

2010

Creating Access

Supporting Survivors of Sexual Assault with Disabilities

*A special information packet
produced by*



CALCASA
CALIFORNIA COALITION
AGAINST SEXUAL ASSAULT

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Preface

Creating Access: Supporting Survivors of Sexual Assault with Disabilities is part of a series of information packets produced by the California Coalition Against Sexual Assault (CALCASA). These information packets were first published in 2001, but have been recently updated to reflect changes that have occurred in the sexual assault intervention and prevention field and in our general society.

CALCASA is a statewide association, based in Sacramento, CA, that provides leadership, vision, and resources to rape crisis centers, individuals, and other entities committed to ending sexual violence. Founded in 1980, CALCASA is the only statewide organization in California whose sole purpose is to promote advocacy, training, public policy and technical assistance on the issue of sexual assault and rape. For more information, please visit CALCASA's website at www.calcasa.org or call (916) 446-2520 or email at info@calcasa.org.

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Introduction

All of us, whether advocates, survivors or both, possess multiple, *intersecting* identities; none of us is fully identified or definable as a member of one group only, whether targeted or privileged. Persons living with disabilities often face being defined and labeled by their perceived disability, rather than being seen as a whole person. In order to provide equitable and helpful services to survivors living with disabilities, we must explore the ways that ableism impacts our rape crisis centers, our communities, and the services and response to survivors living with disabilities.

With the oppression of persons living with disabilities a real factor in American life, how does this fact affect or impact a survivor of sexual violence seeking help in our agencies? And how might your own multiple identities affect your interactions with a survivor? This packet can be used in exploring these questions and in giving some basic information on many of the types of disabilities people live with in your community. This chapter may also be used as an addendum to board, volunteer and staff training that is ongoing within your rape crisis center. It discusses many of the dynamics of sexual violence against persons living with disabilities, some of which are unique to this group, but many which will be recognizable to rape crisis center staff as the dynamics they see every day among the generic population of survivors.

A common tactic of oppression is seeing an entire targeted group, often made up of many diverse individuals with very different lived experiences as a monolithic group (i.e. people of color, immigrants, “non-Christians”). In this chapter, we will seek to shed light on the ways that ableism impacts our services (or lack thereof) to survivors living with disabilities, rather than defining (and thus stereotyping) an entire group of people. While physical accessibility at your facility may ensure that clients with varied abilities can access your services, attitudinal and cultural accessibility will ensure that the services are sensitive and knowledgeable. The information in this chapter, along with genuine commitment of resources and energy and dedication to personal, agency and community anti-oppression work, can assist centers in their goal of bringing about change in their communities and transforming the systems that are responsible for equitable services to survivors living with disabilities.

Legal Rights for Americans with Disabilities

A very recent civil rights victory in this country was the passing of the Americans with Disabilities Act in 1990. This legislation ban discrimination based on disability and guarantees equal opportunity for individuals living with disabilities. This law, effective in January of 1992, bans discrimination in things such as transportation, building access, housing, jobs and services. The ADA defines disability in three ways:

1. “A physical or mental impairment that substantially limits one of more of the major life activities of such an individual;
2. A record of such an impairment; or
3. Being regarded as having such an impairment”.¹

Historically, there have been definitions and understandings of disability that regarded disability as a sickness to be cured by the medical profession (Medical Model) or an impairment or deficiency to be fixed by the helping professional (Rehabilitative Model). These stereotypical views led to many of the oppressive attitudes, policies and lack of civil rights for people living with disabilities. The ADA definition reflects the hard work of disability advocates and allies to change attitudes and language to a social definition and understanding of disability. In the Disability or Social Model, “the problem is defined as a dominating attitude by professionals and others, inadequate support services when

¹ Mastroleo, Cerna, “Persons with Disabilities and Sexual Assault”, 2010. Disability Services, A Safety Awareness Program. Safe Place in Austin, Texas.

compared with society generally, as well as attitudinal, architectural, sensory, cognitive, and economic barriers, and the strong tendency for people to generalize about all persons with disabilities overlooking the large variations within the disability community."² This Social Model reflects an anti-oppression stance that points to *the barriers* as the problem. The nature of disability discrimination is that it often has very little to do with the individual's capabilities and true characteristics. The stigma and stereotypes are the cause of the discrimination, much more than the disability itself. This model argues that the disability per se is not the cause at all, that the *social reaction* to disability is the cause of oppression.³ As advocates, we are responsible for how our reaction (or lack of response) to survivors living with disabilities helps or hinders that individual in the aftermath of sexual violence.

The Intersections of Ableism and Other Oppressions

One of the shortcomings of the early feminist movement in America was that its agenda was not always inclusive of diverse groups of women. Just as the experiences, needs and voices of many women of color were excluded from the mainstream feminist agenda, so too, were women living with disabilities. With approximately 20% of the U.S. population living with some form of disability, we must ask ourselves why our centers serve so few survivors living with various disabilities. How many staff, administrators, volunteers or board members identify as people with disabilities? What disability providers, advocates and activists do you regularly collaborate with for outreach and community events? In order to dismantle ableism in our centers and community, we must ask these difficult questions. How far have we really come as a movement?

Much of the problem has come from a lack of physical and attitudinal accessibility to conferences, meetings, consciousness raising sessions and even our agencies. Without the ability to access such forums, women (and now men) living with disabilities have had difficulty sharing their experiences with the anti-sexual violence movement. Many publications of feminist scholarship and agency brochures, information and forms are not accessible to women with disabilities since they are only available in limited formats (not in Braille, not recorded, etc.)

Still today, most services for sexual assault and services for persons living with disabilities operate in silos, completely separate, with little or no communication. A combination of the civil rights and feminist movements was instrumental in building our current anti-violence against women movement and our rape crisis centers. There is still tremendous work to be done to end all forms of oppression within the movement that still privileges the voices and experiences of generic persons without disabilities and often fails to accommodate survivors living with disabilities. This compartmentalization of services goes against the revolutionary intent of inclusion that began the movement.

In addition, much research on disabilities has excluded the concept of gender and treated disability as a universal concept, without recognizing sexism⁴. Even as awareness of the biases facing persons with disabilities grew, this understanding tended to be based on a male perspective. It is also necessary to remember that survivors living with disabilities are members of other groups that face oppression and those that are bestowed privilege. Therefore, survivors with disabilities who are also women of color or who are from a working class background, for example, face multiple layers of oppression. Although a white, male survivor living with an intellectual disability may receive more attention as a result of male or white privilege—that attention from authorities or helping professionals may come in the form of pity and infantilization due to his perceived ability. It is important to consider the impact of these various types of oppression and privilege on the lives of survivors of sexual violence and the healing process after the abuse. Living at the intersection of multiple identities is often overlooked for persons living with disabilities. Rape crisis center advocates will need to be familiar with the specific ways that survivors with disabilities are groomed and targeted by

² Kaplan, Deborah. "The Definition of Disability". Director of the World Institute on Disability. The Center for an Accessible Society. www.accessiblesociety.org.

³ Ibid.

⁴ The Center on Human Policy. June 1997. "Women with Disabilities: Issues, Resources, Connections Revised" Syracuse University, p. 1.

perpetrators of violence and how this affects disclosure, reporting and the healing process. Despite the fact that many people living with disabilities face multiple types of oppression, they have continued to challenge these barriers and make both the feminist movement and the disability rights movement more aware of their needs and the equitable services they deserve.

Prevalence of Sexual Violence and Abuse of Persons with Disabilities

Rape crisis centers in California provide services to a diverse community of sexual violence survivors, including persons with disabilities. In fact, persons with disabilities are one of the largest minority groups in the United States. Estimates of the population of Americans with disabilities range from 39.1 million⁵ to 54 million⁶ depending on the way disability is measured or defined. Research studies show that persons with disabilities are at greater risk of sexual abuse or assault than generic persons without disabilities. Persons living with disabilities are raped and abused at a rate at least twice, and as great as ten times the rate of the general population.⁷ Men with disabilities are sexually assaulted at rates even higher than those of the generic population of men⁸. The additional barriers faced by male survivors of sexual assault living with disabilities create an even more alarming gap between the number of men who are assaulted and those who receive services.

Many of the disabilities people experience may have been caused by violence earlier in a person's life or development. Any type of violence that results in limiting one or more of the life functions of the victim is defined as a violence-induced disability. Although their origins are often difficult to determine, Sobsey estimates that in 10 to 25% of intellectual disabilities, violence is a significant causal factor⁹. One example of violence-induced disabilities is Traumatic Brain Injury (TBI). TBI may be caused by non-violent accidents such as a fall or car accident or may be incurred at the hands of abusers or violent perpetrators. Whether parents, partners, acquaintances or strangers, many perpetrators injure their victims so severely that permanent disability results. The exact number of people with violence-induced traumatic brain injuries remains unknown because many people are so severely disabled that they cannot communicate to investigators the violent act that led to the disability. Once a person has acquired a TBI, they are at a much higher risk for future abuse, including sexual violence.

In many cases, the person who inflicted the disability-causing injury may continue to be the primary caregiver of the individual. Caregivers and other acquaintances are often the perpetrators of sexual violence against persons with disabilities. As with sexual violence in the general population, sexual assault against persons with disabilities is often committed by someone the survivor knows, likes or loves. One study showed that 97% to 99% of abusers are known and trusted by the victim¹⁰. According to another study regarding the sexual abuse of people with disabilities, the victims knew the perpetrator in 92% of the cases. Most included family members, other people with disabilities and health care providers¹¹. The same study showed that 79.6% of people with disabilities were sexually assaulted on more than one occasion. 50% of those experienced more than 10 victimizations¹². These staggering statistics points out the extremely low reporting and disclosure rates for survivors with disabilities—or we would be serving far more survivors with disabilities in our centers. Ableism in our society and prejudice toward survivors as they come forward, as well as the high rate of caregiver

⁵ Kaye HS. (1997) *Disability Watch: The Status of People with Disabilities in the United States*. A Report by Disability Rights Advocates, Inc. Volcano Press, Inc., Volcano, CA. p. 11.

⁶ VSAarts (1999) *Access and Opportunities: A Guide to Disability Awareness*. Exclusively available online at www.vsarts.org/text/bestpractices/dag/index.html.

⁷ Sobsey, D., *Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance?* Baltimore, MD: Paul H. Brookes Publishing Co., Inc. 1994

⁸ Sobsey, D. (1994) *Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance?* Paul H. Brookes Publishing Co., Baltimore, MD. p. 70.

⁹ Sobsey, D. (1994) *Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance?* Paul H. Brookes Publishing Co., Baltimore, MD, p. 27.

¹⁰ Baladerian, N. (1991). "Sexual abuse of people with developmental disabilities." *Sexuality and Disability*, 9 (4), 323-335.

¹¹ Sobsey, D. & Doe, T. (1991) "Patterns of Sexual Abuse and Assault." *Sexuality and Disability*, 9 (3), 243-259.

¹² Sobsey, D. & Doe, T. (1991) "Patterns of Sexual Abuse and Assault." *Sexuality and Disability*, 9 (3), 243-259.

abuse contribute to the very high risk of experiencing sexual violence for people living with disabilities. Why is the risk so high? (Remember: Being at risk does NOT cause sexual violence. Being *vulnerable* is not equal to being culpable.)

Possible reasons:

- Not believed/not seen as accurate historians
- Often live/spend time in controlled environments, such as day treatment programs, group homes, institutions, or continue to live with family as adults
- These programs often operate on a “token economy”—which rewards compliance and can take away basic freedoms for non-compliance
- Might be over or under medicated
- Often have caretakers that perform personal hygiene duties such as bathing, toileting, and clothing
- Might be dependent on caretaker for medical needs, medication, transportation, or other necessities
- Caregivers are often underpaid, lack training, and do not stay in these positions long term—therefore, there are few thorough background checks. Perpetrators seek out these positions to have contact with potential victims. Other employees may think “no one would want to rape these people” or be afraid of losing a job if they report
- Myths and ableism contribute to the belief that no one would want a person with a disability sexually/ that they are not sexually attractive
- Cannot physically get away/call for help
- Will lose privileges at a group home, institution, family home or hospital if they tell about abuse
- Often receive no sex education, or are seen as asexual which creates more vulnerability to perpetrators’ tactics, deception and misinformation
- Taught to be compliant
- Taught to hug others, even strangers—not taught to have independent boundaries or to assert them
- Infantilized, not given independent choices
- Confusion interferes with disclosure because forced or coerced sexual contact may create pleasurable physical sensations or constitute some form of attention
- Not seen as a good witness
- Myth that they are often perpetrators, or always act out in inappropriate sexual ways
- Many see it as a compliment for a person living with a disability (especially a female) to date a generic, non-disabled person¹³

The Dynamics of Ableism and Sexual Violence

Sexual violence against persons living with disabilities is a crime with its own particular dynamics that shape and inform the survivor’s response to the sexual violence and profoundly influence the lives of survivors. The following dynamics of sexual assault against persons living with disabilities may affect both male and female survivors. Although we’ve tried to provide rape crisis centers with issues that affect survivors with disabilities, it is still necessary to avoid assumptions and be prepared to listen to each individual’s unique experience.

Victim Blaming

Any discussion of the dynamics of sexual violence against persons living with disabilities must first eliminate any notion that survivors are to blame for the violence. As with any survivor of sexual

¹³ Preston, Tiombe. (2009) “Serving Survivors with Disabilities”, SART Conference Presentation Handout. Originally published in Sexual Assault Crisis Agency, Volunteer Manual.

violence, the responsibility for the assault rests solely on the perpetrator. The actions or identity of a survivor never “bring on” the violence. We know that perpetrators of sexual violence are well aware of how society perceives people living with disabilities. This leads many perpetrators to specifically target individuals that they think may be less likely to report or whom society may be less likely to believe. In working with survivors living with disabilities, advocates and counselors must understand that survivors are the experts on their own experiences. The experience of being targeted, the perpetrator’s assumptions about the abilities of the survivor and reclaiming positive identity may need to be explored to decrease self-blame in the survivor. Understanding the power dynamics and manipulation often used in sexual violence against survivors with disabilities will facilitate authentic and accurate support of the survivor. We should never expect the survivor to educate a generic advocate about this.

Caregiver Abuse

The very people entrusted with providing assistance for persons living with disabilities are often the perpetrators of sexual violence against them. When the relationship is also one of a primary caregiver, survivors of sexual violence living with disabilities may be less willing to get help or to identify the relationship as abusive. Caregivers may be family members in the home, employees of residential care facilities, hospitals, institutions or other persons who have a responsibility to provide essential services. The need for assistance varies widely and not all persons living with disabilities need or want caregiver assistance in daily living.

For some survivors, the assistance of a caregiver or assistant may be necessary to accommodate daily living. For some, a caregiver may be responsible for functions such as cooking, bathing, or medical treatment. For others, a partner and/or caregiver may have complete control over one’s finances. Of course, those who provide assistance may also be family members that provide a sense of belonging, love or support to the individual they assist. This relationship may make a survivor less willing to seek help from a rape crisis center, law enforcement or protective services agency. It is also important to address how the victim will remain safe from the caregiver after a report is made.

Advocates will need to be prepared by being well versed in the options that exist for survivors living with disabilities, especially in the event that the perpetrator is also a caregiver. Sexual violence is a crime and may be reported to law enforcement as such, particularly when the victim is in imminent danger of repeated abuse. As in cases of child abuse, mandated reporters must report all cases of suspected abuse of dependent adults to adult protective service agencies.

Adult Protective Services investigates reports of abuse of dependent adults, including physical abuse, sexual abuse, neglect, abandonment, isolation, mental suffering, abduction, financial abuse, or the deprivation by a care custodian of necessary care, goods, or services¹⁴. Rape crisis centers can contact their local Adult Protective Services agency to inquire how they can access their services, to cross-train together and collaborate on outreach and prevention efforts.

The Office of Long-Term Care Ombudsmen is an agency responsible for providing facility oversight, patient advocacy, and investigation of allegations of abuse in long-term care facilities. Regional centers and other service providers may be able to assist with finding new placements or housing for survivors that need to find a safer place to live. *(Please refer to Appendix B for resources and information on how to locate the nearest Office of the Long-Term Care Ombudsmen and Regional Centers)*. These agencies may also provide assistance in appointing guardians to ensure financial and medical decisions are made with the best interest of the individual survivor.

¹⁴ “Technical Assistance Manual for Mandated Reporting of Suspected Crimes Against Victims with Disabilities”. Easter Seals of Superior California, 2000. p. 9.

Isolation

Although advocacy and “mainstreaming” movements are changing this, often persons living with disabilities have been kept separate from the community in which they live. Many persons with intellectual disabilities and mental illness or psychiatric disabilities among others, have been and continue to be institutionalized. Separate schools, classes and programs have long separated students with special needs from their peers. Attitudes of discomfort and discrimination have discouraged the full integration of persons living with disabilities into the community even when they are mainstreamed in schools or live independently in the community. Lack of physical accessibility has also been a major obstacle for persons living with disabilities in participating in the wider community and utilizing public services and spaces.

All of these factors can combine to create a profound sense of isolation and silences the voices of persons living with disabilities. As with sexual violence, silence may create a feeling that society in general does not care about addressing the needs of persons living with disabilities, or issues of sexual violence in particular. This dynamic is important one to consider when working with survivors, as it may affect the response to the trauma.

Perpetrators of sexual violence often seek out persons who are socially isolated or otherwise marginalized. Even when sexual violence against a person with a disability is reported, this isolation often means that the survivor does not receive support and services. Survivors may be unaware of what services are available and outreach methods for mainstream communities at rape crisis centers often fail to reach persons living with disabilities.

It becomes clear that rape crisis centers have an important role to play in this cycle of isolation and violence. With accessible support and services, survivors have an opportunity to heal from the assault through counseling, advocacy, and prevention education.

Attitudinal Barriers and Attitudinal Accessibility

Many prejudices and stereotypes exist about people living with disabilities. These beliefs are at the root of discrimination and ableism. If our rape crisis centers are committed to providing inclusive and equitable services to ALL survivors of sexual violence, then we must learn to be attitudinally accessible. Attitudinal accessibility is defined as “refusing to accept prejudice, myths and stereotypes about people with disabilities, and identifying and removing any negative attitudes about the capability of people with disabilities.”¹⁵ Some of the attitudinal barriers include treating persons with disabilities (even teens and adults) as if childlike, immature or otherwise incapable of making decisions for themselves, speaking louder or more slowly to a person, regardless of the type of disability, or addressing a caregiver or interpreter rather than the survivor. These attitudes and behaviors rob survivors of dignity, autonomy and independence.

Cultural accessibility also implies using knowledge of oppression to create a place where persons with disabilities feel comfortable and confident in coming to receive services. One way to develop cultural accessibility at rape crisis centers is to learn about the history of the disabilities rights movement. Understanding the themes of oppression, paternalism, institutionalization, sterilization and resistance throughout history is important because these realities may affect the way survivors living with disabilities heal from the experiences of violation.

Generic persons without disabilities often take these things for granted, quick to demand respect of their privacy or personal power and space. Yet for persons with disabilities, these rights are often violated or go unrecognized. The right to make one’s own decisions, be seen as a whole human

¹⁵ Definition adapted from ARCH: A Legal Resource Centre for Person with Disabilities, Toronto, Ontario, Canada

being is a basic human right; a right which the feminist movement has championed for women throughout its existence. Rape crisis centers are uniquely prepared to provide advocacy to survivors of sexual violence living with disabilities. The concept of advocacy for survivors of sexual assault parallels that of self-advocacy and independence for people living with disabilities. Both seek to allow individuals to make important decisions affecting their lives with the best possible knowledge of available options and information in spaces that honor and reflect their realities.

Sexuality

Attitudes about the sexuality of persons with disabilities parallel those that existed about the sexuality of women before the feminist movement challenged such beliefs. Women were not routinely educated about their bodies or their right to sexual freedom and self-determination - this type of oppression has also affected the sexual lives of persons living with disabilities.

Refusal to acknowledge normal and healthy sexual lives of persons with disabilities has led to a lack of sexual experience, reproductive and health education opportunities that are accessible in the community. For example, many advocates and centers attempting to provide equitable sexual assault prevention and education meet with barriers in the schools or community because service providers and educators believe persons living with disabilities “don’t need that information”.

The belief that persons with disabilities are asexual has also led some to deny that they can be sexually assaulted at all. Of course, this idea is based on the belief that one has to be “sexual” in order to be sexually assaulted. As rape crisis centers know, sexual assault is a crime of power and control that can happen to anyone, regardless of their perceived sexuality or asexuality. Such attitudes that persons with disabilities cannot be sexually assaulted may exist at various community organizations or reporting agencies so that when survivors of sexual assault with disabilities do make reports, they are not believed.

As a result of being denied access to sexual health education, persons with disabilities may have difficulty recognizing sexual assault as a crime, since they may have never been taught the names of body parts or what constitutes a healthy, consensual sexual relationship. Without such knowledge, it may be difficult to recognize sexual abuse, especially if committed by a family member or other acquaintance.

Providing *accurate* information about sexual violence is of critical importance for rape crisis centers, which have been at the center of providing education to our communities from our earliest activism. Advocates seeking to end sexual violence of all kinds must break the silence and debunk myths that continue to jeopardize those at most risk for sexual violence.

The Power and Control Wheel: A Tool for Recognizing Abuse of Persons with Disabilities

On the following page is a version of a “power and control wheel,” adapted with permission from the Domestic Violence and Developmental Disabilities Committee of the Wisconsin Coalition Against Domestic Violence and Wisconsin Council on Developmental Disabilities. Based on a wheel developed in Duluth, Minnesota by formerly battered women to describe their experiences, the wheel shown here illustrates forms of abuse experienced by persons abused by caregivers. It offers a way to think more broadly about abuse than physical or sexual violence.

A. Coercion & Threat: Threatening to hurt the person, withhold basic support and rights, terminate relationship and leave the person unattended, report noncompliance with the program, use more intrusive equipment. • Using consequences and punishments to gain compliant behavior. • Pressuring the person to engage in fraud or other crimes.

B. Intimidation: Raising a hand or using other looks, actions, gestures to create fear. • Destroying property and abusing pets. • Mistreating service animals. • Displaying weapons.

C. Caregiver Privilege: Treating person as a child, servant. • Making unilateral decisions. • Defining narrow, limiting roles and responsibilities. • Providing care in a way to accentuate the person's dependence and vulnerability. • Giving an opinion as if it were the person's opinion. • Denying the right to privacy. • Ignoring, discouraging, or prohibiting the exercise of full capabilities.

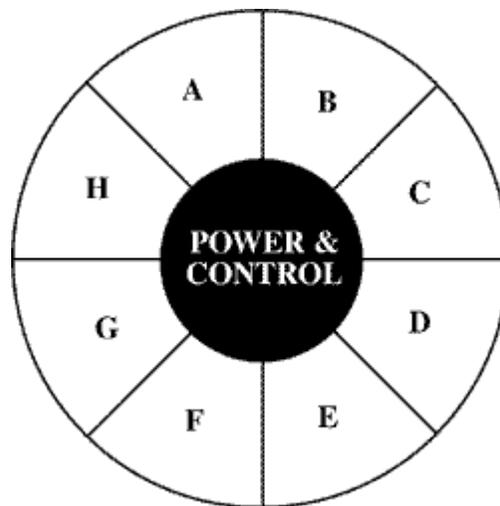
D. Isolation: Controlling access to friends, family and neighbors. • Controlling access to phone, TV, news. • Limiting employment possibilities because of caregiver schedule. • Discouraging contact with the case manager or advocate.

E. Minimize, Justify, & Blame: Denying or making light of abuse. • Denying physical and emotional pain of people with disabilities. • Justifying rules that limit autonomy, dignity, and relationships for program's operational efficiency. • Excusing abuse as behavior management or caregiver stress. • Blaming the disability for abuse. • Saying the person is not a "good reporter" of abuse.

F. Withhold, Misuse, or Delay Needed Supports: Using medication to sedate the person for convenience. • Ignoring equipment safety requirements. • Breaking or not fixing adaptive equipment. • Refusing to use or destroying communication devices. • Withdrawing care or equipment to immobilize the person. • Using equipment to torture people.

G. Economic Abuse: Using person's property and money for caregiver's benefit. • Stealing. • Using property or money as a reward or punishment in a behavior program. • Making financial decisions based on agency or family needs. • Limiting access to financial information and resources resulting in unnecessary impoverishment.

H. Emotional Abuse: Punishing or ridiculing. • Refusing to speak and ignoring requests. • Ridiculing the person's culture, traditions, religion and personal tastes. • Enforcing a negative reinforcement program or any behavior program the person doesn't consent to.¹⁶



[d](#)

Tips for Creating Accessibility

The following suggestions come from people with disabilities, disability advocates, service providers, they are a guide to respectful approaches and behaviors, but because of the diversity and complexity of individuals will not address every situation or be welcome by every individual. It is always appropriate to ask someone how he or she would like to be treated and what accommodations may be helpful or necessary.

¹⁶ Abramson, W., Emanuel, E., Gaylord, V., & Hayden, M. (Eds.). (2000). *Impact: Feature Issue on Violence Against Women with Developmental or Other Disabilities*, 13(3) [online]. Minneapolis, MN: University of Minnesota, Institute on Community Integration. Available at <http://ici.umn.edu/products>

General

- Remember you are speaking to an adult. Talk to the survivor, not a support person, caregiver, interpreter or assistant.
- Do not call a Child Abuse center or Child Advocate to respond to a SART call with an adult with a disability.
- Use caution when allowing a caregiver to be in the room during an interview. They might be a potential perpetrator, acquaintance of the perpetrator, or otherwise present a subtle or overt threat to the survivor about telling the truth, or naming the perpetrator.
- Be aware of any accommodations that might help aid communication, (ASL interpreter), understanding (altering vocabulary used), or mobility (giving a victim with visual impairments information about the lay out of the room) - let the survivor decide how to communicate.
- If you don't understand someone with a disability, ask him or her for clarification – don't pretend to understand.
- Utilize other methods of communication – write, sign or speak the message.
- If you see that a possible accommodation might be made, ask the victim's permission before "helping."
- Remember that most people (85%) with intellectual disabilities have only mild delays or retardation. Avoid talking down to the person, or speaking to an adult like a child.
- People with disabilities have the same right to confidentiality with the rape crisis Counselor/Advocate as other survivors. The information they disclose cannot be shared with a caregiver, parents, social worker, guardians, law enforcement, etc.
- The survivor with a disability has the right to decide who is in the room during the SART exam
- Avoid euphemisms such as "physically challenged," "differently-abled" or "handi-capable". Many disability groups and individuals with disabilities object to these phrases because they are considered condescending and reinforce the idea that disabilities cannot be spoken of in an upfront and direct manner.
- Do not sensationalize a disability by using terms such as "afflicted with," "suffers from," or "crippled with." These expressions are considered offensive and inaccurate to people with disabilities.
- When writing or speaking about people with disabilities, emphasize abilities rather than limitations.
- Use "people first" language that puts the focus on the individual rather than the disability:
 - "Person with a disability" rather than handicapped or crippled.
 - "Person who is blind" or "person with a visual impairment" rather than the blind.
 - "Person who is Deaf" or "person who is hard of hearing" instead of deaf and dumb or suffers a hearing loss.
 - "Person with a mental illness" instead of crazy or psycho.
 - "Person with an intellectual disability" instead of retarded or mentally defective.
 - "Person who uses a wheelchair" instead of confined to a wheelchair, in a wheelchair, or wheelchair bound.
 - "Person with a physical disability" or "person with a mobility impairment" instead of handicapped or crippled.

Considerations for Survivors with Blindness and Visual Impairments

- Ask before touching or petting a service animal, it may distract the animal from working. It is best not to touch them at all—they are not a pet.
- It is especially important to announce oneself when entering and leaving a room with a person who is blind or has a visual impairment. When introducing a person who is blind to a group, introduce each person individually.
- Speak directly to the person in a normal tone and speed.
- Use detail to describe people, objects and places thoroughly.

Considerations for Survivors with /Physical Disabilities or Mobility Impairments

- Wheelchairs are part of a person's personal space, do not lean on, touch or otherwise maneuver someone's chair without permission.
- If you see that an accommodation may be appropriate, ask the survivor before you proceed, "Would you like some help getting out of the chair?"
- Always ask permission. Don't touch or move the cane, prosthesis, wheelchair, braces, etc. of the survivor.
- Allow the survivor to tell you her/his needs, don't bombard with questions.
- Seek to communicate with people at an even level physically, i.e. if someone is using a wheelchair, sit down or kneel when conversing for an extended period of time.

Considerations for Deaf or Hard of Hearing Survivors

- If the survivor signs, always call for an ASL interpreter.
- Speak directly to the person who is deaf, not the sign language interpreter.
- Make eye-contact and speak to the survivor directly, even if you are using an ASL interpreter.
- You can try using notes or lip reading until an interpreter is available, if this is o.k. with the survivor, but be aware that not all deaf people read lips.
- If you are using lip reading: look at the person, don't turn away mid-sentence, don't eat or cover your mouth. There is no need to speak loudly or exaggerate your enunciation for lip reading.
- Ask the person to repeat themselves if you do not understand.
- Use facial expressions, body language, and pantomime.
- Explain any interruptions (such as beeper going off) before attending to it.
- The deaf community is often like a small town—many people know one another. This may mean that the survivor might be concerned about confidentiality or privacy.
- Do not use a partner, parent, friend, or law enforcement as the ASL interpreter.
- Respect what is called "Deaf culture"—this includes that people in the deaf community do not see deafness as a disability and therefore do not necessarily use people first language.
- Be respectful that deaf survivors have the right to refuse so-called "treatments" for deafness such as cochlear implants. Be aware when giving resources that many deaf survivors want to maintain social circles in the deaf community and would rather receive services within the deaf community.
- Isolation of deaf people within the hearing community may make reporting difficult.

Considerations for Survivors with Learning Disabilities

- Be aware that occasional inattentiveness, distraction, or lack of eye contact by the person with a learning disability is not unusual and does not indicate a lack of ability to report accurately. This may be particularly important during law enforcement interviews.
- Be sensitive to the fact that some information processing problems may affect social skills, causing facial expressions, voice, tone or gesture differences.
- Allow extra time for people with learning disabilities to learn certain skills. Remember, information-processing difficulties often interfere with learning. Once learned, however, there is no relationship between a learning disability and the performance of a task. This may mean making adjustments and accommodations during staff and volunteer trainings.

Considerations for Survivors with Mental Illness/Psychiatric Symptoms

- Focus on the victim as a complete person.
- Be patient and allow enough time for the victim to communicate.
- Remember that people with disabilities, especially psychiatric disabilities are 2-10 times as likely to be targeted for sexual assault than the general population.

- If the content of the survivor’s speech seems to be delusional, continue to respond without validating the delusions.
- Do not laugh at/make fun of the delusional content, appear shocked, or try to dismiss or minimize the experience. Debating the reality of the delusions can increase agitation, defensiveness, and symptoms of trauma.
- If the survivor appears to be responding to internal stimuli/hallucinations, do not try to talk them out of it or say, “that is not real”. The feelings are very real. You will not be able to talk them out of the delusions or hallucinations. These symptoms may be particularly pronounced after a recent sexual assault, as a new trauma can exacerbate existing mental health symptoms.
- Remember that the fact that some thoughts or experiences may not be based in reality does not mean that an assault did not occur. People with mental illness are targeted by perpetrators because they are often not believed when they report.
- Remember that people with mental illness or psychiatric symptoms are not “out of reality” most of the time, only when symptoms are active. Having symptoms of mental illness is not the same thing as “making up stories” or “having a wild imagination” the delusions and hallucinations are symptoms of an illness. These symptoms do *not* make people with mental illness more prone to false reporting than the rest of the general population.
- If the survivor has a support person accompanying him/her, resist the temptation to address questions to the support person rather than the victim. Do not speak about the survivor as if he/she is not there.
- Know the difference between a mental illness/psychiatric diagnosis and developmental or intellectual disability. An adult with a mental illness has the life experience and IQ of any adult. Do not speak to or refer to someone as “like a child” or speak to an individual with psychiatric symptoms as if they are children. Phrases like “mentally challenged”, “slow”, or “mentally impaired” do not accurately describe people with mental illness or intellectual disabilities.
- Learn more about the nature of the person’s diagnosed mental illness. If a person is prescribed medication for his or her illness, discussing information on the side effects and impact of their symptoms and medications may help you better understand what that person is experiencing after a sexual assault.
- Clearly explain the reporting process, specifically addressing issues such as using information given in the report against the survivor (this is especially important if the survivor is uncooperative due to experiences of being homeless, a known sex worker or is self-medicating by using drugs). Many survivors are agitated due to anticipating being blamed while reporting or seeking help.
- When at all possible, explain why you need certain information or are asking detailed questions about the survivor’s history, behaviors, etc. This will aid in decreasing defensiveness.
- Allow time for the victim to calm down, if needed. Ask basic, less challenging questions first.
- If the survivor is becoming increasingly agitated, try to discern if this is being caused by a substance, trauma, or other mental health symptoms. If there was alcohol or drug use involved in the assault, you may have to wait to complete the interview.
- Allowing time for the survivor to receive brief crisis counseling with a Sexual Assault Crisis Counselor/Advocate before any SART or law enforcement interview, when appropriate, can help a survivor proceed with the interview and/or examination.

Considerations for Survivors with Intellectual Disabilities

- Adults with intellectual and cognitive disabilities are not children. They are adults and deserve to be treated as such. The role of crisis counselors and advocates as non-judgmental sources of support and information is especially important in order to empower the survivor to make decisions that affect their lives.
- Intellectual and cognitive disabilities are not always visible. Go over any handouts and pamphlets verbally to check for understanding. Make it more comfortable to say “no”, by asking “Am I making

sense?” rather than, “Do you understand?” Ask the person to repeat what they understood about the information.

- Be aware that intellectual and developmental disability is not synonymous with mental retardation. Mental retardation refers to persons with lower levels of intellectual functioning, generally whose I.Q.s are below 70-75. Developmental disability refers to any disability that was caused by differences in fetal development that result in impaired functioning of some type. Developmental disabilities can also refer to mobility impairments such as cerebral palsy.

Considerations for Survivors with Acquired Brain Injuries (ABI) and Stroke

- Help keep a conversation on track. People with acquired brain injuries may digress or change course during a conversation. Redirect them using appropriate cues and reminders of the topic when necessary during hotline calls and in-person crisis counseling.
- Repeat important information about the purpose, duration and guidelines for a presentation, support group, or training. Summarize previous progress and review where previous trainings left off if sessions continue. It may be necessary to provide summaries of previous phone conversations, counseling meetings, or court appointments to survivors with ABIs.
- Keep the environment free of distraction. Try to meet in quiet spaces where there will not be interruptions or suggest having phone conversations during quieter times at the survivor's home.
- People with ABIs may exhibit impulsiveness, irritability, or egocentric behavior. These are behavioral symptoms that can be consequences of the disability. With survivor permission, these symptoms may need to be discussed with detectives or district attorneys before interviews or court dates.

Hidden Disabilities – *This term refers to disabilities that may not be obvious to an outside observer, but still significantly affect the life function of the person who has the disability. Some examples are people living with AIDS, cancer, addiction or other medical disabilities.*

- It is important to recognize that people with certain hidden disabilities such as AIDS and cancer are not necessarily dying from these diseases. Treatments exist for both cancer and HIV and AIDS-related illnesses that can prolong a person's life. Sensitive terminology focuses on the act of living with these diseases, not dying from them, as in the term “living with AIDS”.
- Provide an environment conducive to self-disclosure. This includes hiring people with disabilities; establishing a reputation for confidentiality; and providing descriptive literature and speakers relating your interest in working with people of all abilities. People with hidden disabilities will be more likely to seek services at such agencies and disclose their disability.
- Collaborate with hospitals, long-term care facilities, and drug and alcohol rehabilitation facilities to serve survivors receiving their services.
- Ask questions that will help your organization provide appropriate accommodations. For example, “Is there anything about you we have not discussed that might make it difficult to participate in your volunteer program or other sexual assault services? Are there other ways we can provide assistance and support at our rape crisis center?”

Physical Accessibility

All of the cultural competency and successful outreach will be unproductive if a client cannot utilize the facilities of a rape crisis center. The Americans with Disabilities Act (ADA) provides guidelines for ensuring accessibility to public agencies. It is important to know that many accommodations are inexpensive. Consider organizing a volunteer work party for one-time adaptations such as building a ramp or installing handrails on stairways or in bathrooms.

Obtaining, installing and using TTY/TDD machines or TTY software for your computer is also necessary to making services accessible to people who are deaf or hard of hearing. Call your local

Office of Deaf Access Regional Center (*listed in Resources*) for more training and information on TTY or TDD equipment.

Many centers have requested more in depth instructions on using a TDD or TTY for communication with survivors who are deaf; instructions are available from CALCASA upon request. For centers without TTY/TDD capabilities, the California Relay Service (CRS) (1-800-735-2929) provides operators who allow people who are using TTY machines to communicate with people who do not have a machine. CRS is a confidential service and available 24 hours a day, 365 days a year.

Suggestions for Improving Physical Accessibility

The following suggestions come from people with disabilities, disability advocates, service providers, and VSA Arts Disability Awareness Guide (an organization that creates learning opportunities through the arts for people with disabilities). They are a guide to respectful approaches and behaviors, but because of the diversity and complexity of individuals, will not address every situation or be welcome by every individual. It is always appropriate to ask someone how he or she would like to be treated and what accommodations may be helpful or necessary.

General

- Have written materials available in alternate formats (large print, audio tape, picture).
- Offer solutions to transportation issues: provide money, bus tokens or stipends for cabs, make arrangements with local providers of transportation to persons living with disabilities, or rent a vehicle with a lift.

Accommodating a survivor with Blindness and Visual Impairments

- Ensure that service animals have full access to the same facilities as the person they are serving; this right is guaranteed by law.
- To guide a person who is blind, let him or her take your arm. Identify obstacles as you are about to encounter them.
- When using telephone numbers with words, such as 1-888-9CALCASA, be sure to include the number version as well, since letters on telephone buttons can be difficult to read.
- Have optical magnifiers and other optical aids available.

Accommodating a survivor with Mobility Impairments

- Use floor coverings that allow easy mobility (e.g. non-skid surfaces or low carpets).
- Relocate services and programs to accessible spaces.
- Replace existing hardware and equipment to allow for grab bars, handrails, and other supports where needed.

Accommodating a survivor who is Deaf

- Install a teletype (TTY) writer in your office. Include the number on brochures and flyers. Learn how to utilize a dual-party relay system (e.g., some communities have a 711 system that automatically access the 711 system) provided by the local telephone company.
- Learn how to find a sign language interpreter on short notice. See the listing for California in the *Resources* of this packet

Outreach Strategies

Community collaboration and outreach will improve both the use of rape crisis center services and the effectiveness of these services for survivors of sexual assault with disabilities. Rape crisis centers are uniquely prepared to meet this challenge. As experienced collaborators and educators, the tools to accomplish this goal already exist and merely require adaptation and development to succeed. The following outreach strategies are suggested as initial steps in designing individualized strategies for your community. They are by no means exhaustive and may include action your center has already taken.

- Contact local branches of agencies that provide disability advocacy, services or resources. Request information on their services and programs. Offer to meet with them or send them information about rape crisis center services in return.
- Propose staff cross training on issues of sexual assault and disabilities. Many agencies that serve people living with disabilities do not have specific rape crisis training. Some may have specific staff that deal with issues of abuse but who may not be aware of sexual assault dynamics or services available to survivors at rape crisis centers. Many service providers may be willing to present at volunteer trainings or provide continuing education to your center.
- Contact local agencies that serve persons with disabilities and share handouts, brochures or pamphlets for survivors. Collaborate on how to make them accessible for people living with various disabilities and ask to put brochures in the lobby or information kiosks.
- Be sure to include pictures or photographs of persons with disabilities in publications, and newsletters to represent the diversity of the community your center serves. Incorporate survivor stories and vignettes from persons living with disabilities into training and presentations.
- Ensure that inclusive statements such as “Please contact us about any accommodations needs,” etc., are included in agency brochures and publications along with statements about the agency’s commitment to serving survivors of sexual violence living with disabilities.
- Your local service provider or advocacy agency for people who are blind or have visual impairments may be able to assist in tape recording a center brochure or survivor rights handout. Recruit volunteers to tape record agency brochures or handouts for use by persons who are blind. Consider making it a requirement of training to audiotape handouts, brochures or training manual.
- Making rape crisis center brochures or handouts available in large print will also assist people with low vision or other visual impairments. Make copies available at rape crisis centers and agencies that serve people who are blind or have visual impairments.
- Develop Memorandum of Understanding (MOU’s) that outline clear procedures on accessing agencies in your community that provide services to persons with disabilities.
- Contact the local school for the deaf in your community. Offer to provide rape prevention or self-defense classes with an ASL interpreter.
- Contact local summer camps for children with various types of disabilities. These can be found by contacting local service agencies like Regional Centers, Deaf Service Agencies, and Independent Living Centers located in *Resources*.
- Contact local colleges and ask for disabled student programs or service centers. Offer to provide rape prevention presentations or self-defense training to students.
- Agencies that serve people with developmental disabilities may be willing to collaborate on a pictorial explanation of rape crisis center services, Sexual Assault Response Team (SART) response or benefits of counseling for survivors with developmental disabilities or others who cannot read or are visual learners. (*Note: There is an excellent example of this type of publication available in the RPRC Library, “Survivor: For People with Developmental Disabilities, Who Have Been Sexually Assaulted – Booklet 1: For Those Who Read Best with Few Words” by Nora J. Baladerian*).
- Share job openings, volunteer training announcements and other such opportunities with agencies that serve persons living with various disabilities.

- Develop education presentations tailored to people with particular disabilities. Borrow CALCASA curriculums on sexual assault prevention education for people living with disabilities. Discuss presentation outline ahead of time with service providers or disability advocates to ensure that the presentation will be accessible and pertinent.
- Presentations to persons with intellectual disabilities may require a more in depth discussion about sexuality than rape crisis centers may normally provide. Exploring what type of information on sexuality has already been provided to the audience will greatly assist educators in preparing an effective presentation.
- Explain technical terms or jargon used in your presentation. Consider creating a glossary of terms used in the presentation for attendees to take home.
- Offer individual assistance to persons with intellectual disabilities during presentations or volunteer trainings. For example, an assistant who can take the training with them can provide ongoing explanation, processing or note taking.
- Ensure that interpreters are available for people who are deaf during staff and volunteer trainings. If videos are used in presentations, ensure that captions or interpreters are available.
- Adapt presentation exercises and participation to the abilities of the audience. Exercises that require people to stand up or raise their hands will not be accessible to some people with mobility impairments, for instance.
- Offer Self-Defense training to people with disabilities at independent living centers, care facilities, advocacy agencies, etc.
- When working with law enforcement, prosecution, medical professionals and other service providers, use statistics and other facts to educate them about the prevalence of sexual assault against people living with disabilities.
- Tour courtroom facilities before a survivor with disabilities testifies to assess accessibility and to help the survivor feel more comfortable. Coordinate with your District Attorney's office to ensure interpreters will be available when necessary for survivors at hearings and trials.
- Offer community education in response to crises. For example, if a residential facility for persons with disabilities has a series of assaults, offer to provide a public safety forum to residents. Listen to resident concerns, provide information about personal safety, rape trauma syndrome, sexual assault dynamics, SART process and rape crisis center services. Provide follow-up materials and information in response to the concerns of residents. Offer self-defense training.
- Call your local sign language interpreter service and meet to arrange possible emergency availability for either hospital or office interpretation.

Prevention Strategies

Perhaps the most important aspect of addressing sexual violence against persons living with disabilities is a committed effort to prevent such assaults from occurring in the first place. Rape crisis centers have been leaders in the field of sexual violence prevention for the last several decades. The curriculum and approaches currently used can be adapted to include prevention education to persons with disabilities, caregivers, service providers and other professionals that work with persons living with disabilities.

Preventing sexual violence must include more than mere avoidance techniques or behavioral changes on the part of potential victims. Comprehensive prevention of sexual assault incorporates education about gender stereotypes, forms of oppression, social norms, and sexist behaviors and systems. Educating the community about the roots of sexual violence will provide tools for individuals to change attitudes and behaviors that will bring about a safer community and ultimately prevent sexual violence.

The following prevention strategies will help rape crisis centers to integrate the issue of sexual assault against persons with disabilities into current prevention efforts and expand these efforts to reach a larger segment of the community.

Including Persons with Disabilities in the Community

An important aspect of preventing sexual assault against persons with disabilities is changing the dynamic of isolation that increases their vulnerability to sexual assault. Sobsey indicates that risk reduction through inclusion, thus changing this dynamic of isolation, occurs in three primary ways¹⁷. First, when persons with disabilities live in homes or family residences, it appears that they face fewer inherent risks of exposure to perpetrators because they do not live grouped together in residential facilities where perpetrators may gather.

Second, persons with disabilities that live in their natural environment are less likely to learn skills that are dysfunctional for personal safety. In institutions and residential facilities, persons with disabilities are often taught and rewarded for compliance because this allows staff to manage residents more effectively.

Third, persons with disabilities are more likely to learn skills and behaviors that improve their personal safety in natural environments. For example, persons with disabilities are more likely to be exposed to models of assertiveness, personal space and boundary setting in natural environments than institutions.

Sobsey argues against institutionalization in particular, but his ideas are applicable to the work of rape crisis centers. Including persons with disabilities in prevention education, intervention and other services provided by rape crisis centers is important because it allows persons with disabilities to be exposed to models of personal safety and empowerment such as self-defense and advocacy.

Incorporating the Issue Of Disabilities Into Existing Prevention Efforts

Rape crisis centers in California already provide rape prevention education in their communities. Existing curricula can be adapted to incorporate issues of sexual assault against persons with disabilities for presentations throughout the community. Whether providing prevention education at schools, juvenile halls, law enforcement, faith-based organizations, or other community agencies, it is essential to incorporate the issue of sexual assault against persons with disabilities. Not only will it sensitize the audience to this issue, it will assist in breaking down many of the attitudinal barriers that contribute to discrimination and violence against persons with disabilities. Examples include discussing the cycle of violence that often leads to disability and results in further vulnerability to sexual violence. Discussing the prevalence of caregiver abuse can illustrate the fact that most survivors of sexual assault know the perpetrator. Incorporating aspects of the history of institutionalization and sterilization and how such discrimination leads to isolation and exclusion, can help prevention educators demonstrate the connections between oppression and rape.

Expanding Prevention Efforts

Incorporating information about sexual assault against persons with disabilities into existing presentations is important, but prevention education must also expand its scope to include persons with disabilities and their service providers as primary audiences.

There are numerous agencies that serve the needs of people with disabilities in California; many of them are listed in the *Resources* of this packet. Since many of these agencies provide independent

¹⁷ Sobsey, D., *Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance?* Baltimore, MD: Paul H. Brooks Publishing Co., Inc. 1994, p. 245.

living classes or life skills training to their clients, they are an excellent place to provide primary prevention education to people with disabilities.

Independent Living Centers provide resources, training and information to people with disabilities to assist them with living independently in their communities. California Regional Centers provide a variety of services including assistive technology and life skills training to people with developmental disabilities. Other recommendations include:

- Contacting local service providers and creating a list of disability rights agencies or agencies that serve persons with disabilities.
- Learning what type of services these agencies provide and discuss what services the rape crisis center provides.
- Offering to make presentations in independent living skills classes, resident meetings, seminars or other classes at the agency.
- Building collaborative partnerships with such agencies to provide rape prevention education is an excellent means of providing sexual assault prevention to persons with disabilities.

Intervention and Prevention for Survivors and Perpetrators

Perpetrators of sexual assault against persons with disabilities are often people they know. Providing rape prevention education to staff and volunteers at assisted living centers, foster care placements, adult care facilities, day programs, independent living centers, regional centers, disability advocacy agencies and others that serve people with disabilities is essential to preventing sexual violence before it occurs. Many centers provide training to their staff and volunteers on a regular or ongoing basis. Offer to provide rape prevention education and information about rape crisis center services. Developing linkages between rape crisis centers and agencies that provide services for persons living with disabilities can create an awareness of sexual violence that can lead to intervention should an assault occur as well as deter perpetrators from committing crimes in the first place.

Unfortunately, revictimization rates for survivors of sexual assault are high. Providing intervention services and prevention education to survivors of sexual assault with disabilities can help to prevent survivors from being revictimized. It is worthwhile to contact agencies where known incidents of sexual violence have occurred and offer counseling and prevention education to clients and staff.

Self-Defense

Self-defense courses can provide valuable skills and information to persons with disabilities. Self-defense generally involves some physical fighting techniques that must be adapted to the abilities of individuals with disabilities. Although this can provide a challenge to instructors if unprepared, prior efforts to learn about the abilities of individuals in a class before it takes place can ensure that the physical techniques are appropriate for participants. For example, knowing ahead of time that participants are likely to use wheelchairs or other mobility aides can help an instructor to prepare a class that focuses on how to use mobility aides to protect oneself. A walker, cane or crutches can be used to strike the face or other parts of the body or block a perpetrator's path. Motorized wheelchairs are very heavy and can injure a perpetrator's instep if run over, whereas a person using a non-motorized wheelchair may have a great deal of upper body strength because of the need to propel the chair; thus, a focus on physical strike techniques may be appropriate.

Although each individual's abilities may vary, self-defense instructors are taught a multitude of physical techniques that may merely need to be adapted for persons with physical disabilities to learn. Instructors should review physical techniques before a class and prepare a presentation that will fit the anticipated abilities of the participants; however, as with all self-defense participants,

presentations may need to be adapted on the spot. Multiple sessions are an ideal way to both assess the needs and abilities of participants and provide techniques that are useful and appropriate.

Another vital component of self-defense programs is assertiveness training. A basic component of assertiveness training is setting boundaries. It is important to ensure that both verbal and physical methods of assertiveness are taught to ensure that all participants learn techniques they can use. Again, techniques must be adapted to the abilities of each individual, for example, a person who cannot speak may find that creating physical distance or putting up their hand may be a good way to set such boundaries. For others, yelling or other verbal warnings may be the best techniques.

Assertiveness may have been discouraged for certain participants, particularly those with developmental disabilities. Thus, self-defense courses for persons with developmental disabilities may need to focus on concepts of personal space and the right to personal safety.

As self-defense instructors gain experience in teaching classes to people with disabilities, their knowledge and confidence will grow. The skills they already possess can be easily translated to new groups of participants with preparation and commitment. Self-defense is a powerful concept to teach, even more so when teaching it to a group that has been denied access to it for so long.

APPENDIX A:

KEY TERMS AND DEFINITIONS OF DISABILITY

It is important to recognize the diversity of disabilities that one may experience and encounter. The same disability may affect each individual differently or a person may have a combination of disabilities. The experience of living with a particular disability must be understood through communication with that individual, no medical description or clinical explanation can substitute. These key terms, therefore, should be used to develop a foundation of knowledge that will assist you in interacting with individuals and understanding their distinct experience of living with a disability.

Blindness and Visual Impairment

The terms “blindness” and “visual impairment” can describe a range of vision ability. A person who is **legally blind** has less than 20/200 vision in the better eye or may have a field of vision that is less than 20 degrees at its widest point. Many people who are **legally blind** have some ability to see light, shapes, and colors. The term **legally blind** does not necessarily indicate total vision loss.

As with many disabilities, blindness and visual impairment can be either congenital (since early childhood or birth) or adventitious (occurred later in life). The age that blindness or vision loss occurs is important in understanding the effect the disability has had on an individual. Adventitious blindness may occur as a result of disease or trauma and can lead to acute shock and adjustment difficulties. A person with congenital blindness, however, has usually had education and training since birth or early childhood to prepare them for some of the challenges of being blind in adult life.

Deafness and Communication

People who are **deaf** or **hard of hearing** can communicate in a variety of ways. Many people who are deaf view their deafness as simply a different means of communication, rather than a disability. The method a person uses to communicate may be affected by the age at which they acquired the disability.

The idea that a person who is deaf or hard of hearing cannot speak is often untrue. People who are born deaf (prelingual deafness) have difficulty developing speech ability in the same way a hearing child might, but many attend speech classes in order to learn to use their voice. A person who lost their hearing after learning to speak may also be able to communicate by speaking if they choose to do so.

Other modes of communication for people who are deaf or hard of hearing include American Sign Language, signed English, cued speech, writing, finger spelling and speech reading (sometimes known as “lip reading”). American Sign Language is a unique language whose grammar, syntax and vocabulary are distinct from spoken English. Foreign languages also have their own sign languages such as French or Spanish sign language. Some people who are deaf have been trained in lip-reading, but this process is only 30-40% accurate. Therefore, lip reading should not be relied upon for communication with people who are deaf or hard of hearing. In addition, many people who are deaf or hard of hearing, especially those who primarily communicate through American Sign Language, may be less familiar with the grammar and syntax of written English. It is important to take this into consideration when using a TTY or otherwise communicating with a person who is deaf or hard of hearing, since the issues of communication and intelligence are separate.

Learning Disabilities

Learning disabilities affect approximately 4 million children in America and perhaps many more adults. They are usually lifelong conditions, but because many learning disabilities were not well known or understood until the last decade, it is presumed that many adults remain undiagnosed. Some common types of learning disabilities are:

Dyslexia – substantial difficulties with reading

Dyscalculia – substantial difficulties with mathematics

Dysgraphia - substantial difficulties with writing

Dysphasia - substantial difficulties with speaking

According to the VSA Arts Disability Awareness Guide, “**learning disabilities** are disorders manifested by significant difficulties in listening, speaking, reading, writing, reasoning, and/or mathematical ability”. Although sometimes confused, mental retardation and learning disabilities are unrelated and very different from one another. Most people with learning disabilities have normal intelligence, but difficulties in processing information. Adapting teaching methods to the specific learning style often helps persons with learning disabilities comprehend information successfully.

Mental Illness

Mental illness affects nearly five million Americans per year. One of the most common debilitating illnesses, more people have a form of mental illness than heart disease, cancer or diabetes. The diversity of mental illnesses and their effects on an individual are too great to cover. Professional guidance should be sought whenever a service provider is working with a client who has a mental illness.

Symptoms of these illnesses can vary from person to person; the Diagnostics and Statistics Manual Fourth Revision (DSM IV) should be consulted for more detail. Generally speaking, people with mental illnesses may experience anxiety related to their particular diagnosis. People with mental illness often experience overwhelming feelings and emotions, as in the case of major depression. The symptoms of mental illnesses vary a great deal, as do the beliefs about the origins of mental illness.

While the absolute cause of mental illness remains uncertain, most experts agree that mental illnesses are influenced by environmental, biochemical and psychological factors. Such illnesses often leave a person with a decrease in life function, for this reason, mental illness is defined as a disability. Mental illnesses can sometimes be influenced by sexual assault or sexual abuse; PTSD is a common reaction to sexual assault for example. However, preexisting mental illnesses may place a person at a higher risk for sexual assault, just as with other types of disabilities.

Intellectual Disabilities (formerly called-Developmental Disabilities)

According to the *VSA Arts Disability Awareness Guide*, developmental disabilities are defined as severe, chronic disabilities that are:

- Caused by a mental or physical impairment or a combination of the two;
- Show up before the person reaches age 22;
- Likely to continue throughout life;
- Associated with substantial limitations in one’s ability to function; and
- Resulting in the need for special, interdisciplinary, or generic care, treatment, or other services that are life long or of a long duration.

Intellectual disabilities such as brain injury, autism, cerebral palsy, and other neurological impairments may be considered developmental disabilities as well. Brain injuries will be discussed in the “Acquired Brain Injury” section.

Autism actually refers to several disorders that are caused by an abnormality of the brain. Autism Spectrum Disorders (ASD) are a type of developmental disability that create the need for repetition and routine, while seriously impacting one’s ability to communicate and interact socially. ASD typically appears within the first three years of a child’s life and remains a lifelong disability. Although there is no known cure for autism, specialized training can help develop the skills of a person with autism.

Cerebral Palsy is a developmental disability caused by damage to the brain, which generally occurs before, during or directly after birth. Even though cerebral palsy can result in mental retardation, it is most strongly characterized by an inability to fully control motor functions. This can result in difficulty maintaining balance and changes in depth perception as well as stiff, difficult or involuntary movements. Cerebral palsy may cause a person to exhibit spasms, mobility impairments, impairments in sight, hearing, or speech, or mental retardation.

Although **mental retardation** is a type of developmental disability, all people with intellectual disabilities do not have mental retardation. Developmental disability may refer to a physical disability and not include any form of mental retardation at all. Therefore, the two terms should not be substituted for each other.

Mental retardation is a developmental disability characterized by a lower level of intellectual functioning (IQ) - below 70-75, significant limitations in two or more adaptive skill areas, and an onset of the disability before the age of 18. Mental retardation is generally measured in four levels, mild, moderate, severe, and profound. The causes of mental retardation can vary from lead poisoning to genetic disorders, but three of the most common causes are listed below:

Down Syndrome is the most common cause of mental retardation. Created by an atypical gene structure, Down syndrome affects nearly 4,000 children each year; most function in the mild to moderate range of mental retardation.

Another cause of mental retardation is **Fetal Alcohol Syndrome**, caused by the ingestion of alcohol during pregnancy. This exposure of the unborn child to alcohol causes mental and physical birth defects that can include mental retardation, growth deficiencies, nervous system dysfunction, abnormalities of the head and face and behavioral problems. Not all women who consume alcohol during pregnancy give birth to children with Fetal Alcohol Syndrome. Additional factors such as smoking, other drug use, nutrition and trimester of consumption may affect one’s susceptibility to Fetal Alcohol Syndrome.

A third cause of mental retardation is **Fragile X** syndrome. Fragile X refers to a damaged X chromosome that can cause learning disabilities, mental retardation, attention deficit and hyperactivity disorder, anxiety and unstable mood, autistic-like behaviors, long face, large ears, flat feet and hyper-extensible joints. Fragile X is hereditary and passed on from mother to child; it can be passed on for generations before the gene defect is serious enough to affect the baby’s development. Although developmental disabilities may affect one’s intellectual functioning, it is important to realize that this is separate from mental illness. Mental illness is a biochemical brain disorder that has as much chance of being present in a person with a developmental disability as in one without.

Mobility Impairment

Mobility impairments include a broad range of disabilities that affect a person's ability to move. They may result from cerebral palsy (see description under **Developmental Disabilities**), spinal cord injury, stroke, arthritis, muscular dystrophy, amputation, polio or other conditions and may take the form of paralysis, muscle weakness, nerve damage, stiffness of the joints, or lack of balance and coordination. Many persons with mobility impairments use wheelchairs or other mobility aides, such as crutches, canes, walkers, or scooters. However, use of wheelchairs or other mobility aides does not necessarily indicate that the individual cannot walk; they may be used to cover long distances or conserve the energy of the person using them.

Mobility impairments can be acquired at birth or caused by accidents, illnesses, or the natural process of aging. People with mobility impairments have a diverse range of physical ability and range of motion. Some conditions that commonly cause mobility impairments are:

Amputation – The removal of all or part of a limb as the result of an accident or as a surgical intervention for a medical condition.

Muscular Dystrophy – There are over 40 different types of muscular dystrophy (MD), a hereditary disease that causes degeneration and weakening of the muscles. The hereditary patterns, age of onset and muscle loss vary amongst the 40 types of MD.

Multiple Sclerosis – Multiple Sclerosis (MS) is a disease that affects the nerve pathways of the Central Nervous System (the brain and spinal cord). Although each case of MS is unique, typical symptoms include balance and coordination problems, bowel and bladder problems, fatigue, tremors and spasms, pain, weakness, cognitive deficits, numbness, and tingling. It may also affect vision, hearing or speech. Progression of MS varies by individual, while it may gradually grow worse over time, in others the disease may go into a complete or partial remission.

Polio/Post-Polio Syndrome – Poliomyelitis (Polio) is a virus that damages the nervous system by attacking the nerve cells that control muscle movement. Polio is most common in infants and children. In some cases, Polio can cause paralysis. A Polio vaccine was developed in the mid-1950s that helped to reduce the numbers of persons contracting new cases of Polio. However, in the early 1980s many persons who had contracted Polio began to experience symptoms of pain, and weakness in their muscles and joints. Post-Polio Syndrome (PPS) was identified, but its exact causes are still unknown. It affects people, generally at middle age, who contracted polio years before, often after many years of having a relatively stable living condition.

Spina Bifida – Spina Bifida refers to a variety of birth defects that affect healthy development of the spinal cord and spine. Children born with Spina Bifida may experience paralysis of the lower limbs or bowel and bladder incontinence and may require medical treatment throughout their lives. Immediate surgery afterbirth can help to minimize the effects of Spina Bifida.

Spinal Cord Injury – Injuries to the Spinal Cord can result in paralysis or sensory losses as the main transmitter of nerve information from the body to the brain is damaged. The spinal cord can be damaged by being torn, crushed or severed, the extent of resulting paralysis or sensory loss varies greatly depending on where the injury occurred on the spinal cord. Both loss of motor function and sensory loss do not always result from a Spinal Cord Injury, thus it is possible for persons with paralysis to be sensitive to touch in limbs or places they cannot move. Approximately 10,000 Americans are paralyzed each year from spinal cord injuries. Common causes of Spinal Cord Injuries are automobile accidents, motorcycle accidents, skiing accidents, diving into shallow water, and gunshot wounds.

Acquired /Traumatic Brain Injuries

Acquired Brain Injuries (ABIs), including Traumatic Brain Injuries (TBIs), are caused by external physical forces applied to the head or may occur suddenly in the course of normal development. The most common causes of acquired brain injuries are automobile accidents, falls, assaults, and sports injuries. ABIs typically result in total or partial brain damage that is diffuse or widespread; it is not usually confined to one area of the brain. Thus, potential disabilities are multiple and can affect both cognitive and physical functioning.

People who have had an acquired brain injury may exhibit some or all of the following symptoms. The symptoms will vary in intensity over time, and will interact in unpredictable ways. Symptoms of acquired brain injuries include:

- **Physical Symptoms** – persistent headaches, fatigue, seizures, lack of motor coordination and sleeping disorders
- **Cognitive Symptoms** – short and long-term memory loss, limited attention span, inability to make decisions, and communication impairments.
- **Behavioral/Emotional Symptoms** – mood swings, depression, irritability, impulsivity, and denial of the disability.

Significant improvements can occur over time in the brain function of people with ABI, especially with the assistance of rehabilitation programs.

Another common and disabling brain injury is **stroke**, which is caused by a sudden interruption of blood flow to the brain. When an area of the brain is damaged by stroke, body functions controlled by that area no longer work as they previously did. According to the National Stroke Association, “stroke is our nation’s third leading cause of death, killing nearly 160,000 Americans every year. There are four areas of brain function that are affected by stroke: motor control, sensation, communication/ cognition, and personality. People who survive a stroke often have weakness on one side of the body or trouble with moving, talking, or thinking.

Hidden Disabilities

People with hidden disabilities have conditions such as cancer, epilepsy, diabetes, lung disease, kidney failure, hemophilia, addiction, hypertension, early stages of AIDS, or heart disease that may not be immediately apparent. While their numbers are far greater than those of any one disability group, people with hidden disabilities often do not feel like they belong within the disability community because they are not considered to be “disabled enough.”

APPENDIX B:

RESOURCES

There are many resources available that can help you better serve persons with disabilities. Below we have listed some samples. Please contact Villena Kournis, CALCASA's Administrative and Library Associate, at 916-446-2520, Ext. 320 for a complete list of bibliography of books, videos, articles, curricula and dissertations about serving survivors of sexual assault with disabilities.

CALCASA Trainings

Self-Defense Train the Trainer (SDTT) Programs – Each year CALCASA provides both a Beginning and Advanced training for self-defense instructors. Rape crisis centers are encouraged to select a staff person to apply for this SDTT Program. Contact CALCASA for more information.

California Regional Centers *Provides resources and information to persons with intellectual and developmental disabilities.*

**Alpine, Colusa, El Dorado, Nevada,
Placer, Sacramento, Sierra, Sutter,
Yolo, and Yuba Counties**

Alta California Regional Center
2031 Howe Ave., Suite 100
Sacramento, CA 95825
(916) 924-0400
Fax: (916) 929-1036

**Central LA, Glendale, Hollywood,
Wilshire, Pasadena**

Frank D. Lanterman Regional
Center
3440 Wilshire Blvd., Suite 400
Los Angeles, CA 90010
(213) 383-1300
Fax: (213) 383-6526

**Fresno, Kings, Madera, Mariposa,
Merced and Tulare Counties**

Central Valley Regional Center
5168 N. Blythe, Ste. 101
Fresno, CA 93722
(209) 276-4300
Fax: (209) 276-4360

Bellflower, Harbor, Long Beach, Torrance

Harbor Regional Center
Del Amo Business Plaza
21231 Hawthorne Blvd. (90503)
P.O. Box 2930
Torrance, CA 90509
(310) 540-1711
Fax: (310) 540-9538

**Los Angeles County and
Surrounding Areas:**

**Alhambra, East LA, Northeast LA and
Whittier**

Eastern Los Angeles Regional Center
1000 South Fremont Avenue
P.O. Box 7916
Alhambra, CA 91802-7916
(818) 299-4700
Fax: (818) 281-1163

East Valley, San Fernando, West Valley

North Los Angeles Regional Center
15400 Sherman Way, Suite 300
Van Nuys, CA 91408
(818) 778-1900
Fax: (818) 756-6130

El Monte Pomona, Monrovia,
Pomona, Glendora

San Gabriel/Pomona Regional Center
1521 W. Cameron, Bldg. A
P.O. Box 2280 (91793-2280)
West Covina, CA 91790
(909) 620-7722
Fax: (909) 622-7013

Compton, San Antonio South,
Southeast, Southwest

South Central L.A. Regional Center
2160 West Adams Blvd.
Los Angeles, CA 90018
(213) 734-1884
Fax: (213) 730-0793

Inglewood, Santa Monica West

5901 Green Valley Circle, Ste. 320
Culver City, CA 90230-6938
(310) 337-1155
Fax: (310) 649-1024

**Butte, Glenn, Lassen, Modoc,
Plumas, Shasta, Siskiyou, Tehama
and Trinity Counties**

Far Northern Regional Center
P.O. Box 492418
Redding, CA 96049-2418
(916) 222-4791
Redding Fax: (916) 222-8908
Chico Fax: (916) 895-1501

**Marin, San Francisco, and San
Mateo Counties**

Golden Gate Regional Center
120 Howard St., 3rd Floor
San Francisco, CA 94105-1848
(415) 546-9222
Fax: (415) 546-9203

**Riverside and San Bernardino
Counties**

Inland Regional Center
674 Brier Drive
San Bernardino, CA 92408
P.O. Box 6127
San Bernardino, CA 92412-6127
(909) 890-3000
Fax: (909) 890-3001

Kern, Inyo, and Mono Counties

Kern Regional Center
3200 No. Sillect Ave.
Bakersfield, CA 93308
(805) 327-8531
Fax: (805) 324-5060

**Napa, Solano and Sonoma
Counties**

10 Executive Court, Ste. A
P.O. Box 3330
Napa, CA 94559
(707) 252-0444 Fax: (707) 252-
4215

Orange County

Regional Center of Orange County
Central Tower, Union Bank Square
530 Main St.
P.O. Box 6030 (92610-6030)
Orange, CA 92668-4579
(714) 973-1999 Fax: (714) 541-
3021

**Del Norte, Humboldt, Mendocino
and Lake Counties**

Redwood Coast Regional Center
808 E Street
Eureka, CA 95501
(707) 445-0893
Fax: (707) 444-3409

**Alameda, Contra Costa Counties
Regional Center of the East Bay**

7677 Oakport Street, Ste. 1200
Oakland, CA 94621
(510) 285-2800

**Monterey, San Benito, Santa Clara,
and Santa Cruz Counties**

San Andreas Regional Center
300 Orchard City Dr., Ste. 170
Campbell, Ca 95008
(408) 374-9960
Fax: (408) 376-0586

Imperial and San Diego Counties

San Diego Regional Center
4355 Ruffin Road, #205
San Diego, CA 92123-1648
(619) 576-2996
Fax: (619) 576-2873

**San Luis Obispo, Santa Barbara
and Ventura Counties**

TriCounties Regional Center
5464 Carpinteria Ave., Ste. B
Carpinteria, CA 93013-1423
(805) 684-1204
Fax: (805) 684-3034

**Amador, Calaveras, San
Joaquin, Stanislaus and
Tuolumne Counties**

Valley Regional Center
7210 Murray Dr.
P.O. Box 692290 (95269-2290)
Stockton, CA 95210
(209) 473-0951
Fax: (209) 473-0256

Adult Protective Services (APS) – *Investigates allegations of abuse of dependent and elder adults. **Contact your local county APS office.***

Deaf and Hard of Hearing Resources

**Department of Social Services –
Office of Deaf Access**

744 P Street, M.S. 6-91
Sacramento, CA 95814
Voice: (916) 653-8320
TDD: (916) 653-7651
The Office of Deaf Access oversees eight regional centers that provide direct services to persons who are Deaf or hard of hearing such as advocacy, communication assistance, information and referral, independent living skills instruction, counseling and community education.

**Office of Deaf Access Regional
Service Agencies by County:**

**Imperial and San Diego Counties
- Deaf Community Services
(DCS):**

7851 Mission Center Court, Suite
310
San Diego, CA 92108
Voice: (619) 682-5001
TDD: (619) 682-5000

**Call for Vista Outreach Office
information.**

Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano and Sonoma Counties - Deaf Access Regional Service Agency (DCARA):

Headquarters/Outreach Office
14895 E. 14th Street, Suite 200
San Leandro, CA 94578-2922
Voice/TDD: (510) 483-0753
Call for San Leandro, San Jose and San Francisco Outreach Office information.

Kern, Los Angeles, Riverside, San Bernardino, Orange, San Luis Obispo, Santa Barbara, and Ventura Counties – Greater Los Angeles Council of Deafness (GLAD):

Administrative Offices
2222 Laverna Avenue
Los Angeles, CA 90041
Voice/TDD: (323)478-8000
Call for Bakersfield, Riverside, San Bernardino, Cypress, and Ventura Outreach Office information.

El Dorado, Placer, Sacramento, San Joaquin, Sutter, Yolo, and Yuba Counties - NorCal Center on Deafness (NORCAL):

1820 Tribune Rd., Suite A
Sacramento, CA 95815
Voice/TDD: (916) 921-1045
Publication: "NorCal Newslines"
Call for Stockton and Yuba City Outreach Office information.

Fresno, Kings, Monterey, and Tulare Counties - Valley Advocacy and Communication Center for the Deaf and Hard of Hearing (VACC):

5070 North 6th Street, Suite 169
Fresno, CA 93710
Voice/TDD: (559) 225-DEAF
Call for Salinas Outreach Office information.

Interpreter Service Agencies in California

Dayle MacIntosh Center for the Disabled

228 West Cerritos, Building 16
Anaheim, CA 92805
Phone: (714) 956-4180

Hands on Sign Language Services

P.O. Box 418
Auburn, CA 95604
Voice: 1-800-900-9478

Interpreting and Consulting Services

525 First Street
Benicia, CA 94510
Phone: (707) 747-8200

California Coalition of Agencies Serving the Deaf

6022 Cerritos Avenue
Cypress, CA 90630-4828

LINKS Sign Language Interpreting

800 W Pacific Coast Highway
Long Beach, CA 90806
Voice: 1-888-742-0070

LifeSigns, Inc.

2222 Laverna Avenue
Los Angeles, CA 90041-2625
Phone: (323) 550-4210

Accommodating Ideas, Inc.
11650 Riverside Drive, Suite 4
North Hollywood, CA 91602
Work Phone: 1-800-257-1783

Preston Interpreting Services
P.O. Box 8643
Northridge, CA 91327
Phone: (818) 363-4293

Deaf Services of Palo Alto
P.O. Box 60651
Palo Alto, CA 94306-0651
(650) 856-9262

Shasta College Disability Resource Center
11555 Old Oregon Trail
P.O. Box 496006
Redding, CA 96049-6006
Phone: (530) 225-4888

LifeSigns, Inc.
Regional Office
7344 Magnolia Avenue, Suite 140
Riverside, CA 92504
Phone: (909) 359-5297

Madland Denise
1820 Tribute Road, Suite A
Sacramento, CA 95815
Phone: (916) 921-1243

Sign Language Interpreting Services
3942 Terra Vista Way
Sacramento, CA 95821
Phone: (916) 483-4751

Rolling Start
570 W 4th St #102
San Bernardino, CA 92401
Phone: (909) 884-2129

Deaf Community Services of San Diego
7851 Mission Center Court,
Suite 310
San Diego, CA 92108
Phone: (619) 682-5011

Interpreters Unlimited
P.O. Box 27660
San Diego, CA 92198-1660
Phone: 1-800-726-9891

Bay Area Communication Access (BACA)

973 Market Street, Suite 280
San Francisco, CA 94103-1712
Voice: (415) 356-0405

Goodwill

1080 North 7th Street
San Jose, CA 95112
Phone: (408) 998-5774

Institute for Career Development

1080 N 7th Street
San Jose, CA 95112
Phone: (408) 998-5787

Special Task Interpreters for the Deaf

1001 N Tuslin Avenue
Santa Ana, CA 92705
Phone: (714) 953-3503

Independent Living Resource Center

423 West Victoria Street
Santa Barbara, CA 93101
Phone: (805) 963-0595

Community Resources for Independence

980 Hopper Avenue
Santa Rosa, CA 95406
Voice: (707) 528-2153

Communique Interpreting

856 4th Street
Santa Rosa, CA 95404
Phone: (707) 546-6869

Independent Living Centers – *Provides advocacy, including information and referral, informing people with disabilities of the rights, services and benefits available to them, advocacy with government benefits, housing and personal assistance, and Independent Living Skills Training.*

Access Center of San Diego, Inc.

1295 University Avenue, Suite 10
San Diego, CA 92103
Voice: (619) 293-3500
TTY/TDD: (619) 293-7757
www.accesscentersd.org
Call for San Marcos and El Centro Branch information.

Center for Independent Living

3475 West Shaw Avenue, Suite 101
Fresno, CA 93711
Voice: (559) 276-6777
TTY/TDD: (559) 276-6779
Call for Visalia and Merced Branch information.

Center for Independence of the Disabled, Inc.

875 O'Neill Avenue
Belmont, CA 94002
Voice: (650) 595-0783
TTY/TDD: (650) 595-0743
Call for Daly City Branch information.

Center for Independent Living

2539 Telegraph Avenue
Berkeley, CA 94704
Voice: (510) 841-4776
TTY/TDD: (510) 848-3101
www.cilberkeley.org
Call for Oakland Branch information.

(Independent Living Centers,
continued)

**Central Coast Center for
Independent Living**

234 Capitol Street, Suite A and B
Salinas, CA 93901
Voice: (831) 757-2968
TTY/TDD: (831) 757-3949
www.cccil.org

**Call for Santa Cruz and San Benito
Branch information.**

Community Access Center

4960 Arlington Avenue, Suite C
Riverside, CA 92504
Voice: (909) 637-6900
TTY/TDD: (909) 637-6902

Call for Indio Branch information.

Community Rehabilitation Services

4716 E. Cesar Chavez Avenue,
Building B, Room 75
Los Angeles, CA 90022-1210
Voice: (323) 266-0453
TTY/TDD: (323) 266-3016

**Call for Downtown, San Gabriel
and Pasadena Branch information.**

**Community Resources for
Independence**

980 Hopper Avenue
Santa Rosa, CA 95403
Voice: (707) 528-2745
TTY/TDD: (707) 528-2151

**Call for Ukiah and Napa Branch
information.**

**Community Resources for
Independent Living, Inc.**

439 "A" Street
Hayward, CA 94541
Voice: (510) 881-5743
TTY/TDD: (510) 881-0218

**Dayle Macintosh Center for the
Disabled**

150 West Cerritos, Building 4
Anaheim, CA 92805
Voice: (714) 772-8285
TTY/TDD: (714) 772-8366

**Call for South County and
Riverside Branch information.**

**Disability Resources Agency for
Independent Living**

221 McHenry Avenue
Modesto, CA 95354
Voice: (209) 521-7260
TTY/TDD: (209) 521-1425

www.drail.org

**Call for San Joaquin and Mother
Lode Branch information.**

Disabled Resource Center, Inc.

2750 East Spring Street, #100
Long Beach, CA 90806
Voice: (562) 427-1000
TTY/TDD: (562) 427-1366

**Foundation of Resources for
Equality and Employment of the
Disabled (FREED)**

154 Hughes Road, Suite 1
Grass Valley, CA 95945
Voice/TTY/TDD: (530) 272-1732 or
1-800-655-7732 - www.FREED.org

**Call for Yuba/Sutter Branch
information.**

Humboldt Access Project

812 6th Street
Eureka, CA 95501-1110
Voice/TTY/TDD: (707) 445-8404

(Independent Living Centers,
continued)

**Independent Living Center of Kern
County**

1631 30th Street
Bakersfield, CA 93301
Voice: (661) 325-1063 or 1-800-529-
9541
TTY/TDD: (661) 325-3092
www.ilcofkerncounty.org

**Independent Living Center of
Southern California**

14407 Gilmore Street, #101
Van Nuys, CA 91401
Voice: (818) 785-6934
TTY/TDD: (818) 785-7097
**Call for Lancaster and Santa
Clarita Branch information.**

**Independent Living Resource
Center**

423 West Victoria
Santa Barbara, CA 93101
Voice: (805) 963-0595
TTY/TDD: (805) 963-0595
www.ilrc-trico.org
**Call for Santa Maria, San Luis
Obispo , and Ventura Branch
information.**

**Independent Living Resource
Center, San Francisco**

649 Mission Street, 3rd Floor
San Francisco, CA 94105
Voice: (415) 543-6222
TTY/TDD: (415) 543-6698
Spanish Language: (415) 543-6743
Chinese Language: (415) 543-6768
www.ilrcsf.org

**Independent Living Resource of
Contra Costa County**

3200 Clayton Road
Concord, CA 94519
Voice/TTY/TDD: (925) 363-7293 or
1-800-633-4644 - www.ilrccc.org
**Call for Antioch, Fairfield, and
Richmond Branch information.**

**Independent Living Services of
Northern California**

1161 East Avenue
Chico, CA 95926-1018
Voice/TTY/TDD: (530) 893-8527
**Call for Redding Branch
information.**

**Marin Center for Independent
Living**

710 Fourth Street
San Rafael, CA 94901
Voice: (415) 459-6245
TTY/TDD: (415) 459-7027
www.marincil.org

**Placer Independent Resource
Services**

11768 Atwood Road, Suite 29
Auburn, CA 95603
Voice: (530) 885-6100
TTY/TDD: (530) 885-0326
www.pirs.org

**Resources for Independent
Living**

1211 H Street, Suite B
Sacramento, CA 95814
Voice: (916) 446-3074
TTY/TDD: (916) 446-3074

Rolling Start, Inc.

5701 W. 4th Street, Suite 103
San Bernardino, CA 92401
Voice: (909) 884-2129
TTY/TDD: (909) 884-7396
**Call for Victorville Branch
information**

Service Center for Independent Living

109 South Spring Street
Claremont, CA 91711
Mailing Address: P.O. Box 1296
Claremont, CA 91711
Voice: (909) 621-6722
TTY/TDD: (909) 445-0726

Call for Covina Branch information.

Silicon Valley Independent Living Center

2306 Zanker Road
San Jose, CA 95131
Voice: (408) 894-9041
TTY/TDD: (408) 894-9012

Call for Gilroy Branch information.

Southern California Rehabilitation Services

7830 Quill Drive, Suite D
Downey, CA 90242
Voice: (562) 862-6531
TTY/TDD: (562) 869-0931

Westside Center for Independent Living

12901 Venice Boulevard
Los Angeles, CA 90066
Voice: (310) 390-3611
TTY/TDD: (310) 390-9204 -

www.wcil.org

Call for Airport Branch information.

CALCASA encourages your center to utilize and incorporate the information within this packet in training your board, staff and volunteers. We also invite you to share effective strategies or approaches with CALCASA staff for future updates on this subject. By working together, we can enhance our efforts in preventing sexual assault for persons with disabilities. If you require any technical assistance or would more information on this subject, please feel free to contact CALCASA staff at (916) 446-2520 for assistance.