally drawn in part from N. Hoffman & D. Lopez-Bonasso, *West Virginia goes SANE* (unpublished article).

¹⁰Adapted from U.S. Department of Justice, *A national protocol*, 23.

¹¹Drawn from U.S. Department of Justice, *A national protocol*, 103. As cited in M. LeBeau, *Toxicological investigations of drug-facilitated sexual assaults*, *Forensic Science Communication* (1999), 3.

¹²Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

¹³Bullets drawn from U.S. Department of Justice, *A national protocol*, 30-2.

¹⁴The first two sentences in this paragraph were drawn from the Office for Victims of Crime, *First response to victims of crime who have a disability* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, 2002), 1.

¹⁵Drawn from A. Conrad, *SANE/SAFE organizing manual* (Albany, NY: New York State Coalition Against Sexual Assault, 1998), 7.

¹⁶Drawn from L. Ledray, *SANE development and operation guide* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, 1998), 82–5.