

# Safety Planning

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

## Key Points

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

## **B10. Safety Planning**

### **Purpose**

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

### **Objectives**

Those who complete this module will be able to:

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

### **Preparation**

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

### **Part 1: CORE KNOWLEDGE**

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

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

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

Victims' feelings of security and control in their lives can be enhanced when service providers provide an opportunity to discuss their safety concerns and ways to reduce their risk of further

harm. They can help victims with disabilities examine if and how their disabilities impact safety and identify accommodations that may be useful in overcoming barriers to safety. Recognizing that victims' situations and safety concerns may change over time (e.g., if their level of functioning/mobility changes or if they start having flashbacks years after the assault), safety planning should be an ongoing process rather than a one-time event. It is critical that service providers also realize that victims with disabilities may worry that a disclosure of sexual assault may lead to a loss of independence. Therefore, they should support victims in making their own choices about their safety, to the extent possible, instead of deciding what is best for them.<sup>8</sup> (See *Disabilities 101. Self-Advocacy with Victims with Disabilities.*)

### **What does safety mean to sexual violence victims?**

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

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

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

### **What is safety planning?**

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

There are two main forms of safety planning for victims discussed in this module: planning when victims are in a crisis; and planning when they have time to prepare. When victims are in

crisis and/or experiencing imminent danger, their immediate focus typically is on finding a safe location (e.g., away from the perpetrator, the place where the assault occurred or the situation that is causing them fear) and on seeking support to help them become safer (e.g., law enforcement officers to protect them from the perpetrator, emergency medical services technicians to treat serious injury and/or a crisis counselor to help them deal with their distress). In non-crisis situations, victims have more time to focus on their comprehensive safety needs.

**FYI—Safety plans should be based on victims’ self-identified needs and goals rather than professionals’ opinions or family members’ concerns.** To the extent possible, victims should make their own choices about planning for safety. It is understandable that family, friends and others who support victims want them to be safe from harm after a sexual assault. For example, a family member may want an older victim with disabilities placed in a residential facility rather than living in the community on her own. A service provider may feel that a victim with a mental illness who has suicidal thoughts is the “safest” in an in-patient psychiatric hospital. Yet these safety “solutions” may represent a loss of independence for victims and may not be their personal choices. *Victim-centered safety plans, on the other hand, can help restore power and control to victims as they make decisions about their safety.* For example, the older victim may ultimately choose to remain living in the community, but with a caregiver and enhanced security measures. The victim with a mental illness may decide to address her suicidal feelings through out-patient counseling, contact with supportive friends and use of a 24-hour crisis line.<sup>10</sup> (See *Disabilities 101. Self-Advocacy and Victims with Disabilities, Disabilities 101. Guardianship and Conservatorship and Sexual Violence 101. Working with Victims with Mental Illnesses.*)

### **Which agencies should assist victims with safety planning?**

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

### **How can service providers assist victims who are in crisis in planning for their safety?<sup>11</sup>**

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

### **CHECKLIST FOR SAFETY PLANNING WITH A VICTIM IN CRISIS**

- **Ask the victim the reason she is calling/requesting help.**
  - Convey that you are glad she called/requested help, you believe her, the violence was not her fault, you are sorry the violence occurred, and you can assist her in getting help.
  - Respect and accommodate the pace of communication and the needs, abilities and experiences of the victim.
- **Ask the victim if she has immediate or pending safety concerns for herself, her family, any pets and/or service animals. Ask her to be specific.**
  - Validate her concerns about safety.
  - In the case of imminent danger, call 911 as per your agency's policy.
  - If the assault was recent, explain the importance of getting immediate attention for any injuries as well as for the prevention of sexually transmitted infections and pregnancy (if relevant). Help facilitate medical care for the victim as per your agency's policy. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
  - If relevant, explain to the victim the mandatory reporting requirements, as defined by state law. (See *Sexual Violence 101. Mandatory Reporting.*) Recognize that victims with disabilities may be reluctant to involve law enforcement or other authorities for a variety of reasons. (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors.*) If a mandatory report is required, encourage the victim to initiate the report and offer assistance in reporting.
- **If she discloses having a disability, ask her to explain any concerns she has related to how the disability may affect her safety.**
  - It may be difficult for her to identify if and how a disability impacts the situation (e.g., because she has not considered this issue before or has trouble comprehending the extent of the danger posed). Provide support as necessary in talking through this issue.
- **Ask the victim if you can help her in developing a plan to address her immediate safety needs** (for her and her dependents, pets and service animals as applicable to the situation). The plan should identify specific tasks, persons and resources that can help meet her needs. These could include:
  - Specific steps the victim can take to address her immediate safety concerns. Offer assistance in brainstorming creative solutions to safety that are within her abilities and resources.<sup>12</sup>
  - Supportive persons whom the victim can turn to for help with safety needs and their potential roles in the process.
  - Specific safety strategies that may prove difficult to achieve and accommodations available to reduce or eliminate any barriers. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
  - Essential items needed, if time and safety allow, when the victim has to flee from her current location (e.g., medications, assistive devices, information about services and

financial benefits, key insurance and legal documents, money, caseworker's name and phone number, information about a legal guardian, etc.) and any assistance needed to obtain these items. (See the next section for a more extensive list of items.)

- Referrals to community resources to meet the victim's urgent needs. As appropriate, ask if you can immediately connect her with agencies to help her deal with the situation (e.g., to the local rape crisis center).
- **Encourage the victim to follow up to let you know how she is doing and to develop a longer-term plan for safety and other assistance** (if the victim is not referred to another agency for long-term planning).

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

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

### **CHECKLIST FOR GENERAL SAFETY PLANNING WHEN THERE IS TIME TO PREPARE**

- **Build rapport with and listen to the victim.** Respect and accommodate the pace of communication and the needs, abilities and experiences of each victim. Do not underestimate the power of compassionate listening—victims can benefit simply from being heard, believed and supported in their decisions regarding safety.<sup>14</sup> (See *Sexual Violence 101. Crisis Intervention*.)
- **Help the victim identify fears, obstacles, threats and barriers to safety, health and well-being that may be in her life.** Also consider these issues as they apply to her dependents, pets and service animals. (See the next section on issues specific to victims with disabilities.)
- **Ask the victim if and how any needs for accommodations might impact her safety and safety planning.** Consider what accommodations might help meet her safety needs. (See *Disabilities 101. Accommodating Persons with Disabilities*. Also see the next section on issues specific to victims with disabilities.)
  - Consider support persons who can assist with safety needs and discuss their roles.
  - Consider community resources available for safety and possible barriers she may encounter in accessing them. For example, a courthouse that is not physically accessible may permit a protection order court hearing to occur by telephone to accommodate petitioners who use wheelchairs.<sup>15</sup>
  - If the victim knows her perpetrator, discuss if and how the perpetrator could potentially prevent her from using services and resources. For example, if the victim is deaf, an abusive spouse or caregiver could tell her that 911 will not respond to her TTY calls, or may try to act as an interpreter for her during a hospital visit to control the content of her statements to healthcare providers. Provide the victim with clarifying information and brainstorm options for these situations.<sup>16</sup>
- **Ask the victim what she needs to do to be safe.** The victim is an expert on what safety techniques will work best for her, given her strengths, circumstances and accommodation

needs. Most victims will be able to state their preferred methods for accomplishing a task. Rely on the victim's creativity and knowledge, while providing her with information on sexual violence and, if necessary, suggestions for additional methods of reaching the same goals.<sup>17</sup>

- Recognize, however, that a victim may have difficulty identifying the possible safety solutions and accommodations she needs (due to a disability, misinformation about available resources, isolation from society, etc.). While service providers cannot know every detail about every type of disability, they must understand the basic functions needed to develop and implement a safety plan, be aware of available safety planning strategies, and explore how a disability might affect those safety planning functions and accommodations.<sup>18</sup>
- Help the victim create a safety plan for multiple situations as appropriate to her circumstances and safety concerns and goals. Below are some ideas.<sup>19</sup>
  - **Strategies to prevent future incidents of harm by others:**
    - Report the violence to law enforcement or other authorities (with the expectation that the perpetrator will be arrested/incarcerated or otherwise remove/restrict access to the victim).
    - Minimize financial dependency on one person; include more than one person in financial arrangements (e.g., assisted living staff and a family member or a guardian and a service provider).
    - Obtain and understand basic information on sexual violence, personal boundaries, personal safety and community resources.
    - Inform caregivers and service providers that any sexual violence will be reported to law enforcement and follow through with reports.
    - Reduce isolation through multiple social connections (family, friends, church, neighbors, social networks, etc.).
    - Maintain regular conversations with someone other than the caregiver (with a doctor, advocate, family member, Adult Protective Services (APS) worker, clergy, etc.) who can verify personal safety.
    - Obtain a restraining/protective order, if eligible.
    - Screen personal care attendants before hiring and guardians before appointment.<sup>20</sup> (See *Disabilities 101. Guardianship and Conservatorship.*) If the perpetrator is the caregiver, arrange for alternative personal assistance.
    - Identify a supportive family member/friend to live with, either temporarily or permanently. Also identify family members, friends and others who can regularly check in to monitor safety.
    - If there are children, grandchildren or other dependents, devise a plan of safety for them when with/not with them. Inform schools, day care programs, etc. about who has permission to pick them up and who does not.

- Reduce chances of contact with the perpetrator by moving to another safe, accessible residence or room in a residential facility, transferring to another class/program, changing routines, etc.
  - Identify safe communication methods for corresponding and interacting with service providers (ask providers to use plain envelopes, mail information only to locations deemed safe by the victim, make contact only through phone numbers and e-mail addresses deemed safe by the victim, address victim safety getting to and from appointments, etc.).
  - Change and add locks and install alarm systems and other home security measures (keep windows shut and locked at all times, increase outside lighting, etc.).
  - Change telephone numbers and e-mail addresses. New numbers should be unlisted and unpublished. Screen telephone calls.
  - Hide/disarm/remove weapons.
  - If vehicles and any adaptations are used, they should be in good working order. Keep the gas tank at least half full so there is always enough gas to leave a situation quickly if necessary.
  - Obtain an escort to the car, bus, taxi or other transportation being utilized. Also, a friend and/or family member can be asked to call to check on the victim's safe arrival at a destination at a specified time.
  - If the perpetrator is convicted, make victim impact statements during sentencing and parole hearings. These may result in a longer prison sentence and/or special conditions during incarceration and/or probation and parole.
- o ***Strategies to facilitate protection/seeking help during a potentially unsafe interaction:***
- Ensure access to communication (phone, cell phone, TTY machine, computer/Internet service, etc.) if help is needed.
  - Maintain access to assistive mobility devices.
  - Identify who can help and have emergency numbers and a phone/other communication devices readily available (e.g., program 911 into a cell phone or activate an alarm button).
  - Identify a signal, such as placing a towel in the window or using a code word (e.g., the word “red” could mean “I’m in danger”), which will alert neighbors, family or friends to send help.
  - Teach children and other dependents how to contact law enforcement and emergency services.
  - Plan routes/destinations to escape a variety of dangerous situations (at home, at work, at school, while in transit, in public buildings and places, etc.) and identify/secure accommodations and what assistance is needed. If a service animal



is used or there are dependents, the plan should also include how to get them to safety. If leaving during a dangerous situation, plan to drive directly to the police station.

— Gather together:

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

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

— If a protection order is in place, carry it at all times and give copies to trustworthy people at places of employment, school and other frequented sites or where protection from the perpetrator is needed.

— During an incident, try to move away from rooms that have any possible weapons, like the kitchen. Seek shelter in a room where a door can be locked and that has a working phone/communication device. Or, if possible, look for an exit, yell for help or try to flee.

o ***Strategies for obtaining emotional support:***

— Identify a 24-hour/consistent source of support, crisis intervention and contact as needed.

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

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

The information below offers examples of different safety issues and potential solutions. <sup>21</sup> These examples are not meant to be an all-inclusive listing of points to consider for safety, as each victim’s needs are unique.

## Victims with Cognitive Disabilities

### Safety issues

- Cognitive disabilities generally fall into the following categories: learning disabilities such as dyslexia, attention deficit hyperactivity disorder (ADHD), brain injuries and genetic diseases such as Down syndrome, autism and dementia.<sup>22</sup> People with cognitive disabilities may or may not have issues with language, learning, mobility and capacity for independent living. However, the range of capabilities of people with cognitive disabilities is probably greater than with any other type of disability.<sup>23</sup>
- Some people with cognitive disabilities are overprotected and discouraged from being independent or interacting with others. Often, they are limited to segregated services and programs (e.g., in residential, healthcare, educational and work settings).
- Some individuals with cognitive disabilities are taught to comply with authority at all times and this can impact their ability to identify options for safety. (See *Disabilities 101. Self-Advocacy and Victims with Disabilities.*)

### Possible safety solutions

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

## Victims with Sensory Disabilities

### Hearing

#### Safety issues

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

#### Possible safety solutions

- Check with the victim before engaging any specific services for them (e.g., an emergency interpreter service may work with or for the perpetrator).
- You cannot tell the identity of a person talking on the TTY. Perpetrators may pretend to be victims using the TTY to gain information. If this situation is a possibility, set up a code word with the victim (e.g., the name of her cat) to verify with whom you are speaking.
- Save an outgoing message to 911 typed into the TTY memory so that a victim can quickly request an emergency police response. The message should include her address and any existing protection order information.
- Erase the memory on the TTY machine after a confidential conversation. The TTY has a computer chip that retains previous phone calls in its memory. If a victim is leaving the TTY behind, the perpetrator might be able to find out where she went by reading the phone conversation from the TTY memory.
- Perpetrators may damage TTY machines to prevent victims from communicating with others. Note that the West Virginia Division of Rehabilitation Services ([www.wvdrs.org](http://www.wvdrs.org) or 800-642-8207) provides low interest loans to qualified individuals with disabilities to purchase assistive technology. In addition, the Centers for Independent Living within the state operate a Community Living Services program that also provides funding to individuals with disabilities to purchase assistive devices or pay for home modifications to improve accessibility. See [www.mtstcil.org](http://www.mtstcil.org).
- Flashing lights and vibrating pagers can be connected to a motion detector, alarm system, doorbell or other devices to increase a victim's safety.

### Vision

#### Safety issues

- There are several types of vision disabilities, each requiring differing accommodations. People who are legally blind may be able to read large print or move about without mobility aids. They may be able to perceive light and darkness, some color or see nothing at all. Some persons who are blind may read Braille, but the majority of people who are blind do

not. Some use service animals, some do not. (See *Disabilities 101. Accommodating Persons with Disabilities.*)

- People with service animals WILL NOT leave their animals; service animals need to be included in any plan to flee a situation.
- Perpetrators may try to use the animals to control victims because of their dependency on the animals.

### **Possible safety solutions**

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

### **Speech/Communication**

#### **Safety issue**

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

#### **Possible safety solutions**

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

## **Victims with Mobility Disabilities**

### **Safety issues**

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

### **Possible safety solutions**

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

## **Victims with Hidden Disabilities**

### **Safety issues**

- Hidden disabilities in this module refer to those disabilities that may not be easily detected

by or apparent to others. This category could include disabilities already mentioned, as well as chronic health conditions that can cause disabilities such as HIV/AIDS, seizure disorders, asthma, diabetes, heart disease and substance abuse.

- Some people with disabilities may have difficulty with breathing. Many different substances may be responsible for the constriction of air passages that is symptomatic of asthma. Stress may also be a factor in causing difficulty with breathing.
- People with diabetes who take insulin may be subject to insulin shock brought on by exercise, stress, an overdose of insulin or too little food. Too much sugar in the blood and not enough insulin may result in a diabetic coma.
- An individual's seizure threshold may be influenced by many factors such as emotional upset, bodily discomfort, stress, hunger, fatigue or changes in medication.

### **Possible safety solutions**

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

## **Victims with Mental Illnesses**

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

### **Safety issues**

- Mental illnesses typically are recurring, ongoing conditions. Societal discrimination is a barrier to accessing services for victims with mental illnesses.
- People with certain mental health diagnoses may develop patterns of relating to others that make relationships difficult to initiate and maintain. Community resources available for these individuals may be significantly less accessible for this reason.
- Dissociated or fragmented thoughts and an inability to process information may affect a victim's ability to recognize and avoid danger, as well as possibly impact her credibility from the perspective of the criminal justice system.
- A high percentage of adults diagnosed with serious mental illnesses have histories of childhood abuse. It can be helpful to provide these individuals with basic information regarding flashbacks and memory triggers to traumatic experiences.
- Abusive caregivers/partners may tamper with victims' medications as a control tactic.

### **Possible safety solutions**

- Regardless of whether a mental illness was present before the onset of the sexual violence,

sexual victimization can have many emotional and behavioral effects, leading to a trauma-induced diagnosis or the exacerbation of an existing mental illness. Service providers can stress this fact with victims.

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

## Test Your Knowledge

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

1. How can safety planning help victims increase their safety and well-being? See pages B10.2–B10.3.
2. What steps can service providers take to aid sexual violence victims in crisis in planning for their safety and well-being? See pages B10.4–B10.6.
3. What steps can service providers take to assist victims in planning for their safety when there is time to prepare? See pages B10.6–B10.10.
4. What are examples of specific issues that victims with disabilities face in safety planning, as well as potential safety solutions? Please describe for victims with cognitive disabilities, sensory disabilities (hearing, vision and speech), mobility disabilities, hidden disabilities, and mental illnesses. See pages B10.11–B10.16.

## Part 2: DISCUSSION

### Projected Time for Discussion

2 hours



## Purpose and Outcomes

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

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

## Planning

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

## Suggested Activities and Questions

### 1. Invite participants to identify discussion ground rules to promote open communication. Utilize the following principles: (10 minutes)

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable to express their opinions and feelings on the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and the expectations for confidentiality in the context of this partnership.

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

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

- a. Are the approaches to safety planning that their agencies use narrower, as broad as or broader than the approaches discussed in the *Part I: Core Knowledge*? Explain.
  - b. Do the approaches to safety planning that their agencies use allow for individualized planning and flexibility?<sup>24</sup> Explain.
  - c. What different issues have agencies addressed when safety planning with clients? For example, abuse by caregivers and victims' concerns about long-term care placement.
- 3. Ask participants to read over the following two scenarios and then discuss the questions for each in a large group. (60 minutes)**

### Scenario 1

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

Scenario 1 questions to consider:

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

### Scenario 2

*Hank is a 35 year-old man with moderate autism who lives in a residential facility (a group home). Tom, a new staff person at the group home, takes Hank to a physician's office for his annual physical exam. When helping Hank change into a patient dressing gown, Tom fondles Hank's genitals and buttocks and then tells Hank to lay down on the exam table to wait for the doctor. Hank does what Tom says and is too afraid to say anything about the sexual contact. Back at the group home, Hank avoids Tom as much as possible. Hank's brother, who is Hank's guardian, visits a few days later. He notices that Hank is acting more nervous and withdrawn than usual, especially when Tom is around (Tom is the staff person on duty during his visit). The brother asks Hank what is going on. Hank just keeps repeating "Tom is a pervert" and says that he doesn't want to be around him. The brother isn't sure what to do; he calls your agency for guidance.*

Scenario 2 questions to consider:

- a. What steps can your agency take to respond to the brother and help facilitate Hank's immediate safety?
- b. Subsequently, what steps can your agency take to help Hank develop a longer-term plan for safety? How can the brother fit into the plan?
- c. What other agencies may be able to provide information or assistance to Hank to help enhance his safety and well-being and/or provide accommodations?
- d. What steps can the service provider from your agency suggest to Hank and his brother to connect them with these resources?

**4. As a large group, ask participants to discuss the following questions:<sup>25</sup> (15 minutes)**

- a. How do you support clients in making their own choices about safety, even if risk is involved, and balance that with your concerns for their safety? (See *Disabilities 101. Self-Advocacy and Victims with Disabilities.*)
- b. What are ways service providers exclude victims from their own safety planning? How can agencies strengthen victims' voices in this process?

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

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

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

<sup>2</sup>Although males and females are both victimized by sexual violence, most reported and unreported cases are

females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

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

<sup>4</sup>Victim Rights Law Center.

<sup>5</sup>Victim Rights Law Center.

<sup>6</sup>Victim Rights Law Center.

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

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

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

<sup>10</sup>Concept for this paragraph drawn from Day One et al., 39.

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

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

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

<sup>14</sup>Hoog, *Enough and yet not enough*.

<sup>15</sup>Paragraph from Hoog, *Model protocol*.

<sup>16</sup>Paragraph from Hoog, *Model protocol*.

<sup>17</sup>Paragraph from Hoog, *Model protocol*.

<sup>18</sup>Paragraph from Hoog, *Model protocol*.

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

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

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

<sup>22</sup>Disability definitions, [http://studentdisability.wayne.edu/handbook/010.\\_disability\\_definitions\\_list\\_6.05.pdf](http://studentdisability.wayne.edu/handbook/010._disability_definitions_list_6.05.pdf).

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

<sup>24</sup>Question adapted from Day One et al., 40.

<sup>25</sup>Questions adapted from Day One et al., 39-41.