

ILLINOIS IMAGINES

NEEDS ASSESSMENT REPORT

BACKGROUND/INTRODUCTION

In 2006, the Illinois Department of Human Services (DHS) received a three-year grant from the Office on Violence Against Women (OVW) to examine and propose changes to the systems responding to women with disabilities who experience sexual violence. DHS' grant project, called Illinois Imagines, is designed to strengthen the service delivery systems so that women with disabilities who survive sexual violence will receive a proactive, individualized, compassionate response to their experience.

Illinois Imagines convened a project team including representatives of key agencies working in the fields of disability and sexual assault. Each one brings a wealth of expertise and resources to the project: self advocates; members of the DHS Divisions of Community Health and Prevention, Rehabilitation Services, Mental Health, and Developmental Disabilities; representatives from the Illinois Coalition Against Sexual Assault (ICASA); Illinois Family Violence Coordinating Council (IFVCC); Illinois Network of Centers for Independent Living (INCIL); Illinois Voices, and the Blue Tower Training Center. While bringing together partners from various areas of study can be challenging, all project team members share a common vision of justice, compassion, person-centered services, and the empowerment of all women with disabilities who have survived sexual violence.

The team members met twice monthly for the first year of the project to establish a charter, educate one another about the people they serve and fields of work that they each represented and to achieve consensus on the project focus and goals.

As part of that foundation work, Illinois Imagines developed a mission statement. That mission is "to develop, implement, formalize, and sustain integrated systems in Illinois that will achieve the following goals.

1. Empower women with disabilities to actively shape those systems.
2. Prohibit and interrupt sexual violence perpetrated against women with disabilities.
3. Support and empower women to report sexual violence to any provider, agency or law enforcement official.
4. Provide survivor-centered crisis response, advocacy and counseling for women with disabilities.
5. Remove all obstacles faced by women with disabilities who are survivors of sexual violence."

This mission statement guided the Needs Assessment process for each of the five mission areas. The team developed global questions related to each area of the

mission. The questions for each of the mission areas shifted focus depending on whether we were asking individual women with disabilities, community-based service providers or representatives of the state systems serving women with disabilities and survivors of sexual violence. The global questions centered on several key areas. See Appendix A for global questions.

- Needs of women with disabilities who may have experienced sexual violence or know someone who has and their experiences in accessing services;
- Policies, procedures, and practices of the state service delivery system responsible for the administration of disability and sexual assault services;
- Policies, procedures, and practices of disability service providers and sexual violence service providers at the community level;
- Capacity of sexual assault centers to provide services to women with disabilities;
- Capacity of disability service providers to identify sexual violence and link women with disabilities to sexual assault services;
- Linkages among agencies serving women with disabilities and sexual violence survivors; and
- Involvement of women with disabilities in making and implementing policy/protocol of agencies that serve them.

The areas of the Needs Assessment which focused on women with disabilities was directed toward their ideas about what would be useful if they experience sexual violence. With service providers and state agencies, the Needs Assessment focused on awareness, knowledge, skills, and resources related to serving women with disabilities and responding to sexual violence. Attitude assessment was woven throughout the surveys, focus groups and interviews. Collectively, the process has informed the project team about opportunities for change at the individual, community and statewide levels.

Now that the Illinois Imagines project team has assessed the current system's strengths and challenges, it will engage in a strategic planning process to identify opportunities for enhancement. Development of a planning process which builds upon lessons learned through our work as a statewide collaborative will transfer these insights into a working model for community systems at the local level. Additionally, statewide systemic supports will be addressed, such as policy development, the improvement of a regional support system, more in-depth training requirements, and the creation of teaching tools and resources that address this life-altering topic. This two tier approach will promote sustainability and a customization of services to meet the needs of women with disabilities who experience sexual violence.

GUIDE TO TERMS

The System – The system responding to women with disabilities and survivors of sexual violence in Illinois has multiple segments. A brief description of the central parties and their roles follow.

Woman with Disabilities – woman who has a developmental disability, physical disability, mental illness and/or who is Deaf/Hard of Hearing.

Illinois Department of Human Services (DHS) – state agency responsible for: 1) administering funds, establishing standards, and monitoring services to women with developmental disabilities and mental illness through community based providers via the Division of Developmental Disabilities and the Division of Mental Health and 2) providing direct services to women with disabilities via the Division of Rehabilitative Services.

Disability Provider Agency – local, community-based provider of direct services to women with disabilities, usually focused on developmental disabilities or mental health.

Illinois Coalition Against Sexual Assault (ICASA) – statewide non-profit association of local sexual assault crisis and prevention centers. ICASA administers funds to and monitors local centers, conducts training, sets policy/standards.

Rape Crisis Center – community-based agency providing a specific set of services to sexual assault victims, their significant others and community. Services must include 24-hour hotline, 24-hour medical/criminal justice advocacy, counseling, public education, professional training, institutional advocacy and information and referral. Services are free and confidential and is protected via state statute specific to sexual assault survivors.

Required Reporters - any employee who suspects, witnesses, or is informed of abuse or neglect. An employee refers to any person currently (or formerly) providing services at the direction of the owner or operator of the facility or the community agency on or off site. The service relationship can be with the individual, the facility or agency. Also, any employee or contractual agent of the Department of Human Services involved in providing or monitoring or administering mental health or developmental services. This includes but is not limited to payroll personnel, contractors, subcontractors, and volunteers.

Sexual Violence – Sexual violence is non-consensual or coercive sexual conduct. Sexual violence includes any unwanted behavior or contact of a sexual nature, from sexual harassment/bullying to sexual assault.

METHODOLOGY

I. PARTICIPANTS/RECRUITMENT

The Needs Assessment sought information at the individual level (women with disabilities), the community level (rape crisis centers and disability service providers) and the state level (ICASA and DHS staff). It is anticipated that to be successful, enhancements of the system must address each of these levels. This multi-level approach was embedded into the plan in order to examine the experiences and perceptions through the unique lens of all those who comprise the service delivery system in Illinois. Additionally, we sought to ensure that we reached individuals from many different areas in Illinois, so that our findings would give us an accurate picture of the needs across the state and support our statewide change efforts.

A. Women with Disabilities – Individual Level

The collaboration sought to reach 200 women with disabilities, primarily through focus groups, but also using some individual interviews. Individual interviews were conducted with women who were unable to attend a focus group or preferred an interview. We wanted to have equal representation in terms of disability type, so we recruited approximately equal numbers of women with mental illness, women with developmental disabilities and women who utilized vocational rehabilitation services and/or Centers for Independent Living (CILs).

Women with disabilities were recruited to participate in focus groups through groups that already worked with or serve the women. We also e-mailed flyers to advocacy organizations (Illinois Voices, The Arc of Illinois, INCIL), and disability service providers (home services program, vocational rehabilitation), so that they might convene a group of the women they serve. Women with disabilities were not asked to complete a survey instrument.

B. Sexual Assault Service Providers – Community and Statewide Level

The collaboration sought to reach 50 individuals who work in rape crisis centers. Information from these community level providers was collected through focus groups and electronic surveys. Focus groups were conducted with rape crisis center staff at pre-existing meetings of various subcommittees of ICASA. Surveys were sent via e-mail to the directors at all of the 33 rape crisis centers in Illinois.

Individual interviews were conducted with various staff members at ICASA. Those staff were selected because of their particular roles in leadership and in policy making at the statewide level.

C. Disability Service Providers – Community and Statewide Level

The collaboration sought to reach staff in disability service agencies through focus groups, and more of those staff through electronic surveys. Focus groups were conducted with at pre-existing meetings such as regional network meetings or agency staff meetings. Surveys were e-mailed to the network managers of the Division of Mental Health and Division of Developmental Disabilities within DHS. The network managers then e-mailed those surveys to community providers.

Within the Division of Rehabilitation Services (DRS), surveys were e-mailed to direct-line staff members. These counselors and case managers located in local offices across the state serve in a similar capacity as community-based providers.

To gain the state level perspective, individual interviews were conducted with non-direct service staff in all three departments of DHS. These staff included training coordinators, bureau chiefs and network managers.

II. MEASURES

The chart below details the projected numbers and the actual number of people reached via each method.

| TARGET POPULATION/ STRATEGY | Projected Individuals | Actual Individuals | Projected Groups | Actual Groups |
|--------------------------------|--------------------------|-----------------------|---------------------|------------------|
| Women with Disabilities | | | | |
| Focus Groups | 200 | 133 | 18 - 24 | 20 |
| *Individual Interviews | 20 | 3 | | |
| Rape Crisis Centers | | | | |
| Surveys | 30 | 27 | 3-5 | 3 |
| Focus Groups | 50 | 24 | | |
| ICASA Key Informant Interviews | undecided | 4 | | |
| Disability Community | | | | |
| Surveys | 135 | 137 | 9 | 8 |
| Focus Groups | 50 | 88 | | |
| DHS Key Informant Interviews | 10 | 15 | | |
| **DRS staff survey | | 207 | | |

* Individual interviews were offered as an option for women who preferred to provide feedback outside of a group setting. The projected numbers were not reflective of desired goals, but instead used to guide team planning.

** Original projections included DRS staff as a part of the disability provider group. Respondents were later separated out due to data collection process.

Note: Overall the number of focus groups conducted aligned with the projected numbers; however, some groups were not as well attended as expected. The needs assessment team reviewed target population reach throughout the process and determined that saturation had been obtained.

The Needs Assessment utilized three different modes of data collection: focus groups, individual telephone or in-person interviews, and electronic surveys. The manner in which data was collected was dependent upon the target audience, and the type of information desired.

Illinois Imagines developed its questions for each group based upon the global questions in the Needs Assessment plan. Separate sets of focus group questions varied depending on the target audience. The questions for women with disabilities focused on factors influencing disclosure of sexual violence, the desired response to that disclosure, and barriers that prevented the women from getting that desired response. Questions for rape crisis center staff and disability service providers focused on awareness of the issues, current response

practices around sexual violence, obstacles they faced in improving their response to women with disabilities and barriers to collaboration with other key players in the response system. Copies of the focus group questions can be found in Appendix B.

Surveys were created for rape crisis center staff, disability service providers, and direct service staff working for DHS. The questions in the surveys focused on the same issues discussed in the focus groups. Copies of the survey questions can be found in Appendix C.

Individual interview questions were created for key informants at ICASA and upper management staff of DHS. In addition to themes covered in focus groups and surveys for disability service providers and rape crisis centers noted above, the individual interviews for state system staff included questions about contractual requirements, monitoring services, and consumer involvement in policy making. Copies of the interview questions can be found in Appendix D.

III. **PROCEDURE**

A. Focus Groups

Focus groups were held statewide, convening in rural, suburban and urban areas of the state. Focus groups were conducted with women with disabilities, community-based disability provider agencies and community-based rape crisis centers. All groups were assured that participation was voluntary and that all comments were kept confidential.

Focus groups of women with disabilities included women living with families, living independently, and living in group homes. The population included women with developmental disabilities, physical disabilities, mental illness and women who are Deaf/Hard of Hearing.

Women with disabilities received \$10 each for participation in a focus group, and all their transportation costs were paid when necessary. Disability service providers and rape crisis center staff were not paid for participating in focus groups. Accommodations were provided for all people with disabilities for focus groups.

Many members of the collaboration either facilitated or recorded data in focus groups. Groups were always facilitated by team members whose affiliations would not create a conflict of interest. Groups with rape crisis center staff were not facilitated by team members who were also ICASA staff. Groups of DHS service providers were never facilitated by team members employed by DHS that monitor their services.

Each focus group had two facilitators: one asked the questions and kept the conversation on task, and the other facilitator took notes. Notes were first recorded on a flip chart in summary form; this permitted participants in the group to correct the information recorded. The notes were then synthesized on a standard form and sent to the project coordinator to forward to Needs Assessment Team.

When conducting groups with women with disabilities, both the facilitator and recorder were female, and neither was a required reporter. A trained sexual assault counselor was present to provide support to group participants who wish to talk privately during or after the focus group meeting.

B. Individual Interviews

Individual interviews were conducted with key informants via telephone or in person. All participants were assured that their participation was voluntary and that their responses were confidential. As with the focus groups, interviews were conducted by team members who were not affiliated with the organization represented by the interviewee. Interviewers conducting interviews with key informants recorded interviewee responses on a standard form.

C. Surveys

Surveys were created using an Internet based tool and a custom-tailored survey instrument that was compatible with screen readers. Participants were given approximately two weeks to respond to the survey.

IV. **DATA ANALYSIS PROCESS**

The Needs Assessment, conducted February through March 2008, yielded a great deal of data. Electronic surveys, completed using both Survey Monkey and a custom made electronic survey tool to enable participants with disabilities to participate, yielded quantitative data from rape crisis centers and disabilities providers. Focus group and interview data was more qualitative.

The four member Needs Assessment Team divided the work into three sections. Though each member read all of the responses from each target population, they each concentrated on a different area of the overall data analysis. Amy Walker and Jenn Scott analyzed feedback from DHS Services providers, Jenn Scott analyzed feedback from rape crisis centers and Carol Corgan analyzed data from the women with disabilities. Teresa Tudor read all the responses, reviewed the summaries and contributed observations.

V. **IMPLICATIONS OF METHODOLOGY ON FINDINGS**

As noted previously, the needs assessment was multi-faceted. Three distinct levels of feedback were sought: individual, community, and state. To achieve as diverse of a perspective as possible, a variety of methods were utilized to collect data: surveys, focus groups, and individual interviews. Additionally, to obtain input that was representative of the entire state, individuals and agencies participating in the process were from across Illinois including rural, urban, suburban geographic areas.

This broad brushed approach resulted in tremendous information to guide systems change in Illinois. The counterpoint of such an approach is that data was not collected at the level of individual communities nor by disability type. This has two major implications for the data and related findings: 1. findings may appear to be in conflict between needs assessment participants and 2. conclusions can not be definitively drawn by disability type.

For example, overall rape crisis centers reported a more positive collaborative relationship with disability service providers while disability service providers did not report the same level of support. Several factors may have influenced these results. While it is possible that a disability provider and a rape crisis center in the same community may have a different perspective on their relationship, it is more likely that the data was representative of providers in different areas of the state or reflective of a relationship with one provider. Rape crisis centers were asked to rate their relationship with disability service providers, including community mental health centers, independent living centers, and developmental disability programs. The rape crisis center may have a strong relationship with the local DHS, Division of Rehabilitation Services office and have no ties with other disability service providers. The recorded response may have been a collaborative relationship. Additionally, the volume of disability service providers in the needs assessment process far outweighed the amount of input gathered from rape crisis centers (447/27). These factors may have created the conflicting perspective surrounding linkages between disability service providers and rape crisis centers. Despite the “messiness” of the data, feedback clearly points to the need for improved connections between the service systems.

Secondly, methodology impacted the ability to pull out findings by disability groups. It was determined in the needs assessment plan that equal representation of women with disabilities across disability types would be strategic through the recruitment of disability service providers. However, women would not be asked during the focus groups to identify themselves or their disability(ies). Facilitators and recorders were able to pick up on some nuances related to intensity of services and level of independence in the community. These observations indicate differences in experiences, perceptions, and recommendations among women with disabilities and suggest a need for comprehensive system supports.

The strategic planning process will take these factors into consideration. They point to the need for a menu of intervention strategies and models to be developed through the strategic planning process. Illinois Imagines strives to offer choices to fit individual and community needs and most importantly enhance the service delivery system. The challenge in strategic planning will be ensuring quality service standards across the state while allowing for customized community responses which address local capacity, unique needs of individuals and agencies, and availability of resources.

NEEDS ASSESSMENT FINDINGS

Needs assessment findings center around 4 key areas of exploration across every target population: Disclosure, Response, Connection to Services, and Policy/Rules. Common themes and recommendations are noted across groups and are highlighted in this section.

I. WOMEN WITH DISABILITIES

A. Overview

We held 20 focus groups with 133 women with disabilities attending. An additional three women with disabilities participated in an individual interview. The level of services varied with some women residing in group homes and participating in sheltered workshops, while others lived alone in the community and were employed by an independent business. It should be noted that no women living in state operated facilities participated in the needs assessment.

Questions for women with disabilities centered on what they or someone they know would want if they experienced sexual violence. The range of questions included whom they would tell, the response they would want, the barriers to getting their desired response and their advice about improving the service system.

Despite the considerable diversity of the groups based on geography, type of disability, and current living situation, common themes emerged in the women's responses to most of the questions posed in each focus group.

B. Disclosure of Sexual Violence

For women with disabilities information we gathered in the area of disclosure included exploring issues of trust and strategies for promoting disclosure of sexual violence, i.e. use of screening tools by service providers.

Global questions addressing trust and disclosure were posed to focus groups of women with disabilities. We asked what would make a person trustworthy to tell about sexual violence. The overwhelming response focused on three characteristics that make people in general trustworthy.

1. The person must be a good listener. Definitions of a good listener varied, but generally included descriptions such as "not hurried," "focused on me," "talks directly to me."

2. The person will keep the information private/confidential. This was identified over and over as a priority. Women said they would disclose to the person who had previously kept a confidence, was not a required reporter or was otherwise trusted to protect the privacy of a disclosure.
3. The person is perceived as helpful. Helpful was described as being supportive, empathic, non-blaming, non-judgmental and, likely to believe the woman's disclosure and take action to assist.

Conversely, the women indicated they would distrust someone who would not keep a disclosure confidential, either because they weren't trustworthy or because they were required reporters.

When asked specifically whom they would trust, the women identified a variety of people, listed in rank order as follows:

| WHO WOULD YOU TRUST? | NUMBER OF RESPONDENTS |
|--|--|
| Staff | 100 |
| Family | 95 |
| Friends | 86 |
| Police | 67 |
| Caregivers | 45 |
| Others (those identified were medical personnel, pastor, guardian, counselors, rape crisis hotline, neighbor, God) | Categories suggested by WWD were recorded without specific numbers |

* Respondents could report multiple people they trust.

Though family members were the second most trusted, many women noted it would be hard to disclose sexual violence to family because: 1) they might not believe it, especially if the perpetrator is a family member and 2) the family would be stressed/hurt and/or feel guilty about not keeping the woman safe.

Beyond an unsolicited, spontaneous disclosure, we wanted to know if women with disabilities would like to be asked if they had or were experiencing sexual violence. So, we asked whether disability service providers should inquire about sexual violence.

The response to this question was split fairly evenly, with three emphatic viewpoints on this question.

Yes – Some women with disabilities said disability service providers should ask questions about sexual violence. Many women provided guidance on how to ask the questions, such as,

- Only ask once, at intake.
- Only ask if the person asking is trained and skilled enough to respond to a disclosure effectively.
- If the question is asked on a paper intake form and the woman can choose not to respond.

No – Some women said not to ask the question, because it is intrusive to ask, it could re-traumatize a woman and it invades her privacy.

“Only If” – Several women with disabilities said it is only okay to inquire about sexual violence under certain circumstances. The various conditions specified follow.

- If the woman initiates a conversation.
- If the interviewer sees signs or indicators of abuse.
- If the interviewer has a previous relationship of trust with the woman.

The varied input from women regarding disability service providers asking about sexual violence suggests caution in the development of intervention strategies promoting disclosure, such as, screening tools and policy development. Such strategies must balance the viewpoints of women with disabilities who would find the inquiry offensive and consequently would discontinue disability services to those women who would welcome the support and encouragement of workers addressing sexual violence. Responses from focus group participants suggest that a more intense level of services corresponded with stronger support for the inquiry, whereas the women less involved in services and more independent in the community viewed the questioning as invasive.

C. Response to Sexual Violence Against Women with Disabilities

After discussing disclosure, we focused upon global questions addressing the kind of response they would want in the event of sexual violence.

1. **What is Helpful?**

The Needs Assessment asked women with disabilities several questions about the response they wanted if they disclose sexual violence. Women with disabilities indicated similar desires in group

after group. Like other survivors of sexual violence, women with disabilities said that in the event of sexual assault, they want:

- to be believed, to be treated with respect, and to have choices;
- nonjudgmental, comforting response and help to heal;
- to tell their story once, rather than multiple times;
- help calling the police and dealing with all the steps of the court system;
- medical care; and
- safety – keeping the perpetrator away.

Additional desires, particular to having a disability included:

- responders to pay attention to the sexual violence, not the disability;
- a rape crisis worker who is able to communicate without an interpreter; and
- a rape crisis worker who is comfortable with the disability.

D. Connection to Services

Questions in this area prompted participants to explore the strength of connections between women with disabilities who are survivors of sexual violence and rape crisis centers. Linkages to rape crisis centers (RCC), access to services, and resources were included in the discussion.

1. Established Linkages

Women responded to global questions addressing outreach and awareness of services. Some women knew about their local rape crisis center, but many did not, until after experiencing sexual violence or until the day of the focus group. Individuals who shared they had accessed rape crisis services indicated there was a strong connection and follow up services were always available.

2. Access to Services

Regarding difficulties with access to rape crisis services, women cited transportation as the number one barrier. In every focus group, women said they needed transportation to the crisis center; some said free transportation was essential.

In response to the questions, “If you or someone you know wanted to access sexual assault services, what do you think would work best?” and “What obstacles may stand in the way?” women indicated that physical access within the center was not a significant issue. However, concerns about communication access (interpreters,

assisted communication devices, materials written in an accessible format) were identified in several groups.

Several groups also suggested that the rape crisis center conduct support groups at facilities serving women with disabilities. They said this would: 1) enhance awareness among women with disabilities about sexual violence, 2) improve the women's access to services and 3) remove the transportation barrier.

In two groups, women indicated a need for more privacy and confidentiality. Specifically, they wanted to be able to call a rape crisis center without telling disability service staff first and they wanted more clarity about the definition of required reporters (e.g., of the staff and people who work with them, which ones are required reporters).

3. Resources

Women with disabilities reiterated that they needed resources to connect to sexual assault services centered around awareness and access. They overwhelmingly said they would want the help of the crisis center and that they, their families and their staff (residential/day treatment, drivers, counselors, caregivers, etc.) should know about how to get help from a rape crisis center. Suggestions for addressing the barrier of transportation included pick-up services, reimbursement or vouchers, and provision of on-site services.

E. Policy/Rules

We asked if women with disabilities knew of rules to help them if they experienced sexual violence. The question was often either unclearly stated or misinterpreted to be about rules of conduct for women with disabilities rather than rules guiding what should happen in the event of a sexually violent incident. Therefore, the responses were not especially germane as to whether there are rules to help a woman with disabilities to get help if she experienced sexual violence.

F. Recommendations

Women with disabilities identified recommended strategies for improving the service delivery system for survivors. Again, responses fell into similar themes in all the groups. Their priorities, in order based on number of responses (most to least), follow.

- Awareness – Women with disabilities, their families and their service providers need to be aware of sexual violence and rape crisis centers and staff of disability service agencies should be aware of sexual violence and rape crisis centers.

- Get help for women with disabilities – They need to be able to identify sexual violence, to tell, to call a rape crisis center for help and to seek counseling. Services need to reach women with disabilities where they are at, i.e. groups held at disability provider agency.
- Provide survivor-centered response – Responders to women with disabilities who experience sexual violence should focus on the incident of sexual violence rather than the disability. Responders should listen, make eye contact and ask what she needs.
- Training – Rape crisis centers should be trained regarding disabilities and their services should be fully accessible.

G. Observations

The focus group team noted underlying perceptions and experiences which appeared to influence participant responses and should be taken into account when developing the strategic plan.

- Although trust was a significant issue across the board for women with disabilities, we noted that the dynamics of trust were influenced by level of independence and participation in services. Women engaged in higher levels of disability services and maintaining lower levels of independence corresponded to more trust in others and the system. Conversely, women in focus groups who were not as actively involved in services and lived more independently in the community expressed more concern about trusting others. Though we did not collect data to confirm this observation, it was reported by facilitators and by the Needs Assessment Team upon review of focus group reports. This may have been influenced by disability type and recruitment strategies. This observation points to the need for a variety of approaches to be incorporated into the strategic plan.
- In response to being asked about their knowledge of available resources, women with disabilities frequently replied by sharing a history of sexual violence beginning in childhood. This appeared to influence their definition of sexual violence, the normalization of sexual violence, their ability to trust, and their perception of service systems. The reality of repeated trauma and its impact on women with disabilities will be an important factor in development of the strategic plan. This is especially significant for rape crisis centers as they provide services for a population that has a significant portion of women experiencing complex trauma.

- General service connection with women with disabilities is clearly with the disability service system. This theme was echoed throughout needs assessment activities by women with disabilities. To be effective, outreach and educational efforts need to reach women with disabilities where they are at. Although some general awareness strategies were suggested by women with disabilities, most emphasized the importance of targeted outreach by rape crisis centers through the disability services system. In sum, the disability service provider initiates the connection to the rape crisis center and the rape crisis center provides the ongoing support, counseling, and advocacy services.
- Data gathered through needs assessment may be influenced by confusion about sexual assault and domestic violence services. In focus groups participants often referred to the rape crisis center as “the shelter” or “the crisis center.” At times the facilitators were aware, from the context of the remarks that the reference was to a domestic violence shelter, not the local rape crisis center. To further confuse the issue, in some communities, the rape crisis center is part of the domestic violence shelter, and in other communities they are two separate organizations. This may have influenced the input provided by women with disabilities; however, it is believed that the feedback and suggestions gathered in focus groups were mostly relevant. Experiences/perceptions of women with disabilities with domestic violence services may influence personal choice regarding future access of sexual assault services. Any outreach or educational efforts developed as a part of the strategic planning should address this misunderstanding of the service delivery system.

II. DEPARTMENT OF HUMAN SERVICES STAFF AND PROVIDERS

A. Overview

Data from DHS were multi-faceted. We used three methods to gather information from two divergent target groups: state level staff of DHS and the staff working in community-based disability provider agencies or local DHS offices throughout the state. Though both groups work daily to serve women with disabilities, the scope of their work is quite different. The state level administrative personnel takes a macro approach with such tasks as formulating policy, administering contracts and evaluating statewide efforts. Staff in local provider agencies and local DHS offices are more focused on immediate responses to the daily living needs of women with disabilities.

1. Staff Awareness

The input from disability service providers (local and state) began with establishing a baseline of awareness regarding the issue of sexual violence against women with disabilities. The first question on our Illinois Imagines electronic survey of 136 community agencies stated, "How big of a problem do you believe sexual violence is for women with disabilities?" Providers could choose a number between 5 (huge) and 1 (minor). Sixty-six percent of those surveyed rated this issue as 4-5 with another 27% rating it as a 3.

Validating their perception about the magnitude of the problem, 65% of survey respondents said the agency had served women with disabilities who had experienced sexual violence within the past 2-3 years. Yet when asked about the number of times per year their agency responded to sexual assault of a woman with a disability, 22% said never and 37% said 1-2 times. This number of victims seems low compared to the incidence expected based on research. This may be explained by lack of outreach; 89% said there is no outreach to women with disabilities who have experienced sexual violence.

Recognition of the problem of violence against women with disabilities noted above was consistent with the responses from the DRS survey, focus groups and individual interviews of state level workers. Additionally, participants in all focus groups indicated their agencies had served women with disabilities who had experienced sexual violence.

B. Disclosure of Sexual Violence

Input from disability service providers around the global area of disclosure included both consumer and staff barriers. Consumer barriers related to factors influencing whether women with disabilities would make a disclosure, while staff barriers addressed issues impacting identification of sexual violence by disability service staff.

1. Consumer barriers

Across the board, respondents in all needs assessment activity types gave similar responses. The issues were markedly similar to the response given by women with disabilities. Staff in response to global questions on obstacles to disclosure identified five key obstacles for women with disabilities who experienced sexual violence. Listed below in random order:

- Women with disabilities are afraid of not being believed, being labeled as crazy and/or not being viewed as credible to law enforcement.

- Women with disabilities may be unaware of or confused about healthy sexuality versus sexual violence and their own rights regarding sexual relations.
- Women with disabilities are concerned about privacy and confidentiality.
- Women with disabilities were concerned about safety and/or privacy and;
- Women with disabilities may not know how to get help

One barrier was cited by focus groups that was not identified by the state level workers. Women with disabilities are afraid of losing independence or services if they disclose sexual violence. What this means is that women with disabilities applying for benefits from the state may perceive that disclosure of sexual violence jeopardizes their eligibility. Because DRS counselors do not use disclosure as a factor in determining eligibility, they may not be aware of that perceived fear and its influence on their work with the consumer.

2. Staff Barriers

One particular issue identified by disability service staff as an issue impacting handling of disclosure was training. Gaining knowledge and skills as it related to identifying possible indicators of sexual violence was mentioned most often. More general information on training will be described in the next section.

C. Response to Sexual Violence Against Women with Disabilities

Disability service providers were asked for feedback on issues impacting the response to sexual violence against women with disabilities. Such factors included, staff training and comfort level with sexual violence.

1. Staff training

Regarding global questions on knowledge and skills needed to respond to sexual violence against women with disabilities, DRS workers surveyed indicated they have no training regarding indicators of abuse and how to respond to abuse.

Workers perceived that their level of training impacted their ability to respond to sexual violence. 42% of those surveyed indicated their comfort level was 1, 2 or 3 on a 5 point scale. Only 41% felt prepared to serve a woman with a disability who experienced sexual violence.

Training requirements emerged as another priority, with 98% indicating there are five or less hours of mandatory training on sexual violence in the agency. Department administrative staff interviews noted that training for staff and providers addresses abuse and neglect, this

training is not specific to sexual violence and generally does not feature women with disabilities as trainers.

D. Connection to Services

The global area of connection to services entailed several components: established linkages, access to services, and needed resources.

1. Established linkages

Lack of networking and established linkages was a prominent theme across all disability provider staff (community and state level). This was apparent in the provider survey as 66% of community provider staff indicated they knew where sexual assault services are provided. However, 50% said they do not work with the local rape crisis center on a regular basis. DRS staff further commented on the issue emphasizing that workers need to know where to refer women with disabilities who are abused and be sure services will be free, prompt and responsive to women.

The disconnection in the service delivery system occurred in several key points according to disability service providers: 1. women with disabilities do not know where to get rape crisis services; 2. disability providers do not know about rape crisis centers or believe they are unable to serve women with disabilities; and 3. rape crisis centers and disability service providers do not coordinate services.

2. Access to Services

Disability service providers at all levels appear to be keenly aware of access issues. Most providers shared the concern that referrals outside of the disability system can be a challenge in terms of access. Specific access items included:

- Physical barriers and communication can be a deterrent (both because of women's expectations that services aren't accessible and the actual response of medical, law enforcement and rape crisis centers).
- Transportation to/from services. The comments from providers reinforced the feedback from women with disabilities.
- Rape crisis centers are not comfortable serving women with disabilities or are otherwise unresponsive to referrals. Women with mental illness and developmental disabilities were mentioned as populations having difficulty accessing services outside of the disability service network.

Note: This perception of access to services did not completely align with the feedback obtained from women with disabilities focus groups.

Women with disabilities did not report physical barriers, but did identify communication as an issue.

3. Resources

55% of community based disability service providers said their agency does not have the resources to serve these women and 84% of respondents said both local and state resources for these women are insufficient. Resources that are needed were ranked as follows:

| Resource | Percentage of Respondents* |
|--|----------------------------|
| 1. Training | 90% |
| 2. Educational materials for women with Disabilities | 73% |
| 3. Specialized staff | 59% |
| 4. Linkage with sexual assault center | 55% |
| 5. Peer support groups | 48% |
| 6. Policy | 32% |
| 7. Physical accommodations support | 23% |
| 8. Interpreters | 18% |

* Respondents could select multiple resources.

E. Policy/Rules

Global questions around policy and procedures asked about both formal and informal directives guiding several key issues: identification and response to sexual violence against women with disabilities; linkages between disability service agencies, and training requirements.

At the state level, most of the DHS administrators interviewed indicated that the Department has no specific requirements for local providers regarding how to identify and/or respond to sexual violence of women with disabilities beyond Rule 50 – the general rule for reporting abuse and neglect and investigative response in Illinois. Additionally, linkage agreements were not mandated and training requirements did not specifically address sexual violence against women with disabilities.

Most disability service providers at the community level indicated that they do not have formal policies and procedures to respond to disclosures of sexual violence (both past and current incidences of sexual violence). Clinical best practices, such as, clinical supervision, team staffings, and case file reviews were noted as the standards for guiding identification, response, and treatment planning for women with

disabilities who are survivors of sexual violence. Such standards guide the work on all consumer issues, including sexual assault.

Across all levels of disability service staff opinions were split about whether more state requirements would be helpful. Some said development of new policies, rules and procedures to be implemented and monitored by DHS could support an improved response. Others said that – rather than mandates – DHS should provide support, resources and models to local providers to enable them to build better local responses.

F. Recommendations

The following recommendations were given by disability service providers in multiple venues (surveys, focus groups, and individual interviews).

- Provide tools for providers to aid in identification and response to women with disabilities who experience sexual violence.
- Formalize collaboration between disability providers and rape crisis centers.
- Develop referral protocols, training resources and options for sexual assault services to be provided on-site at disability service agencies.
- Clarify definitions and guidelines to improve shared understanding regarding guardianship and confidentiality for both disability providers and rape crisis centers.
- Provide tools for women with disabilities to promote awareness of sexual violence, their rights and how to access services.
- Provide transportation for women with disabilities to rape crisis center.
- Ensure that local agencies have the resources to develop effective collaborative responses (training, communication, etc.).
- Provide immediate access to resources/services when a woman with a disability experiences sexual violence.
- Develop and conduct public awareness campaigns to make women with disabilities more aware of sexual violence and rape crisis centers
- Provide information lines/hotlines/Internet, information about sexual violence and services for women with disabilities and disability providers.
- Involve consumers (women with disabilities) in decision-making and systemic changes.
- Develop training and print material to increase worker's awareness of sexual violence.

G. Observations

The focus group team noted underlying perceptions and experiences which appeared to influence participant responses and should be taken into account when developing the strategic plan.

- Data gathered through needs assessment may be influenced by confusion about sexual assault and domestic violence services. In focus groups participants often referred to the rape crisis center as “the shelter” or “the crisis center.” At times the facilitators were aware, from the context of the remarks, that the reference was to a domestic violence shelter, not the local rape crisis center. To further confuse the issue, in some communities, the rape crisis center is part of the domestic violence shelter, and in other communities they are two separate organizations. This may have influenced the input provided by disability service providers; however, it is believed that the feedback and suggestions gathered in focus groups were mostly relevant.
- Perceived philosophical and programmatic differences between disciplines also emerged during focus groups. Confidentiality and stigma were two themes that came up in several groups. For example, disability providers mentioned not receiving referrals from rape crisis centers. To quote one group, “referrals are a one way street.” In reality due to confidentiality, RCC may be making referrals, but this is done in a less direct manner than typical social service system referrals. Associated stigma with being a “rape victim” was noted as influencing the connection between women with disabilities, providers, and rape crisis centers.
- Training was frequently mentioned by disability staff at all levels as a recommended strategy to improve system response to sexual violence against women with disabilities. Although this approach has much support and can be a viable piece of the strategic plan, it will not be the focal point of Illinois Imagines. The strategic plan will concentrate on interventions which support systemic change now and into the future. Training may be addressed through agency/ professional requirements, adaptation of current training systems, and development of resources. Through the strategic planning process, alternate methods to match respondents’ desired outcomes of training will be explored.

III. RAPE CRISIS CENTERS

A. Overview

Data from rape crisis center staff were also multi-faceted. We utilized three different methods of data collection with two target audiences: state level staff of ICASA and local staff working in rape crisis centers across the state of Illinois. Both of these groups work to serve people dealing with sexual violence, but their roles are quite different. Local center staff work directly with survivors of sexual violence to address their immediate needs. Much of the work done by local center staff is shaped by the communities that they serve. The state coalition, on the other hand, takes a broader approach with tasks such as formulating policy, standardizing training and education requirements and overseeing the local rape crisis centers.

1. Staff Awareness

In concert with the disability service provider input, the discussion with rape crisis staff (local and state) began with establishing a baseline of awareness regarding the issue of sexual violence against women with disabilities. Overwhelmingly, rape crisis center staff were aware of the scope of sexual violence against women with disabilities. The first question on the electronic survey sent to center directors asked how big the problem of sexual violence against women with disabilities was. Ninety-six percent of respondents responded to the survey with a 4 or 5. A score of 5 corresponded to “huge” as a descriptor. Further, 85% of centers indicated that their agency had served at least one woman with a disability in the past 2-3 years. This survey information was reinforced within the focus groups. All of the center staff in the focus groups stated that their agency had served at least one individual with a disability within the last few years.

B. Disclosure of Sexual Violence

No direct questions about issues impacting women with disabilities disclosing to rape crisis center staff were asked. However, in response to a focus group question about barriers to working with disability service providers the following perceptions were identified:

- disability providers do not take disclosures of violence seriously enough, and/or do not respond in a victim-centered manner;
- disability providers have misconceptions about sexuality, sexual expression and sexual violence as it pertains to people with disabilities.

C. Response to Sexual Violence Against Women with Disabilities

Rape Crisis Center staff were asked for feedback on issues impacting their ability to respond to sexual violence against women with disabilities. Such factors included training and personal comfort level with women with disabilities.

We asked survey respondents how comfortable rape crisis center staff were with working with women with disabilities. Thirty-one percent said staff were very comfortable (5 on a 5 point scale), and another 31% responded with a score of "4." Center staff mentioned that they were aware of the privileges that come with not having a disability, and that such awareness was part of the reason that they felt they could use more training around being comfortable around individuals with disabilities. Survey respondents indicated they would be more comfortable and informed if they had more information about:

- identifying and serving women with all types of disabilities;
- knowledge of state and local resources for women with disabilities;
- working with alternative forms of communication;
- strategies for increasing accessibility.

All of the survey respondents said that they received less than five hours of training annually on sexual violence against women with disabilities, and 63% said they had no training at all. This echoes the feedback received from interviews with ICASA staff.

Comments in the focus groups reinforced that training was a huge component of need. No one felt they had had significant training on the topic previously. Some respondents expressed a desire for information about types of disabilities, but the majority of training requests were about being able to communicate more effectively with women with disabilities and being able to feel more comfortable around them.

D. Connection to Services

The global area of connection to services entailed several components: established linkages, access to services, and needed resources.

1. Established linkages

88.9% of survey respondents were aware of the disability agencies in their communities, 73% indicated that they were networking on a regular basis with those agencies. Further, centers were asked to rate the quality of their relationship with disability service providers. 84%

described their relationship as either collaborative or cooperative. In contrast, focus groups indicated that their relationships with disability service providers could be improved.

Several individuals stated that there are no formal referral systems or linkage agreements between providers, but that informal referrals do happen. Those that do get/give referrals have had greater success working with mental health providers than with developmental disability service providers. One member of a focus group stated that their local disability service provider was extremely closed to the idea of collaboration.

Specific comments were provided about what made establishing linkages difficult. Firstly, rape crisis center staff stated that they do not have relationships with staff at disability provider agencies. Secondly, RCC staff felt that disability service providers lacked an understanding of 2 major tenets of rape crisis center's work: the victim centered philosophy and the confidentiality policies applied to rape crisis workers. These philosophical differences made rape crisis centers hesitant to pursue collaboration further.

Note: the responses from rape crisis center staff about linkages with disability service providers do not match the information obtained from disability service providers. This could be influenced by a variety of factors. Most importantly, it should be kept in mind during the strategic planning process as efforts directed at building collaborative relationships at the local level are developed. Specifically, recruitment efforts, team building strategies, shared planning activities, and reciprocal working agreements.

2. Access to Services

Survey respondents indicated that 69% of staff were very prepared to respond to women with disabilities who experience sexual violence. Rape Crisis Center staff had encountered individuals who sought out services, but those individuals' guardians did not want them seeking services. Thus, rape crisis center staff were unsure what steps they should take in serving these women. Many were unclear about how confidentiality and guardianship affected one another, as well as how guardianship affected the client's ability to access services and their rights in terms of confidentiality.

3. Resources

Additionally, groups said that they needed more educational/informational materials that they could use for clients with developmental disabilities and clients who were blind/low vision or Deaf/Hard of Hearing.

ICASA staff also informed us that they do not provide their rape crisis centers with brochures or material addressing sexual violence against women with disabilities. ICASA's materials have a broader target audience, and individual centers create their own materials if a need arises.

E. Policy/Rules

Global questions around policy and procedures asked about both formal and informal directives guiding several key issues: provision of services for women with disabilities who are survivors of sexual violence, linkages between disability service agencies, and training requirements.

On our survey, we asked rape crisis centers if they had policies and procedures regarding serving individuals with disabilities. Seventy-three percent stated their center had policies pertaining to accessibility of services and 84% said they had policies in regard to providing clients with reasonable accommodations. Only 48% said they had a policy pertaining to working with disability service providers. Less than 40% had policies around working with survivors who utilize TTY relay services, sign language interpreters or service animals.

When we asked about policies in the focus groups, no one was aware that their agencies had written policy pertaining specifically to serving women with disabilities. Some said that they had informal agreements with landlords about building accessibility or that they arrange to meet clients in accessible spaces. Some cited the core value of "victim-centered services" (mandated by ICASA) which dictates that center staff serve all the individuals who seek their services. The "victim-centered philosophy" also dictates that the client gets to decide what they need/want in terms of assistance from center staff. No one mentioned the need or desire for any kind of separate policy, as the one already in place seemed all-encompassing. Only 12% of survey respondents indicated a need for policy around this issue. Overall, local rape crisis centers reported that they did not have policy mandating training for center staff addressing working with women with disabilities.

These findings were echoed at the state level. Each of the ICASA staff interviewed were aware of the obstacles faced by women with disabilities, but stated that ICASA does not have standards or mandatory policies specific to serving women with disabilities. For example, ICASA does not require centers to have linkage agreements with local disability service agencies. Instead, ICASA mandates that centers serve *all clients* who seek services. This is included in both ICASA's philosophy and a code of ethics.

ICASA monitors all of its centers through site visits, quarterly reports, and annual funding applications to ensure they are serving all of their clients well. Services provided to women with disabilities are not specifically monitored.

In addition to policy requirements, we asked staff about training for local center staff on serving women with disabilities. ICASA mandates that all rape crisis center staff and volunteers complete 40 hours of training; disability issues are not covered within that training. At the moment, women with disabilities do not facilitate any of these ICASA trainings, but guest trainers with disabilities have presented workshops at statewide conferences.

Note: A comparison of rape crisis center data from surveys and focus groups noted a significant difference in responses about policy. This could be a result of the methodology and/or the level of staff.

F. Recommendations

The following recommendations were given by sexual assault service providers in multiple venues (surveys, focus groups, and individual interviews).

- Change policy so that a women with a disability does not need a guardian's permission to access services
- Clear up confusion about how guardianship affects the survivor's confidentiality rights
- Hire women with disabilities to be on staff at ICASA
- Get the input of women with disabilities in developing trainings, policies, and resources
- Develop formal networking agreements and cross training plans between rape crisis center's and disability service providers
- Educate each other on what the various providers do/their responsibilities

Finally, we asked about how rape crisis center staff and disability service providers can work together to improve services to women with disabilities and what the ideal collaboration would look like. They said that developing formal networking agreements and cross training plans were important, and that a great deal of cross training should be implemented. Staff also identified a pressing need for both groups (rape crisis centers and disability providers) to educate themselves about, and develop a profound respect for, the roles and responsibilities of the other agency. That way, biases and resistance to collaboration could be overcome. They also said that, ideally, both groups would work to involve more

women with disabilities in shaping the system and truly listen to what those women need.

G. Observations

- The impact of professionals learning from women with disabilities was evidenced in discussions with rape crisis staff. During focus groups several participants informed us that they had learned that often times women with disabilities needed the same things that clients without disabilities needed: acceptance, patience, and someone to believe them. They also learned that women with disabilities are very competent to make decisions, but that the women lack critical information about sexuality, sexual violence and their rights. Further, they learned that women with disabilities often lacked support from family or others around sexual violence issues.
- The desire for collaboration came up much more strongly for rape crisis centers than disability service providers. Staff also identified a pressing need for both groups (rape crisis centers and disability providers) to educate themselves about, and develop a profound respect for, the roles and responsibilities of the other agency. That way, biases and resistance to collaboration could be overcome. They also said that, ideally, both groups would work to involve more women with disabilities in shaping the system and truly listen to what those women need.
- A comparison of data from surveys and focus groups noted a significant difference in responses. This could be a result of the methodology and/or the level of staff. Surveys were sent to Executive Directors of rape crisis centers and required a written response to question, whereas, focus group participants tended to be direct-line staff or first line of supervision who responded verbally in a facilitated dialogue.

CONCLUSION

We see many themes among our findings across the three target groups. The responses from women with disabilities, rape crisis centers and the disability service systems have many commonalities as do the responses at the individual, community and state levels. What women with disabilities say they need is consistent with what rape crisis centers say they have to offer. The barriers experienced by women with disabilities align with the limitations identified within disability provider agencies and rape crisis centers. The lack of and need for better connection between disability providers and rape crisis centers is articulated by those in the service systems and women with disabilities.

When analyzed together, these descriptions of need draw a coherent picture. That picture allows us to clearly see the needs of each group and to identify the intersections that have promise as points of intervention and change.

A. Needs of Each Group

1. **Women with Disabilities**

Women with disabilities want and need what all survivors want in the event of sexual violence.

- Safety – physical safety, emotional support, order of protection or other means to keep perpetrator away.
- Privacy and confidentiality – particular to women with disabilities, this means resolution of concerns about required reporters and guardianship.
- Survivor-centered services – particular to women with disabilities, this means services focused on the sexual violence, not the disability and services that accommodate any need for physical access, assisted communication, transportation.
- Awareness of and access to services that are free, convenient, respectful/responsive.
- Accountability for offenders in the criminal justice system.

2. **Disability Providers**

Community-based disability provider agencies and the Illinois Department of Human Services recognize that sexual violence is a significant issue for women with disabilities. To better respond, providers need:

- models for a best practice response to a woman with disabilities who discloses sexual violence including intake screening, referral to and coordination with rape crisis services,

development of treatment plans, and support for individual choice;

- knowledge that the rape crisis center serves women with disabilities and understood the role and services of a rape crisis center;
- confidence in the capacity of the rape crisis center to serve women with disabilities;
- models for collaboration with a rape crisis center to serve women with disabilities who experience sexual violence.

3. **Rape Crisis Centers**

Rape crisis centers and ICASA recognize sexual violence is a significant issue for women with disabilities. To better respond, providers need:

- confidence about their capacity to help women with disabilities;
- confidence about responding to particular needs of women with disabilities related to mobility, vision and communication;
- models for collaboration with local disability providers to provide rape crisis services to women with disabilities;
- referrals when women with disabilities report sexual violence;
- clarity regarding policies and requirements related to guardianship and confidentiality with women with disabilities.

B. Intersections Among Identified Needs

The needs of the target groups have several intersections. These areas of commonality between the two service systems include the need for:

- mutual awareness and understanding of services and roles;
- confidence and comfort in providing services;
- coordination of service systems;
- models for collaboration, accompanied by policy and training guidelines.

A key intersection relates to lack of connection: 1) women with disabilities are not connecting to rape crisis centers and 2) disability service providers and rape crisis centers are not connecting with each other to serve women with disabilities. Though both service systems provide a comprehensive menu of services for the population they serve, the challenge is to capitalize on the strengths of each system to create an integrated program addressing the needs of women with disabilities who experience sexual violence. Since, women with disabilities are clearly connected with the disability service system, this must become the link to connect a woman with a disability who has experienced sexual violence to a rape crisis center. Strategies to capitalize upon this link may include on-site rape

crisis services such as education, outreach and counseling at disability service agencies.

C. Planning for Connection

As noted in the Needs Assessment, philosophical and programmatic differences create a barrier between the disability and rape crisis service providers. Further complicating any collaboration is their mutual lack of knowledge and/or mistrust about the other's expertise. Disability service providers see themselves as experts in serving women with disabilities and do not believe rape crisis centers are able to meet the needs of women with disabilities who experience sexual violence. Conversely, rape crisis centers are not sure that disability providers will respond appropriately to a disclosure of sexual violence and make a referral for rape crisis services. Consequently, the strategic plan must go beyond traditional cross-training approaches and support community-level collaboration models that foster connection.

Illinois Imagines will create a strategic plan focused on creating connection: a key goal is to ensure that rape crisis centers and disability providers work together to serve women with disabilities who experience sexual violence. These connections will be developed through collaboration at the state and community levels. To achieve collaboration and connection, we will develop, promote and support local community efforts. Strategies will include development of model policies and linkage agreements, referral protocols, training standards and other tools.

D. What Comes Next?

Based on the Needs Assessment, we have identified several outcomes to achieve through the strategic planning and implementation phases of the project. The outcomes we have prioritized respond to the Needs Assessment findings. They also embody the values and mission articulated in our Charter, which focuses on keeping women with disabilities and survivors at the center of our work.

1. Build a survivor-centered, best practice, collaborative response system that engages both the disability provider and the rape crisis center in responding to a woman with a disability who reports sexual violence.
2. Include and empower women with disabilities in every aspect of the systems' changes to be achieved through this project.
3. Identify key elements of response protocol to women with disabilities who experience sexual violence, and develop models for implementation in local communities. Embed models within local collaborations via technical assistance and/or mandates/standards.

4. Adopt training requirements and policies to build confidence and competence of rape crisis centers in responding to with women with disabilities in partnership with a disability provider agency to meet the presenting needs of the survivor.
5. Adopt training requirements and policies to build confidence and competence of disability service providers in recognizing sexual violence and responding in partnership with a rape crisis center to meet the presenting needs of the survivor.
6. Promote universal access to rape crisis services via removal of barriers related to physical access, communication and transportation.

Organizational change within the disability and sexual assault service systems will be essential at all levels (community and state) to support sustainable change. True change translates into no wrong door for services. Women with disabilities should be connected to services of their choice to support their healing from the experience(s) of sexual violence. Change is needed in both systems to ensure women with disabilities this choice.

The strategic plan will lead us toward a vision where Illinois Imagines **“All women with disabilities will be guaranteed an environment free from sexual violence, where they are empowered to speak and act for themselves. Survivors of sexual violence will be assured a proactive, individualized, compassionate response to their experience.”**

Appendix A

| MISSION | QUESTION AREAS FOR EACH AUDIENCE | | |
|---|--|--|---|
| | Individual | Service Providers | State Systems |
| Empower women with disabilities to actively shape those systems | 1. What advice would you give about how to better serve women with disabilities who have experienced sexual violence? | 1. Do women with disabilities serve on agency committees/ board? 2. How are women with disabilities involved in policy making? | 1. Do women with disabilities have adequate input into state policies, regulations, training programs, etc.? 2. How could input opportunities expand? |
| Prohibit and interrupt sexual violence perpetrated against women with disabilities | 1. What do you think should be done to help women with disabilities that experience sexual violence? (How should the system look?) | 1. Does staff have the knowledge and skills necessary to identify sexual violence against women with disabilities? 2. Does staff have the knowledge and skills necessary to provide services to women with disabilities who experience sexual violence? | 1. Is there state-mandated training for disability service provider agencies regarding sexual violence? 2. Does ICASA mandated training include sexual violence and women with disabilities? |

| MISSION | QUESTION AREAS FOR EACH AUDIENCE | | |
|--|---|--|--|
| | Individual | Service Providers | State Systems |
| Support and empower women to report sexual violence to any provider, agency or law enforcement official | <ol style="list-style-type: none"> 1. What would make you or a person you know trust someone to tell him/her about sexual violence? 2. If you or someone you know were going to tell someone else about being sexually assaulted, who would that person be? | <ol style="list-style-type: none"> 1. Do you have a link with the local rape crisis center? Disability service provider? 2. Describe policy to respond to and assist women with disabilities who report sexual violence. | <ol style="list-style-type: none"> 1. What guidelines are in place to link disability providers and sexual assault agencies? 2. What are the challenges to a collaborative response between disability and sexual assault providers? What works well? |
| Provide survivor centered crisis response, advocacy and counseling for women with disabilities. | <ol style="list-style-type: none"> 1. If you or someone you know were sexually assaulted what would you want to happen? 2. What kind of help would you want or would you want for a friend, if you were being sexually assaulted? | <ol style="list-style-type: none"> 1. Does staff at disability provider agencies know how to respond when someone discloses sexual violence? 2. Does staff at disability provider agencies know how to access services for disabilities that experience sexual violence? 3. Do sexual assault centers have the skills, resources, and willingness to provide services to women with disabilities? | <ol style="list-style-type: none"> 1. Do you require providers to have written policies and procedures regarding the handling of sexual violence? 2. How well does your Division respond to women with disabilities who are survivors of sexual violence? 3. What promising practices are occurring at the community or state level, which promote a survivor centered response to women with disabilities? |

APPENDIX B

WOMEN WITH DISABILITIES INTERVIEW QUESTIONS FOR FOCUS GROUPS/INDIVIDUAL INTERVIEWS

1. What would make you or someone you know trust someone else to tell her/him that you were sexually abused?
2. Raise your hand if you or someone you know would trust a (fill in with list below) to tell them about sexual abuse.

- Family member
- Friend
- Staff (disability service, sexual assault)
- Caregiver
- Police
- Other person

Note to Recorder: Record approximate number for each.

3. Do you think that service providers working with women with disabilities should ask women whether they have been sexually assaulted? Would this be a good way to help victims? When should this be done?
4. If you or someone you know were sexually assaulted, what would you want to happen? What kind of response would be helpful? What can disability service providers do? Mental health centers? Sexual assault centers?
5. Do you feel you know what resources are available to get assistance for sexual violence? If sexual assault centers want to talk to women with disabilities, where should they go to talk about services? What do you think would work to get more women to go to sexual assault programs?
6. If you or someone you know wanted to access sexual assault services, what do you think would work best? What obstacles do you think may stand in the way?
7. Are there rules to help you if you are sexually abused? How did you learn about the rules? Are the rules followed where you live? Where you work? *Provide examples of rules.*
8. What advice would you give about how to better serve women with disabilities who have experienced sexual violence? Disability providers? Sexual assault?

RAPE CRISIS CENTERS INTERVIEW QUESTIONS FOR FOCUS GROUPS

1. Has your agency served any women with disabilities during the past 2-3 years? If yes, what types of disabilities did the women report? i.e. cognitive, physical, mental illness. What type of disability is reported most often?
2. What have you learned from your experiences in providing services to women with disabilities? What went well? What could be improved? What are the barriers, if any, this agency faces when working with women with disabilities who have experienced sexual violence?
3. Does your agency have policies and procedures around serving women with disabilities? If not, why not? If yes, please share an example of a policy which makes it easier/more difficult to serve women with disabilities. If yes, how are the policies enforced? *Get a copy of policy.*
4. Describe any training you have received about ways to serve women with disabilities who have experienced sexual violence? What topics were covered? How long was the training? What do you need to feel more comfortable with identifying and responding to sexual violence against women with disabilities?
5. Is your agency networking and communicating on a regular basis with local agencies serving women with disabilities? If yes, what types of disability service providers are represented i.e. employment workshops, CILAs, advocacy organizations, community mental health centers. Describe your relationship and any joint activities including training, community outreach, referrals, and formal linkage agreements.
6. What are the barriers, if any, to when working with local disability services providers? What are the successes you have experienced when working with local disability services providers?
7. Do you have the resources necessary to work with women with disabilities? If not, what more do you need? Training? Policies? Accommodations support? Connections with disability organizations? Help with building collaboratives with agencies that serve women with disabilities?

ILLINOIS DEPARTMENT OF HUMAN SERVICES

SERVICE PROVIDER

INTERVIEW QUESTIONS FOR

FOCUS GROUPS

1. Has your agency served any women with disabilities during the past year that disclosed a history of sexual violence or reported a recent incidence?
2. What have you learned from working with women with disabilities who have experienced sexual violence? What went well? What could be improved? What are the barriers, if any, this agency faces when working with women with disabilities who have experienced sexual violence?
3. Does your agency have policies and procedures around responding to women with disabilities who disclose sexual violence? If not, why not? If yes, please describe agency response to sexual violence including client safety, offender issues, reporting, and linkage to services. If yes, please share an example of a policy which makes it easier/more difficult to serve women with disabilities. If yes, how are the policies enforced? *Move discussion beyond rule 50 reporting. Get a copy of policy.*
4. Describe any training you have received about how to identify and respond to sexual violence against women with disabilities. What topics were covered? How long was the training? What do you need to feel more comfortable with identifying and responding to sexual violence against women with disabilities?
5. Is your agency networking and communicating on a regular basis with local rape crisis centers? Describe your relationship and any joint activities including training, community outreach, referrals, and formal linkage agreements.
6. What are the barriers, if any, to when working with local rape crisis centers? What are the successes you have experienced when working with local rape crisis centers?
7. Do you have the resources necessary to respond to sexual violence against women with disabilities? If not, what more do you need? Training? Policies? Connections with rape crisis centers? Help with building collaboratives with rape crisis centers?

APPENDIX C

9. How many hours of mandatory staff training on sexual violence and women with disabilities does your agency have in a year?
 0 1-5 6-10 over 10

10. How many times each year do representatives from agencies serving women with disabilities train your agency staff?
 0 1 2 3+

11. Do you have outreach efforts that target women with disabilities who have experienced sexual violence?
 Yes No Don't Know

12. Do you ask women if accommodations are needed to support participation in services?
 Yes No Don't Know

Describe accommodations your agency has in place _____

13. Are women with disabilities involved in policy and program decisions in your agency?
 Yes No Don't Know

If yes, how? *Check all that apply.*

Board members

Hiring of staff

Training of staff

Needs assessment

Evaluation of services

Other: _____

14. Do you feel your agency has the resources needed to serve women with disabilities?
 Yes No Don't Know

If not, what is needed? *Check all that apply.*

policy training physical accommodations support interpreters

alternative format materials (large print, Braille, audio recording)

specialized staff linkage with disability service provider

other, specify: _____

15. Are there any comments or suggestions you would like to make regarding providing services to women with disabilities? *Please comment below.*

10. How many times each year does the sexual assault center conduct training with your agency staff?

- 0 1 2 3+

11. Do you have outreach efforts that target women with disabilities who have experienced sexual violence?

- Yes No Don't Know

12. Does your intake tool include questions to screen for sexual violence?

- Yes No Don't Know

Do you have educational materials about sexual assault available for women with disabilities?

- Yes No Don't Know

13. Are women with disabilities involved in policy and program decisions in your agency?

- Yes No Don't Know

If yes, how? *Check all that apply.*

- Board members
 Hiring of staff
 Training of staff
 Committees
 Needs assessment: surveys, focus groups
 Evaluation of services
 Other: _____

14. Do you feel your agency has the resources needed to serve women with disabilities who have experienced sexual violence?

- Yes No Don't Know

If not, what is needed? *Check all that apply.*

- policy training physical accommodations support interpreters
 educational materials for women with disabilities peer support programs
 specialized staff linkage with sexual assault center
 other, specify: _____

15. Are there any comments or suggestions you would like to make regarding responding to sexual violence against women with disabilities? *Please comment below.*

ILLINOIS DEPARTMENT OF HUMAN SERVICES

STAFF SURVEY

Hello. Thank you for filling out this survey. The survey is part of a needs assessment for the Illinois Imagines Project, which is a group of disability services organizations and rape crisis centers working in concert with the Illinois Department of Human Services (DHS) to improve services for women with disabilities who experience sexual violence. As part of this project, we are conducting surveys with service providers in order to assess services for women with disabilities who are victims of sexual violence. Your participation in this project is invaluable, and we thank you for taking part in this project.

SURVEY QUESTIONS FOR DHS STAFF

For purposes of this survey, sexual violence means non-consensual or coercive sexual conduct. Sexual violence includes any unwanted behavior or contact of a sexual nature, from sexual harassment/bullying to sexual assault.

1. How big of a problem do you believe sexual violence is for women with disabilities?

| | | | | | |
|-------------|---|---|---|---|--------------|
| <u>Huge</u> | | | | | <u>Minor</u> |
| 5 | 4 | 3 | 2 | 1 | |
2. How big of a priority do you believe services to women with disabilities that have been sexually abused is for the Department?

| | | | | | |
|-------------|---|---|---|---|--------------|
| <u>Huge</u> | | | | | <u>Minor</u> |
| 5 | 4 | 3 | 2 | 1 | |
3. How well does your Division respond to sexual violence against women with disabilities?

| | | | | | |
|--------------|---|---|---|---|-------------|
| <u>Great</u> | | | | | <u>Poor</u> |
| 5 | 4 | 3 | 2 | 1 | |
4. Does your Division require provider agencies to have written agreements to contact local rape crisis centers in regards to disclosures of sexual violence against women with disabilities?
 Yes No Don't know
5. How frequently do you think your service providers respond to sexual abuse against women with disabilities? *Response includes reporting, referrals to rape crisis centers or counseling programs, advocacy, etc.*
 Never 1-2x annually 3-6x annually Monthly Weekly

10. Thinking through your current strategies, what could you build upon to reach more women with disabilities who have experienced sexual violence?

11. Does your Division require provider agencies to include women with disabilities on committees, boards, or other decision-making entities?
 Yes No Don't know

12. How are women with disabilities involved in policy and program decisions in your Division? *Check all that apply.*

- Advisory Councils
- Training
- Committees
- Needs assessment: surveys, focus groups
- Evaluation
- Other: _____

13. Do you feel your Division has the resources needed to serve women with disabilities who have experienced sexual violence?
 Yes No Don't know

If not, what is needed? *Check all that apply.*

- policy training administrative support
- educational materials for women with disabilities peer support programs
- specialized staff linkage with sexual assault system
- other, specify: _____

14. Are there any comments or suggestions you would like to make regarding responding to sexual violence against women with disabilities?
Please comment below.

APPENDIX D

INDIVIDUAL INTERVIEWS

ICASA

INDIVIDUAL INTERVIEWS

1. What obstacles to service do you think exist for women with disabilities when they experience sexual violence?
2. Does ICASA have policies regarding rape crisis center services to women with disabilities? If so, what is covered in the policies?
3. How does ICASA monitor local rape crisis center services to women with disabilities who experience sexual violence?
4. Does ICASA require training on providing services to women with disabilities? If so, how many hours? If yes, please describe.
5. Does ICASA have women with disabilities facilitate trainings? Please describe their involvement.
6. How does ICASA support accessible services for women with disabilities?
7. Does ICASA provide material specifically for women with disabilities or for centers in working with women with disabilities? (brochures, website, etc.) Please describe the types of materials available, i.e., training, outreach.
8. What changes in rules, policies or practices would better serve women with disabilities who are survivors of sexual violence?
9. How could ICASA and rape crisis centers create meaningful ways for women with disabilities to provide input into policies, regulations, training programs, etc.?
10. Does ICASA require linkage agreements between rape crisis centers and disability service providers? If yes, please describe.
11. How do you see rape crisis centers and disability services working together to respond to violence against women with disabilities?
12. How can we promote collaborative efforts among rape crisis centers and provider agencies to address the service needs of women with disabilities who experience sexual violence?
13. What are the challenges to a collaborative response? What strategies or successes can be built upon to enhance collaboration?

14. Describe the ideal service system for addressing sexual violence against women with disabilities. What role would rape crisis centers play? What role would disability service providers play?

IDHS STAFF

INDIVIDUAL INTERVIEWS

1. What obstacles to service do you think exist for women with disabilities when they experience sexual violence?
2. Does your Division require disability service providers to have policies and procedures in place to identify and respond to sexual violence against women with disabilities? If so, what does the policy say?
3. How does your Division monitor disability service providers response to women with disabilities who experience sexual violence?
4. Does your Division require training on identifying and responding to sexual violence against women with disabilities? If so, how many hours? If yes, please describe.
5. Does the Division have women with disabilities facilitate trainings? Rape crisis center staff?
6. How does your Division support accessible services for women with disabilities who experience sexual violence?
7. Does your Division provide materials for women with disabilities about sexual violence and available resources? (brochures, website, etc.) Please describe the types of materials available, i.e. training, outreach, peer programs.
8. What changes in rules, policies or practices would better serve women with disabilities who are survivors of sexual violence?
9. How could DHS and provider agencies create meaningful ways for women with disabilities to provide input into state policies, regulations, training programs, etc.?
10. Does your Division require linkage agreements between disability service providers and rape crisis centers? If yes, please describe.
11. How do you see disability service providers and rape crisis centers working together to respond to violence against women with disabilities?
12. How can we promote collaborative efforts among rape crisis centers and provider agencies to address the service needs of women with disabilities who experience sexual violence?

13. What are the challenges to a collaborative response? What strategies or successes can be built upon to enhance collaboration?
14. Describe the ideal service system for addressing sexual violence against women with disabilities.
15. How does state policy support personal choice in the area of sexual violence? What role do women with disabilities who are survivors of sexual violence play in determining the response to sexual violence?