



An Educational Resource Manual

**On Domestic Violence
Advocacy
For Persons With
Disabilities**

In Washington State

Revised 2003

**Washington State Coalition Against Domestic Violence
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Available in alternative formats

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INTRODUCTION AND THE CHALLENGES WE FACE

Enough and Yet Not Enough?

There is a Rabbinic teaching from the Talmud that says: *It is not incumbent upon you to complete the work, yet neither are you free to desist from it.* As advocates, we are aware of how much work is left undone, yet we need to take pride in all that each of us has accomplished in our work with domestic violence survivors. This teaching reminds us that we may not finish the work, but we are expected to do all that we are capable of doing to carry it on. We don't have to do it perfectly, but survivors need all of us to keep trying.

While meeting to plan this manual, "It is enough and yet not enough" came up as a perfect example of a domestic violence advocate's feelings while trying to run a shelter for 30 battered women, and yet being unable to serve a victim in a wheelchair. Domestic violence shelters are doing enough; in the past few decades we have made great strides on many fronts to fight violence against women. We can be proud of Washington state and its excellent policies against abuse. We have served an ever-increasing number of diverse victims, and represented the issues of battered women in many governmental, business, and criminal justice system arenas. We are doing enough, it would seem, but it is not enough for people with disabilities.

It is not enough for people with disabilities because domestic violence shelters are under-serving them. Statistics repeatedly cite very high levels of abuse among persons with disabilities. If there is such a high rate of violence against persons with disabilities, why is the rate of domestic violence services to those individuals so low?

We have yet to meet the wide range of service needs presented by the estimated 10% or more of the population that has one or more disabilities, and persons with disabilities who are also victims of domestic violence are even further underserved. Disability advocates serve some victims, some are served by state caseworkers, and some are not served at all. The obstacles preventing some victims from reaching services if they are victimized often seem insurmountable.

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Problems have been noted by researchers with regard to obtaining accurate incidence statistics about violence and disability. Varying definitions of abuse and reporting rates, for example, make it difficult to measure the difference in risk faced by people with and without disabilities. However, there is an accumulation of independent findings which suggests that violence is a problem of considerable magnitude for persons with disabilities. (Chart at right.)

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Extent of the Problem of Violence Against Persons with Disabilities
(The Roeher Institute, 1994)

Who?	Level / Form of Violence	Source
Women with disabilities	40% 83% have been assaulted, raped or abused will be sexually assaulted in their lifetime	<i>Stimpson and Best, 1991</i>
Boys who are deaf	54% have been sexually abused	<i>Sullivan, Vernon and Scanlan, 1987</i>
Boys who are hearing	10% have been sexually abused	<i>ibid.</i>
Girls who are deaf	50% have been sexually abused	<i>ibid.</i>
Girls who are hearing	25% have been sexually abused	<i>ibid.</i>
Girls with developmental (intellectual) disabilities	39-68% will be sexually abused before 18 years of age	<i>The Roeher Institute, 1988c</i>
Boys with developmental (intellectual) disabilities	16-30% will be sexually abused before 18 years of age	<i>ibid.</i>
Psychiatric outpatients	68% have been victimized by physical or sexual assault	<i>Jacobson, 1989</i>
Psychiatric inpatients	81% have been victimized by physical or sexual assault	<i>Jacobson and Richardson, 1987</i>
Clients admitted to a hospital-based unit for people with intellectual disabilities	56% have received anti-psychotic drug treatment without diagnosis of psychosis or related disorders	<i>Hoefkens and Allen, 1990</i>
Children with multiple disabilities admitted to a psychiatric hospital	39% have suffered maltreatment (mainly physical abuse)	<i>Ammerman, et al. 1989</i>
Sexually abused children with multiple disabilities admitted to a psychiatric hospital	40% have been abused by more than one perpetrator	<i>ibid.</i>
Pre-puberty boys in a psychiatric inpatient setting	16% have histories of being sexually abused	<i>Kohan, et al. 1987</i>
Pre-puberty girls in a psychiatric inpatient setting	48% have histories of being sexually abused	<i>ibid.</i>
Consumers of attendant care services	10% 40% have been physically abused have encountered theft by attendants	<i>Ulincy et al., 1990</i>
Residents of a psychiatric institution	71% 53% 39% 55% 27% have been threatened with violence within the institution have been assaulted by other residents have been assaulted by staff have been sexually assaulted by other residents have been sexually assaulted by staff	<i>Nibert et al., 1989</i>
Never-married females without disabilities	29% have been physically or sexually assaulted by their partners	<i>Statistics Canada, 1994</i>
Never-married females with disabilities	39% have been physically or sexually assaulted by their partners	<i>ibid.</i>
Interviewees with psychiatric disabilities who have experienced violence in the community	90% 74% 38% have experienced verbal/emotional violence have experienced physical violence have experienced sexual violence	<i>Jim Ward Associates, 1993</i>
Nurses and aides in nursing and intermediate care facilities who were interviewed	41% 40% admitted to engaging in physical abuse of clients admitted to engaging in psychological abuse of clients	<i>Pillemar and Moore, 1990</i>

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Our Challenges

After Linda David was “rescued” from years of abuse at the hands of her husband and caregiver, Governor Gary Locke convened a Domestic Violence Action Group to examine the circumstances surrounding Ms. David’s abuse and issue recommendations regarding domestic violence intervention and prevention. In its report, published in October 1999 and entitled *Everybody’s Business*, the Domestic Violence Action Group states:

People with disabilities are especially vulnerable to domestic violence. They may be more dependent on a spouse or other caregiver, less able to communicate with the police or social workers, or less mobile. Traditional shelters and advocacy programs are often not accessible or equipped to serve them. Too little is known about the nature and frequency of victimization of citizens with disabilities or about the strategies that could be deployed to prevent their victimization. (p. 28)

Included in the report’s recommendations are:

Recommendation 18. More information should be gathered on domestic violence against people with disabilities, and people with disabilities should be included in community coalitions and other groups seeking more effective responses to domestic violence. (p. 28)

Recommendation 19. A training manual should be developed to help domestic violence programs better serve people with disabilities. (p. 28)

In response to these recommendations, the Washington State Coalition Against Domestic Violence (WSCADV), under contract with the Department of Social and Health Services (DSHS), has worked to develop this education and resource manual as a foundation for future training efforts with disability and domestic violence advocates throughout Washington state. In the course of our work, we encountered numerous challenges that will continue to require specific attention by domestic violence and disability advocates alike:

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- In a meeting of domestic violence advocates and disability advocates, it was clear that the domestic violence advocates had barely started improving the accessibility of their services, and that most of the disability advocates had little knowledge of abuse issues, laws and resources. Discussion between the two groups of advocates is needed to help the fields identify common visions and goals, and prepare coordinated, action-oriented plans to assist all persons regardless of disability.
- The definition of “domestic violence” has traditionally included spousal or intimate partner abuse, with no mention of abuse by caregivers. Changes in RCW 74.34 have expanded the definition of “vulnerable adult” to include persons receiving services from paid caregivers and criminalized violations of such orders under RCW 26.50. Advocates will need support to incorporate these changes into their daily advocacy and prevention activities.
- There are additional laws and systems related to disabilities and adult protection that complicate the legal situation and remedies for victims who have disabilities. Advocates will need to be particularly thoughtful in developing expertise and model practices in this area.
- No research has been done to measure the effectiveness of present service systems and prevention models in working with victims with disabilities. Domestic violence programs will need to be creative in developing tools that provide a meaningful measure of program effectiveness.
- As domestic violence programs provide services that are accessible and do outreach to make these services known, it is likely that we will find that there are more victims than we are now aware of. Given overall statistics in a Colorado study citing 85% of persons with disabilities abused in some form, we should anticipate an initial rise in reporting and be prepared to expand resources to meet the need in all services for domestic violence victims.

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- Presently, it is difficult to find information for an accurate referral to an accessible shelter. Many shelter advocates do not know the details of their facility's accessibility. The state domestic violence hotline and WAVAWnet have databases that include information about shelter accessibility, but the information provided seems incomplete. Many domestic violence programs could benefit from a current assessment of physical access, services, budgets, policies, and procedures to remove as many barriers as possible to serving victims with a wide variety of disabilities.
- Domestic violence shelters have been working with tight budgets for many years, and very few are now in modern and accessible buildings. For many shelters to become accessible, large capital campaigns will be needed. Information and support need to be available to these programs so they can take on these challenges.
- Even if they are physically accessible, most shelters have not done much outreach in the disability community. "If we build it, they will come," works only if we let them know, and if we have the attitude and knowledge needed to inspire trust.
- Serving persons with multiple oppressive issues, such as disabled lesbians, disabled persons of color, disabled immigrants and refugees, and disabled children of victims presents additional unique challenges. A victim can be in more than one protected class. The more layers of oppression that exist within an individual victim's circumstance, the more isolated and targeted she may be by the perpetrator who takes advantage of these barriers, and the more underserved the victim will be by the domestic violence and disability systems.
- Men with disabilities are also cited as experiencing abuse at a higher rate, again indicating perpetrator behaviors that specifically target victims, including men, who are seen as unable to understand, defend themselves, or communicate with others.

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Violence against people with disabilities has been characterized as “occurring in the context of systemic discrimination against people with disabilities in which there is often an imbalance of power, including both overt and subtle forms of abuse, which may or may not be considered to be criminal acts” (The Roeher Institute, 1994). Persons with disabilities actually experience a much higher rate of abuse and have significantly fewer pathways to safety. Although people with disabilities are susceptible to the same general types of violence as the population at large, the barriers they face expose them to additional ways for perpetrators to target their abuse.

Consider the following story:

Sally has been battered by her husband for years. Since she is blind, when he hits her, she cannot usually anticipate where the strikes will come from. She tries at all costs to avoid trouble. He sometimes throws water on her without warning. He has accidentally bumped her into things, or left her standing on the street in a strange place to teach her a lesson. He selects her clothing and makeup. He reads all the family mail, and she has only his word of what that mail contains. Her husband usually accompanies her to the bank. (The bank employees all think that he is a saint for his tireless attention to her needs.) She got a computer with a braille reader board, and for a while she was talking in Internet chat rooms, but her husband hid the cord, and she hasn't found it yet. The physical abuse is the least of Sally's worries when she comes to an advocate for advice. She wants to be able to continue to work at the office where they have invested in an expensive computer that is adapted, but it takes a long time to get mobility training so she can learn the way to new places, and she is worried he will watch the places she works and gets support. There are no alternatives for those. Where will she live and how could she do it all without the information about her accounts and insurance?

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Purpose of this Manual

The goal of this education and resource manual is to expand the definition of what is “enough” when it comes to domestic violence advocacy, so that all domestic violence services are as accessible as possible to all persons regardless of disability.

I encourage you to read this manual and participate in the accompanying trainings that will be offered by WSCADV in the future. This manual is designed to offer practical guidelines for working with victims with disabilities. In it, we include: current issues facing victims of disability in Washington state, the laws requiring domestic violence shelters to be accessible, different types of disabilities and resources, history, experiences of victims with disabilities, tools to measure and carry out an accessibility plan, and a chapter on building allies in the disability community.

Domestic violence advocates are uniquely positioned to understand the complex suffering of people with disabilities who are victimized by violence. Our task is to take this understanding and apply it to our everyday advocacy work, to stretch the boundaries of “enough,” and to think expansively about ending all forms of violence in Washington state.

Cathy Hoog

THE DUALITY OF EXPERIENCES:
ISSUES FACING VICTIMS WITH DISABILITIES

“The Disability Pride Week That Wasn’t”

About ten years ago, there was a planning committee for a “disability awareness day;” it was a sub-committee of a county government disability advisory committee to ensure human rights in services within that county. Attending the meeting was a strong group of advocates for persons with disabilities, most of them disabled. It was suggested that the event be called a pride day instead of an awareness day. That suggestion was quickly met with loud resistance to the use of the word “pride” in connection with persons with disabilities. In fact, one person in a wheelchair asked, “How can we be proud of something that is wrong with us?”

This attitude of internalized oppression is not unique to persons with disabilities; there are many other oppressed groups that experience it. What is concerning is that this perception of “there is something inherently and unchangeably wrong with me” is readily accepted as fact by others, and narrows our perceptions of the possibilities for self-determination in persons with disabilities.

The medical model sees a disability as a lack of something, a sad and tragic loss. Some disabled persons literally have to struggle to have an identity as a person. They are sensitive to looks, jeering, and people identifying them by their disability (e.g., “the blind guy”). A person with a disability may also be defensive if she feels that professionals are viewing her solely for the disability, rather than as a full person.

The following excerpt is from the Wall Street Journal article “Nike Rescinds Advertisement, Apologizes to Disabled People” (Grimes, 2000):

Nike Inc. pulled a print-magazine advertising campaign for a new running shoe after disabilities-rights groups claimed the ads were offensive. The advertisements for the Nike ACG Air Dri-Goat appeared in several national and nine regional outdoor magazines and referred to people with disabilities as “drooling and misshapen.”

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“The ad expressed the kind of antiquated bias we are fighting to eradicate,” said Mark Kleid, channel producer at eBility.com, a Web site for people with disabilities (www.ebility.com) that launched the protest Monday. “It is outrageous that Nike and its ad agency allowed such denigrating words to be published,” he said in an e-mail.

After pulling the ads, Nike’s director of USA Communications, Lee Weinstein, issued a formal apology on the sportswear company’s Web site. “We feel just horrible about this ad,” he said. “Clearly, disabilities of any form are no laughing matter and that paragraph should not have been included in the ad.” Nike said the ad was intended to show how the right equipment can prevent injuries.

The text accompanying the ad includes the following sentence: “Right about now you’re probably asking yourself, ‘How can a trail running shoe with an outer sole designed like a goat’s hoof help me avoid compressing my spinal cord into a Slinky on the side of some unsuspecting conifer. Thereby rendering me a drooling, misshapen non-extreme-trail running husk of my former self. Forced to roam the earth in a motorized wheelchair with my name, embossed on one of those cute little license plates you get at carnivals or state fairs, fastened to the back?’ ”

The agency’s chief executive, Dan Wieden, also apologized in a statement. “We have stepped over the line with this advertisement and there is no excuse for it. The ad has been pulled from all publications except the December issue of Climbing Magazine, he said.

There are many possible ways to view a disability, with two extremes being:

- A clinical view of the disability as a loss of some sort affecting the body, to be fixed if possible, and, if it is not fixable, it is a tragedy of science and humankind.
- A cultural perspective that people are born in many different types and that, even after they are born, many things can happen to make them different.

How Is the Abuse of Persons with Disabilities Different?

Research has shown that disability changes the experience of the abuse. Examples of why the experience of abuse differs between women with disabilities and those without disabilities include (Myers, 1999):

- The inaccessibility of battered women's shelters.
- Hot line counselors who do not have knowledge of issues related to disability.
- Women with disabilities may be more economically dependent on the abuser, which makes escape more difficult.
- The woman may also be physically dependent on the abuser, making escape more difficult.
- A woman with a disability may be experiencing the abuse in the form of withholding of medications, orthotic equipment, and/or the refusal to do personal care.
- Difficulties within the legal arena are faced by all battered women; however, women who have disabilities that cause speech and/or communication difficulties or motor coordination difficulties (e.g., as in cerebral palsy) may also be faced with police officers who assume they are intoxicated, and therefore do not take the report seriously.
- The courts may find the abuser a more fit parent than the victim simply because the victim has a disability.

The following is excerpted from The Roeher Institute (1994), *Violence and People with Disabilities: A Review of the Literature*, which reviewed relevant literature in Canada pertaining to violence and people with disabilities:

People with disabilities are statistically more likely to experience the following forms of abuse:

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- Physical abuse, which can include hitting, shaking, burning, the administration of poisonous substances or inappropriate drugs; inappropriate handling, personal or medical care; over-use of restraint or inappropriate behavior modification, experimental treatment; false information given to the medical/psychiatric community resulting in wrongful diagnosis/commitment/medication;
- Sexual abuse, including unwanted or forced sexual contact, unwanted touching or displays of sexual parts, threats of harm or coercion in connection with sexual activity; denial of sexuality, denial of sexual education and information, forced abortion, birth control or sterilization;
- Psychological and emotional abuse, including the lack of love and affection, verbal attacks, taunting, threats (of withdrawal of services or of institutionalization, for example), insults and harassment;
- Neglect and acts of omission, including ignoring nutritional, medical or other physical needs, the withholding of the necessities of life, the failure to provide required medical care or appropriate educational services;
- Financial exploitation, including the denial of access to, and control over, individuals' own funds and the misuse of their financial resources, forced to lie to/exploit governmental benefit systems.

Specific factors that increase the exposure of people with disabilities to abuse

Researchers have identified a number of factors that can place people with disabilities at particular risk of abuse. In examining risk factors, several researchers have emphasized that it is not the disability itself that may put people with disabilities at risk, but the social conditions in which people with disabilities are likely to find themselves that makes it more likely that abuse will occur.

A number of studies address in some detail the risk factors associated with sexual abuse and other forms of violence affecting people with disabilities, several of which are mentioned below.

This study discusses the risk factors for violence perceived by people with disabilities. The main risk factors presented in the literature are:

- Negative public attitudes about disability;
- Social isolation of people with disabilities and their families;
- Reliance of people with disabilities upon others for care;
- Lack of support for care-givers;
- Lack of opportunity for people with disabilities to develop social skills through typical social interaction;
- Nature of disability;
- Gender, particularly with reference to sexual abuse (where women face very high risk of victimization);
- Poverty and other economic factors affecting people with disabilities;
- Lack of control or choice of people with disabilities over their personal affairs;
- Perceived lack of credibility of people with disabilities when they report or disclose abuse;
- Socialization of people with disabilities to be compliant, and learned helplessness;
- Alcohol and drug abuse by perpetrators;
- Ineffective safeguards (The Roeher Institute, 1994).

It has been proven that perpetrators are very calculating and target their victims using real or perceived measures. Offenders rape very old and very young people; they are often looking for persons they perceive as without power. Some perpetrators view persons with disabilities as easy targets—persons no one will care about or persons who will be grateful for their attention. A clinician at Atascadero State Hospital reported that he overheard one sex offender tell another, “Get a job in the developmental disability system when you get out, it’s easy pickings.”

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What About the Use of the Word *Vulnerable*?

The language we use to identify a group of people can shape our expectations. In the past, it was common for women to be considered weak and vulnerable; in fact, they were at much higher risks for abuse and human rights violations. Women were at higher risk not because that's the way women were, but because they did not have any individual human rights to assert. When battered women of the 1870s went to court for redress, they were turned away as having no place in the system. It was expected that they were to be abused, because they were vulnerable. In the present day, after much struggling for equal rights for women, most would be insulted to be called weak or vulnerable.

There is broad acceptance in the literature of the use of the word “vulnerable” when describing a person with a disability as being at risk of abuse. It is felt that using the word “vulnerable” to label persons with disabilities could be perceived as acceptance of the inevitable, and therefore nothing we could do would change it. The use of the word “vulnerable” assumes that persons with disabilities will be abused at a higher rate, simply because they are disabled.

Statistics do show that people with disabilities are at a higher risk of being abused, but why? Is it because they are (seen as) weak, vulnerable, or incapable of taking the steps they need to protect themselves? Are they somehow less able to protect themselves by virtue of their disability? Indeed, “vulnerability” is very difficult to measure. Perhaps it is not because they are disabled, but because they are underserved, that their risk for abuse is higher. Services for battered women and for people with disabilities have not done enough to ensure the access of all individuals to critical systems for support (e.g., emergency and criminal justice systems, domestic violence programs and disability advocacy systems).

The concept of “vulnerability” is actually victim-blaming, and is used by the abuser to maintain power and control. Abusers isolate their victims, saying it is for their own “protection and safety.” The word “vulnerable” is used to condition persons with disabilities to accept restrictive living arrangements in the name of safety. In actuality, if services designed to protect all people aren't good enough to protect persons with disabilities, then the services are inade-

quate. If domestic violence and disability agencies assume that victims are “vulnerable,” they might find it hard to see that their advocacy needs to improve.

Who Are the Abusers of Victims with Disabilities?

Typically, domestic violence advocates and the battered women’s movement think of perpetrators as intimate partners. This definition of the perpetrator needs to be broadened to include family members and paid caretakers. This rationale comes from listening to victims with disabilities and is supported by research among people with disabilities.

The Roeher Institute study (1994) identifies the following as places where violence may occur:

- social groupings such as the family, or some other personal relationship;
- residential settings such as homes, apartments, boarding homes;
- services settings such as hospitals, group homes, institutions;
- public spaces.

The research indicates that more than half of the abuse of people with disabilities is perpetrated by three groups of offenders: family members; paid care-givers; and other people with disabilities, especially those living with their victims in service settings such as residential institutions, group homes, and sheltered workshops (The Roeher Institute, 1994).

For victims with disabilities, the concept of intimacy and who participates in an intimate relationship is not limited to traditional categories of husband, spouse, partner, boyfriend, and significant other. Intimate contact by care-givers or family members gives perpetrators access and opportunity to abuse another person. Intimate contact is key to understanding when and where abuse happens regardless of who is perpetrating the abuse.

The following chart, “Comparing Levels of Intimacy,” illustrates similar abusive tactics used by intimate partners against women without disabilities and paid caretakers against women with disabilities. When making a comparison between the levels of intimacy, note that caretakers have access to many

**The Duality of Experiences:
Issues Facing Victims with Disabilities**

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intimate aspects of the disabled person’s life, and sometimes caretakers have more access to the victim than many “intimate partner” abusers. (Note: This chart is not a comprehensive list of activities or function levels; it is intended only for comparison purposes.)

Comparing Levels of Intimacy

Can affect person who	Intimate partner of women without disabilities	Caretaker abuse of women with disabilities
Bathing		
has mobility loss	Partner is not usually in control of bathing.	Caretaker has full control of when, where and how bathing takes place, and must by function touch all private areas of the body.
Medication		
needs life-sustaining and enhancing medicine	A partner usually has to hide activity when abusing persons with their medications.	May have authorized access to dispense medications (full power and control).
Toileting		
is incontinent	Partner not usually in control over partner’s toileting.	Is responsible to care for hygiene, catheterization, diapering needs. Abuser is often paid to exert full power and control over victim’s body.
Interaction with others		
is deaf-blind	Partner usually has indirect control of a hearing victim’s conversations with others.	Caretaker of deaf-blind person usually has full power and control to direct and interpret (as they wish) the victim’s conversations with non-signing persons.
Banking		
has a cognitive disability	A partner may work for partial to full control of a victim’s banking.	Caretaker may have legally authorized full power and control over the victim’s funds.

Fear of Disclosure

Excerpted from: The Roeher Institute, 1994. *Violence and People with Disabilities: A Review of the Literature*. National Clearinghouse on Family Violence, Family Violence Prevention Division, Health Canada.

The study commented that people with disabilities may be reluctant to report abuse for similar reasons that non-disabled children and women do not report abuse. These reasons include fear of retaliation, dependency, and shame. Studies suggest that, for children or adults with disabilities, the difficulties of disclosing abuse are further compounded by the particular situations of living as a person with a disability. The literature suggests that people with disabilities may:

- feel ashamed or feel that they are somehow to blame;
- fear retaliation from their abuser if they report;
- be afraid because they are unsure of the consequences of reporting (fear of losing privileges, removal to a more restrictive ward of a unit, seclusion or restraints, increased medication, being labeled a problem, deportation, or removal of children);
- be dependent financially, physically and emotionally on the person who abuses them, which can make it difficult to report the violence against them;
- feel isolated and are unaware that many other people with disabilities have experienced violence;
- be seen as attention-seeking, out of touch with reality, lying, manipulative or seeking revenge;
- have difficulty “telling on” or challenging the actions of an able-bodied authority figure, given the compliance and obedience instilled in children who are disabled.

Some of the factors identified as influencing a person’s decision to report or not to report abuse include:

- The significance the victim attaches to the incident;
- Whether the victim has the physical means of communicating with others;
- The victim’s confidence and strength of purpose;
- The communication skills of the victim and of the respondents to the disclosure;
- Whether the victim has or perceives there to be anyone to whom to report;
- The receptivity and perceived trustworthiness of the person to whom the victim discloses;
- The probability of being believed;
- The perceived consequences to the victim’s and others’ safety and well-being as a result of disclosure;

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- Whether the victim feels any sympathy for a perpetrator;
- The perceived probability of receiving a just and efficient response to the complaint.

Domestic Violence That Results in a Disability

Excerpted from: Myers, 1999. *Serving Women with Disabilities: A Guide for Domestic Abuse Programs*. Center for Research on Women with Disabilities, Baylor College of Medicine.

There is the possibility that, in a domestic violence situation, the victim will acquire one of many temporary (e.g., broken bones or other musculoskeletal problems) or permanent (e.g., head injury, burn injuries, spinal cord injuries) disabling conditions. When this occurs, the individual may be seen first in a hospital setting and then possibly transferred to a rehabilitation facility. Both the experience of domestic violence and the new onset of a disability need to be dealt with by the individual. The individual will be facing two life-altering events at once, and this can become overwhelming. The domestic violence agency should try to become part of the rehabilitation team to help the individual make the adjustments related to the domestic violence. The individual should be seen as someone at great risk for Post Traumatic Stress Disorder (PTSD) and dealt with accordingly. Since the individual will be experiencing essentially two losses, they may go through the stages of adjustment to a disability and/or the stages of PTSD. Both of these stage theories are similar, though the individual may progress through them at different rates. The following are examples of the two stage theories:

Stages of Adjustment to Disability	Phases of PTSD
1. Shock	Outcry
2. Expectancy of recovery	Denial
3. Mourning	Oscillation between denial/numbing
4. Defense	Working through
5. Adjustment	Completion

To effectively help the individual deal with both situations, the domestic violence agency can help her identify and contact disability resources

(e.g., independent living centers, support groups) that can assist the person in her adjustment to the disability. Working as a team with agencies that can help the individual with the disability aspect of the event will make services to the individual more comprehensive and effective.

What If a Perpetrator Has a Disability?

Since research has shown that victims with disabilities are often abused by a person with a disability, the inaccessibility of the criminal justice system is doubly problematic, particularly for the victim. The victim's use of the legal system can be virtually blocked by its inaccessibility.

The barriers to services can occur at many levels. Here are some anecdotal examples offered by domestic violence advocates:

- A blind person was viewed as innocent in an assault because “How can you prove a blind person’s intent to hit?”
- A multi-disabled abuser who attempted to murder his wife was almost released from jail because he was not provided his medications and meals.
- When responding to a domestic violence incident where the alleged perpetrator was mildly retarded, officers verbally scolded the abuser and sent him to his room.
- When batterer’s intervention programs are inaccessible, judges are likely to order another type of counseling. They may send an offender to counseling with someone who can deal with the disability, but does not have the training to respond to tactics of abuse used by a perpetrator.
- A perpetrator intervention provider attended a training by a disability/ domestic violence advocate for the deaf. The provider commented that he thought that deaf abusers were the worst abusers. After education about the lack of accessibility in the criminal justice system and barriers to service, he realized that deaf abusers weren’t inherently evil, but that the system did not begin to hold them accountable until after repeated criminal violations.

GETTING PREPARED—
HOW TO ASK AND LEARN ABOUT TYPES OF DISABILITIES

How to Ask an Individual About Their Access Needs

Whenever possible, it is preferable to learn some basic information about the disability of the victim you are working with before you meet with her. For example, if you have information about people who are visually impaired, then have critical educational and resource materials available in multiple formats such as large print or on cassette tape. Limit your questions to the information needed in order to provide services; avoid general questions about the disability or its source (unless the information is volunteered). Remember, the reason the person is talking to you is to receive domestic violence services, not to educate you about their disability, unless it directly impacts their choices and options.

All screening and intake practices should include general accessibility questions. By routinely asking every person who requests services, the agency's ability to respond to victims with disabilities will improve. Remember, not all disabilities are visible. While most victims can explain their needs, others may not offer information beyond knowing their type of disability. Within this manual, there are sources for information on specific disability access issues and disability advocacy agencies (see Appendix for resources).

After learning about the victim's disability, try not to make any assumptions regarding the person's ability to function. During the development of the manual, many individuals wanted the information regarding types of disabilities omitted because they feared labeling and misunderstandings about a person's ability to function. We have included the descriptions of disabilities to begin educating domestic violence programs and improve accessibility for all people. Persons with disabilities have individual preferences for naming their disability, which may differ from the terminology in this manual.

Most disabilities have a continuum of capability and functioning levels; for instance, a person with visual loss may range from a mild to a severe loss of function. The victim is expert in her ability to determine her ability to function

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at any given time. One’s functionality can change on a daily basis (e.g., a person might be stronger in the morning or hear better in one room than another).

Victims with disabilities may be sensitive to others “taking over” and understandably frustrated with unwanted help, which may be harmful. As a legally protected group of people, people with disabilities have gained rights to access in only the past ten years—rights to access the rest of us take for granted.

What Can I Ask About?

Be aware that persons who appear able-bodied may have a hidden disability. Ask questions that allow the person to identify their disability, to talk about their needs and necessary accommodations to participate fully in the program. Under the Americans with Disabilities Act, you cannot ask someone if they are disabled because this question is viewed as discriminatory. However, you could ask the following types of questions:

- Do you have any accommodation/accessibility needs?
- Is there anything else we should know about?
- We are working towards being fully accessible. Please feel free to tell us if you have needs that you think we should be aware of (NCADV, 1996).

Individuals may not tell you about their disabilities immediately, but you have to let the person know that you are open to acknowledging and accommodating their needs. Building trust takes time, and it is likely that a person with a disability has overcome many barriers to connect with the domestic violence program.

The first time a victim with a disability connects with a domestic violence program sends a powerful message about the agency’s understanding of accessibility. Sometimes, when a deaf victim calls a crisis line for shelter, the first question she is asked on the TTY is “Can you talk?” or “Can you write notes?” These kinds of questions make the deaf caller believe that she must be able to talk or write English in order to be accommodated. Of course, shelter staff

want to know if they will be able to understand the deaf person or if they will need an interpreter. However, the staff must remember that even if the deaf victim has English skills, she will not be able to understand what staff says without an interpreter. She needs an interpreter to communicate in all educational and strategizing situations, including intake to the shelter. During the initial call, staff should ask “Do you use sign language?” or “Would you like us to call an American Sign Language interpreter?”

Some Things to Remember

- Always ask a person with a disability if they would like help before taking action. Offering assistance is respectful, but avoid jumping in and taking over. Special instructions may be involved, or your help may not be needed. Most persons prefer to ask for help if they need it. This approach works well, leaving decision making up to the individual.
- If the subject of the person’s disability comes up, discuss it with the person directly if possible, rather than asking an aide or assistant.
- Speak directly to the person. She can speak for herself.
- See a person with a disability as a person first.
- Be neither patronizing nor reverential. Understand that the life of a person with a disability can be interesting.
- Avoid appealing to others for help by reminding them that they do not have a disability and should be grateful.
- Treat adults as adults. Call the person by her first name only when extending the familiarity to others.
- Treat people with disabilities like you would like to be treated.
- Appreciate what a person is able to accomplish. Difficulty may stem from society’s attitudes and environmental barriers rather than the disability itself.

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Mobility

- Don't ask personal or intimate questions until you know someone well, unless you are willing to answer personal questions about yourself.
- Relax and plan for extra time. A calm and reassuring demeanor will benefit all victims you serve (adapted from Spies, 1995).

Types of Disabilities

Unless otherwise indicated, all material in this section is adapted from: National Coalition Against Domestic Violence, 1996. *Open Minds, Open Doors: Technical assistance manual assisting domestic violence service providers to become physically and attitudinally accessible to women with disabilities*. Denver, CO.

Mobility

Spinal Cord Injuries. Spinal cord injuries, or bruising of the spinal cord, can be caused by automobile accidents, abuse, gunshot wounds and other types of physically traumatic incidents. Spinal cord injuries can also be present at birth. The spinal cord is the pathway along which information travels from the brain to the body. Thus, any injury to it can disrupt the flow of communication. Once communication is interrupted, the body may no longer be able to function. If damage occurs in the pathways along which the brain tells the body to breathe, a person may not be able to breathe without a respirator.

Muscular Dystrophy. Muscular Dystrophy (MD) is the term often used to refer to a family of neuromuscular disorders. A neuromuscular disorder is a condition that originates in the nervous system but affects muscle tissue. Some types of MD affect only males and can lead to death by early adulthood. Other types of MD do not manifest until middle age, while other types are present from birth and can last a lifetime. MD is usually characterized by a gradual weakening of the muscles that control arm and leg movements, spinal support, swallowing, and/or breathing. Progression of MD varies from person to person. Many women with MD use a mobility aid, such as a wheelchair, a walker or crutches and some may need assistance with personal care.

Cerebral Palsy. Cerebral Palsy (CP) is most commonly caused by a lack of oxygen to the brain at birth. It can also occur later in life, however, following a

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Mobility

head injury. CP is a complex disability that can have different manifestations depending on the extent of the trauma. The most common areas affected by CP are the limbs, speech, hearing and sight. These functions cannot be regained once the brain has sustained permanent damage.

Multiple Sclerosis. Multiple Sclerosis (MS) is a disease of the central nervous system. The central nervous system has two major parts, the spinal cord and the brain. Fatty tissue called myelin surrounds and protects the nerve fibers of the central nervous system, allowing them to do their job. MS causes the body's autoimmune system to destroy its own myelin, leaving scars called sclerosis. When myelin is destroyed or damaged, the ability of nerves to conduct impulses to and from the brain is disrupted, producing the symptoms of MS.

The symptoms of MS vary from person to person according to which areas of the central nervous system have been attacked. Very often, a person will experience more than one of the following symptoms: weakness, tingling, numbness or impaired sensation, poor coordination, fatigue, balance problems, visual disturbances, involuntary rapid eye movement, tremors, spasticity or muscle stiffness, slurred speech, sensitivity to heat or problems with short-term memory, judgment or reasoning.

MS is much more common among Anglos than it is among African American, Latina, or Asian Pacific populations. A woman's chance of getting MS is three times as high as a man's. While MS may be genetically predisposed, it is not inherited, nor is it contagious.

There is no cure for MS. However, there are treatments that lessen the severity of the symptoms. Prescription drugs can help ease pain, stiffness and fatigue; regular exercise can help regulate appetite and sleep patterns and give one a feeling of well being. Physical therapy can help strengthen weak or unconditioned muscles, occupational therapy can help a person with MS learn how to live more independently, and speech therapy can improve communication skills for those who have difficulty speaking or swallowing.

Coping with MS means different things to different people. It can mean coping by keeping active, managing time, conserving energy, examining priorities,

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Mobility

getting help with hard to solve problems, making time for fun, maintaining one's sense of humor, taking care of oneself physically, emotionally and spiritually and living one day at a time.

Things to remember when working with a victim who has mobility impairment:

- Someone's wheelchair is a part of her body space and needs to be treated as such.
- Ask the person what is needed for her accessibility. Don't make assumptions or decisions for the person.
- The person needs to be in charge of what happens to her wheelchair at all times. Someone's wheelchair is a person's mobility. Do not touch the wheelchair without being asked.
- Sit or kneel at eye level when engaging in any lengthy conversations if possible.
- Get training before trying to use or maintain expensive equipment.
- Speak directly to the person, not to their attendants.
- Patting someone on the head is degrading.
- Try to give clear and specific directions to locations, including distances. Also include the accessible routes into the building and bus/alternate access information.
- It is okay to use an expression like "running along" when speaking to a person in a wheelchair.
- Using a wheelchair does not mean confinement, or being "wheelchair bound."
- Don't discourage children from asking questions. It is a natural curiosity, and needs to be satisfied to prevent fears or misconceptions. Most people using wheelchairs are not offended.
- Some wheelchair users can walk, and some can walk with the use of a cane, braces, or a walker (adapted from Spies, 1995).

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Visual

Visual Impairments

A visual impairment can range in intensity from poor vision to blindness. An estimated 25% of the population has some kind of visual impairment. Only about 1% of all blind people read braille; individuals who lose their sight later in life do not often learn to read braille and may rely primarily on large print materials, taped reading material, or require readers.

Things to remember when working with a victim who is blind:

- Talk in normal tone and speed of voice. Shouting is insulting.
- Speak directly to the person, not to a third party.
- When leaving the room, say so. Let them know what is going on visually around them.
- When guiding someone to a chair, simply guide their hand to the back of the chair and tell the person if it has arms.
- Resist the temptation to pet a guide dog. If the dog is distracted from its work, its owner can be in danger. Always ask permission of the owner before interacting with the dog.
- Give instructions to the owner of the dog, not the dog. If the dog needs to be moved, tell the owner, not the dog.
- Let the blind person take your arm. One's personal space needs to be respected.
- As a victim, a blind person may be very sensitive to unexpected touch. Tell the person what you are doing beforehand, so they can anticipate your motions and touch.
- Guided tours are helpful to familiarize persons who are blind with new surroundings. Be sure to take time for the person to orient herself by touch to the area and provide reference points. For example, use the person's new shelter room as a starting point, and reference all the pathways to and from that room in the shelter (adapted from Spies, 1995).

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Hearing

Deafness

Adapted from: Abused Deaf Women's Advocacy Services. 1999. Outreach and educational materials—"Deafness." Seattle, WA.

What is Deafness? Persons who cannot hear, or persons who cannot understand what they hear (with or without amplification), are deaf.

To understand deafness and its implications, it is necessary to remember that hearing persons learn a language primarily through hearing. They hear parents and siblings talk and they imitate what they hear. People who are born deaf cannot learn speech through sound, nor can they rely on it as a source of feedback. They must use other modes, such as visual, tactile, and kinesthetic senses. These senses are not as reliable for speech learning; therefore, persons who were deafened in childhood before the development of language consider English their second language, and sign language as their native language.

American Sign Language (ASL) is a language of manual gestures called signs, with its own grammatical structure and syntax. When English is introduced to a Deaf child who has grown up using ASL, English is learned as a second language. Reading and writing difficulties may be experienced because of the difference in concept and structure between ASL and English.

Deaf persons are visually oriented. They use their eyes not only to communicate in signs, but also to relate to environmental and situational stimuli. Touch and kinesthetic feedback are also important to Deaf individuals. Sound vibrations made in building structures, furniture, and cars can alert deaf person to events that hearing people identify by noise.

A common misconception is that all Deaf people can lip-read. Lip-reading, or speech reading, may help a Deaf person to understand you, but it is a skill that people possess in different degrees. Even the best lip-readers can lip-read only about 26% of all words.

Hard of Hearing. Persons who have difficulty hearing or understanding speech, but who can be assisted in hearing speech with amplification (hearing aid), are hard of hearing.

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Hearing

Their ability to understand speech varies, and some speakers can be understood more easily than others. Noisy surroundings may interfere with a hard of hearing person's attempts to auditorily focus on one speaker.

Make sure you get the attention of a person who is hard of hearing while you are talking. Don't cover your mouth with your hands or move around while you are speaking. Do not become frustrated by requests to repeat your conversation. If you are having difficulty with communication, writing notes may help, or if the person knows sign language, use an interpreter.

Devices. Although heard of hearing persons may be able to use the telephone with an amplification device, Deaf persons cannot use the telephone. There are telecommunication devices for the Deaf, also known as TTYs, which when coupled with a telephone receiver, allow Deaf people to communicate by typing messages and receiving printed words from a TTY at the other end.

Many Deaf persons wear hearing aids to help them identify environmental sounds, but the aids will not help a Deaf person understand speech sounds.

Some Deaf people use hearing-ear dogs to alert them to doorbell, telephone, baby cries and fire alarm sounds. These dogs have the same privileges as seeing eye dogs for the blind; they are allowed access wherever their owners may go, and must not be distracted from their duties.

Deaf Blindness

Adapted from: Abused Deaf Women's Advocacy Services, 1999. Outreach and educational materials— "Deaf Blindness." Seattle, WA.

What is Deaf Blindness? Deaf blindness is a double impairment—a visual impairment severe enough to fit the legal definition of blindness, and a hearing impairment severe enough to be called deaf. It is a simple definition, but persons who are deaf-blind cannot be easily categorized when it comes to their abilities. Most deaf-blind persons are not totally deaf or totally blind. Some have usable hearing and vision.

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Hearing

Deaf blindness may be present from birth, or occur through an accident or later in life. The most common cause of deaf blindness is a disorder called Usher's Syndrome. In this syndrome, a person who is congenitally deaf experiences a gradual loss of vision caused by retinitis pigmentosa. In other syndromes, congenital blindness is followed by a gradual or sudden loss of hearing. Sometimes, the onset of the secondary sensory impairment does not occur until adolescence or early adulthood. This means that the person who has already adapted to one disability must learn to accept another.

Persons with Usher's Syndrome experience stages of progressive loss of vision. Generally, this disorder begins by affecting one's ability to see in the dark, a condition known as night blindness. Then gradually it affects peripheral vision, making the field of vision narrower with the progressive worsening of the disease. This is known as tunnel vision. Depending on the severity of the tunnel vision, some vision may still be usable in the very center of the visual field.

Deaf-blind people rely on many aids and devices to enhance their residual sensory abilities. Available are vibrating devices that warn the person of doorbells, alarms clocks, telephone calls, and fire alarms. There are machines that relay braille over the phone on a modified TTY machine, which is called a Tele-Braille machine. Also, many devices adapted to blind or deaf persons are used.

Communicating with someone who is Deaf, Deaf-Blind or hard of hearing:

- Look directly at the person who is Deaf while speaking, not the interpreter. Use facial expressions, nodding, and direct eye contact to show that you are paying attention. Be natural about it.
- When speaking to a person who reads lips, face the person directly. Make your lips accurate, but don't over-exaggerate.
- Wait for the Deaf person to offer information as to the cause of her deafness.
- Speak in your usual tone of voice. Don't shout.
- To get the Deaf person's attention, tap her shoulder or leg, wave, or stomp your foot.

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Hearing

- Keep your hands away from your mouth while speaking.
- When you are not part of the group, but need to interrupt a conversation, tap the person who is signing on the shoulder, not the listener, even though you may wish to speak to the listener. When not part of the conversation, but waiting, don't watch the conversation.
- For brief communications with someone who is deaf-blind, try palm writing: that is spelling out words with your finger writing on their palm, one letter at a time. For any complex communication a tactile sign language interpreter is usually the communication method preferred, although there are many methods.
- Call a Deaf advocate for support and ideas.
- Do not pretend to understand a Deaf person's speech if you can't understand it. Ask the person to repeat the message or write it.
- Deaf individual are able to produce vocal sounds. It is not appropriate to use the term "deaf-mute" or the term "deaf and dumb."
- Do not try to rely on lip-reading, it is inexact (at best 26%) and very frustrating for most deaf people to try and lip-read. Use this method only if the deaf person asks you to.
- Sometimes a Deaf person will find one individual easier to understand than others. If you are having difficulty communicating, see if a co-worker can be understood more easily.
- Try to avoid sitting or standing where light is coming from behind you. Backlighting creates a glare and often casts shadows on your face so that it is difficult to read lips and facial expressions.
- Balance problems are not uncommon among persons with hearing impairments. These problems are intensified at night and in dimly lighted rooms. Don't assume that a Deaf person is drugged or drunk if they waver when walking (adapted from Spies, 1995).

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Speech

Cognitive

Communicating with someone with a speech impairment:

- Give your whole undivided, unhurried attention to the person.
- It is very important to allow someone to speak for herself. Finishing someone's sentences or speaking in a patronizing tone of voice is condescending.
- Be considerate of the extra time it might take for a person to get things said or done.
- If you don't understand what someone has said, ask them to repeat. If you still don't understand, ask the person to say it another way. Don't pretend you understand.
- When necessary, ask questions that require short answers.
- Observe the person's method of communication: written notes or sign language.
- In a crisis, speech may be slower or more difficult to understand (adapted from Spies, 1995).

Cognitive Disabilities

Cognitive disabilities affect a person's ability to comprehend, remember, or discern. Many people with cognitive disabilities have received schooling or training that emphasized compliance with the wishes of authority figures. Because of this, people with cognitive disabilities may answer questions based on what they believe the questioner wants. It is important to remember to use simple and specific language and make sure the person is listening when you ask a question. Ask her to repeat what has been said or agreed, or ask the same question in different ways and notice if the responses are consistent.

Head Injuries. Head injuries can cause physical, cognitive, and psycho-social behavioral impairments. Head injuries can be caused by gunshot wounds, repeated blows to the head, a lack of oxygen reaching the brain, or sharp jerking movements. Any head injury can affect the ability of the brain to communicate with the body. The brainstem, which connects the brain to the spinal

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Learning

cord, contains neurons that control breathing, heartbeat, eye movements, swallowing, and facial movements. Damage to the brainstem can affect the ability of the brain to communicate with the body. Sustaining a head injury can force a person to relearn physical, cognitive, or behavioral/social skills. Some people with head injuries may need staff to present one piece of information at a time, not give complex instructions. The conversation should take place in a setting that is free of distractions, while at the same time, being careful not to patronize the person.

Communicating with someone who has a cognitive disability:

- Keep concepts clear, concrete, and concise.
- Talk at someone’s level without talking down to the person.
- Don’t ask someone with a developmental disability or a brain injury to do things you wouldn’t ask others to do.
- In some situations, the person may seem to react differently than you expect. The person is not being rude. She may just respond in a way that you are not accustomed to.
- Remember why you are there. Gently bring someone back to the interview as you would anyone else. You don’t need to listen to someone rambling on, but you may need to be polite and firm.
- When checking out whether someone understood something, don’t ask her yes or no questions. Experiment with the modality of your message if things aren’t working (adapted from Spies, 1995).

What Is A Learning Disability?

Adapted from: Abused Deaf Women’s Advocacy Services, 1999. Outreach and educational materials—“Learning Disabilities.” Seattle, WA.

People with learning disabilities (LD) receive inaccurate information through their senses and have trouble processing that information. Like static on the radio, the information becomes garbled as it travels from the eye, ear, or

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skin to the brain. The inaccurate sensory information leads to problems with reading, writing, or other vital activities such as driving. Either these skills have not been learned, have been learned after a huge effort, or have been learned poorly. Many adults with LD have trouble listening and speaking. Common problems are:

- accident proneness
- having to work at a slower pace
- being careless if hurried
- frequent errors
- often misunderstanding
- having to think through what others do automatically
- difficulties with school work

Learning disabilities are different than mental retardation. Persons with mental retardation have limited learning capacity. Persons with learning disabilities on the other hand have had specific trouble with perception or taking information in through their senses. In general, they are capable of learning and performing at their age level, but their learning is affected by the problems they have with perception. They tend to have unique ways of gathering information from the world around them.

Learning Disabilities and Attention Deficit Disorder. People who have learning disabilities process information differently and often have difficulty with writing, reading, spoken language, math, or memory. It is important to remember, however, that having a learning disability does not affect a person's overall intelligence.

Some people with learning disabilities may also have attention disorders or hyperactivity. Individuals with attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) may be restless, easily distracted, moody, disorganized, impulsive, and have a low tolerance for stress. People

with ADD/ADHD often benefit from medication and training in time management and organizational skills.

Effective communication with people who have learning disabilities or ADD/ADHD can be facilitated by having the person reflect back what she has heard and by limiting the amount of information presented to her at once. For people with ADD/ADHD, it is also helpful to keep steady eye contact and talk in a setting free of distractions.

Mental Health Disabilities

Schizophrenia, Major Depressive Disorder and Bipolar Disorder are all biologically based illnesses, which have genetic backgrounds. Physical and psychological impairments can result if these illnesses are not treated. Environmental stressors do not cause mental health disorders, but they can trigger the first symptoms of mental illness.

Schizophrenia. The typical age of onset of schizophrenia is the late teens to mid-thirties. Schizophrenia can cause delusions, hallucinations and disorganized speech. A woman with schizophrenia may believe, for example, that she is being followed or that others are controlling her thoughts.

Major Depressive Disorder. Possible indicators of major depressive disorder include a loss of interest in doing things that one has found enjoyable in the past, changes in sleeping or eating patterns, fatigue. A person may exhibit feelings of worthlessness or guilt, difficulty concentrating, recurrent thoughts of death or suicide, and complaints of pains.

Bipolar Disorder. Bipolar depression includes both manic and depressive episodes. Features of a manic episode may include talkativeness, a decreased need for sleep, persistently elevated moods, racing thoughts and distractibility. A person with bipolar depression will usually alternate between manic and depressed states.

Schizophrenia, major depressive disorder and bipolar depression can all be treated with medication and therapy.

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Seizure Disorders

Communicating with someone who has a hidden disability or psychiatric disability:

- Remember why you are there. Let the person decide if she wants to talk about her disability. Realize they may be reluctant to disclose the fact due to the severe stigma that may be associated, and the fear that their victimization testimony will be discredited because of their disability.
- Ask the victim what is needed for her accessibility.
- Maintain a supportive, open-minded attitude. The victim may not be able to work with you if she feels unsafe.
- Arrange meetings in a way that minimizes noises and distractions. Be flexible in scheduling and take breaks when needed (adapted from Spies, 1995).

Hidden Disabilities

Seizure Disorders/Epilepsy. Epilepsy is an umbrella term covering about twenty types of seizure disorders. Seizures occur when there is a brief change in the function of the electrical system of the brain. Thus, seizures are a physical disorder, not a mental disorder. Each time a person has a seizure, the flow of oxygen to the brain is limited, causing irreplaceable brain cells to die. This can affect speech, muscle coordination and vision.

Seizure disorders have no single “cause,” but can develop from a number of conditions that injure or affect the functioning of the brain such as head trauma, brain tumors, strokes, withdrawal from alcohol or other substances, poisoning, infections and developmental problems of the fetus in the womb. Seizure disorder can affect anyone, at any age, at any time.

Seizures have many forms. A person may experience massive convulsions or only a brief change in awareness, an involuntary movement, a muscle spasm, or a sensory change. For the majority of people who have epilepsy, seizures are brief and infrequent. Further, seizures can be controlled with medication. Many people with seizure disorders have not had a seizure for years and statis-

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tics show that they will probably continue to be seizure-free as long as they continue taking their medication.

To keep the airway clear during a convulsive seizure, the person only needs to be gently turned on her side.

*Environmental
Illness*

Environmental Illness. Environmental Illness (EI) is a condition in which a person's immune system responds adversely to environmental agents, resulting in an allergic reaction. When a person's immune system hyperacts, the response is out of proportion to, and more harmful than, the initial threat of the substance. This hypersensitivity from environmental exposures may produce respiratory disorders, cognitive disorientation, skin disorders, seizures, or anaphylactic shock. This disability can be very individualized and requires working with the person to provide what is needed for them. A person with environmental illness may require the use of oxygen, the use of non-scented products, the use of air filters, or just a continuous flow of air from the outside. For severe EI, it may be necessary to have a room without carpeting or furniture made of fiberboard. Work with the woman with environmental illness to determine her needs.

*Respiratory
Diseases*

Respiratory Diseases/Asthma. Chronic respiratory diseases include emphysema, allergies, asthma, chronic sinus disease, interstitial lung disease, and chronic bronchitis. Though not all of these illnesses can be cured, many can be treated and their negative impact lessened.

Smoking most often causes emphysema, but 5% of patients who never smoke develop emphysema, indicating that a genetic defect may be the cause. Chronic bronchitis and respiratory infections are common in people who have emphysema. There is no cure for emphysema. People who have emphysema often feel continual stress because of the debilitating effects of the disease.

A narrowing and obstruction of the airways, causing problems with breathing, characterize asthma. Symptoms of asthma include coughing, wheezing, shortness of breath, and tightness in the chest. Asthma symptoms vary a great deal from person to person and from day to day.

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AIDS

Some asthmatics have only occasional or seasonal symptoms. Others have a more chronic form of the disease and experience symptoms daily. Some persons have “asthma attacks” when symptoms seem to develop suddenly. Attacks can be brief or last several days; prolonged attacks can be life threatening.

Asthma is a chronic respiratory disease that can be controlled by medication and could be irritated by smoking, dust, fumes, allergies, infections, exercise, occupation, and stress. If a person is suffering from an asthma attack and her normal medications and treatments do not work, she should contact her doctor or a hospital.

AIDS. Increasing numbers of women are becoming infected with Acquired Immunodeficiency Syndrome (AIDS). AIDS is caused by the human immunodeficiency virus (HIV). HIV suppresses the immune system, rendering a person’s body unable to fight diseases and infections, which may lead to death. People infected with the virus often look and feel healthy; the only way to determine whether one is infected is to get a blood test. There is no cure for HIV, but with education, the further progression of the virus may be slowed.

As a service provider who may interact with infected women or women who are at risk for infection, it is important to be aware of the facts about HIV/AIDS and sensitive to the needs of women who are infected with HIV/AIDS.

AIDS is spread through vaginal, anal, or oral sex with someone who is infected, or sharing a needle with someone who is infected. AIDS is not spread through handshakes, coughs or sneezes sweat or tears, food, mosquitoes, hugging, cuddling, or massage with an infected person. AIDS can be transmitted from a mother to her baby during pregnancy, childbirth, or breast-feeding. AIDS is not transmitted through swimming pools, toilet seats, phones or computers, straws, spoons, cups or drinking fountains.

For women facing the reality that they are infected with this deadly, stigmatizing virus, it is important to provide them with emotional support from support groups or therapists. It is important for staff members to remember that a woman’s HIV status is a private and personal issue: it is crucial that staff members do not inadvertently “out” a woman by sharing her HIV status with

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Diabetes

Chemical Dependency

other residents. Another issue to watch for is exploitation of a woman's life insurance policy: a batterer may force a woman who is HIV-positive to cash in her life insurance policy and then take her money.

Diabetes. According to the American Diabetes Association, diabetes is a disease in which the body does not produce or properly use insulin, a hormone that is needed to convert sugar, starches, and other food into the energy needed for daily life.

Over 13 million Americans have diabetes. Diabetes is incurable, but can be treated through diet, exercise, and/or insulin, depending on which type of diabetes a person has.

There are two main types of diabetes: insulin-dependent (Type I) and non-insulin dependent (Type II) diabetes. About 10% of all people with diabetes have Type I diabetes. People who have Type I diabetes generally develop diabetes in childhood or adolescence and must take insulin injections daily. Approximately 90% of people with diabetes have Type II diabetes, or non-insulin dependent diabetes. People who have Type II diabetes generally develop it after the age of 40 and must control their diet and exercise to control their diabetes. Some individuals may also need to take insulin or medication. Most people who have diabetes can learn to monitor and control their diabetes through diet, exercise, and insulin injections.

As your program becomes more attitudinally accessible and open to providing services to women with disabilities, women will become more open about talking about their disabilities and asking for specific accommodations.

Chemical Dependency. Keep in mind that not all people who drink or use drugs are alcoholics or addicts. When alcoholism or addiction is present there is great pain, shame, fear and isolation. The ADA requires you to be accessible to a recovering alcoholic, or drug addict, but does not require you to accommodate someone who is using drugs or alcohol.

Adapted from: Bland, P., 2001. *Perinatal Partnership Against Domestic Violence: Train the Trainer Curriculum*. Seattle, WA: Washington State Department of Health, Community & Family Health, Maternal Child Health and the Washington State Coalition Against Domestic Violence.

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Chemical Dependency

- Alcohol and drug use is associated with greater severity of injuries and increased lethality rates. However, substance abuse does not cause domestic violence.
- Being identified as either an alcoholic or an addict (even if people are in recovery) can impact the ability to get housing and gain or maintain child custody. This may affect careers, community standing, and/or support (or lack thereof). Increased insurance rates and legal difficulties may also be experienced.
- Chemically dependent people face many service barriers. Shelter space is often denied, detox may not be available immediately, and treatment may seem less urgent than getting safe.
- Chemically dependent battered persons are not powerless. They are victims of both a life-threatening disease and violent crime. Empowerment for these survivors involves both safety and sobriety.
- Many substance-abusing victims of domestic violence are introduced to drugs by partners who use substances to gain and maintain power and control. This is a form of physical, emotional, social and spiritual abuse. Recognizing this may help establish trust and reduce stigma.
- Substance-abusing victims of violence are often battered by substance-abusing perpetrators. Cessation of drinking and drug use alone cannot ensure safety. Often, recovery is accompanied by more danger for victims. As victim sobriety increases, perpetrators may find their ability to control their partners threatened. They may encourage relapse by seeking to sabotage recovery efforts or looking for new ways to regain control. Refer people to support groups addressing both chemical dependency and domestic violence issues.
- Treatment for substance abuse can pose many risks for victims of domestic violence. Conjoint and couples counseling are not appropriate and should not be encouraged by providers. Domestic violence victims in methadone

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Chemical Dependency

- programs may be particularly vulnerable because they must appear daily at a set time for their dose and thus can be easily tracked by a batterer.
- Validate that anyone might use drinking or drugging to cope, but that there are safer ways to survive. Offer options but recognize substances impair judgment, making advocacy-based counseling more challenging. Don't be afraid to refer to 12-step programs, but be able to explain both strengths and limitations. Be aware of alternative referrals, especially for gender-specific or culturally appropriate support groups or chemical dependency treatment providers.
 - Recognize euphoric recall and blackout make safety planning harder. Denial of use is not about fooling the provider. It's a tactic to be addressed in a respectful manner. Facing the truth is scary and painful for the alcoholic or addict. Always be honest and direct, but remember tact and dignity.
 - Chemical dependency undermines both health and judgment. Withdrawal symptoms can be painful and life-threatening. Encourage people to seek medical attention prior to detoxing.
 - Realize that chemically affected victims of violence often believe their use of a substance means the violence directed against them is warranted. Always affirm that no one has the right to hurt them, and that violence directed against them is never their fault under any circumstance.
 - Understand that both negative stereotypes and negative internal views about domestic violence and addiction act as barriers preventing people from realizing they need support. Additionally, service providers must examine their own beliefs about alcohol and other drug use, abuse and addiction to ensure addict phobia is not impairing their ability to effectively advocate for recovering or actively using victims of violence.
 - Refer people addressing both chemical dependency and domestic violence issues to the Alcohol Drug Help Line Domestic Violence Outreach Project at 1-800-562-1240 (WA only) or 206-722-3703.

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Chemical Dependency

Chemical Dependency Definitions

12-Step Program

A self-help group that is often used as an adjunct to treatment but which is not treatment. 12-step programs can support lifetime recovery and can be extremely useful; however, battered women will also benefit from referrals to gender-specific groups and battered women's advocacy programs for safety planning as a recovery issue.

Addiction or Chemical Dependence

Is characterized by continuous or periodic impaired control over drinking alcohol or using other drugs, preoccupation with use, use despite adverse consequences and distortions in thinking (e.g., denial). The neurochemical dysfunction in addiction is best described as a chemical deficiency in pathways of the brain.

Addict phobia

Includes fear of addicts and addiction, holding negative stereotypes pertaining to people suffering from addiction; refraining from offering services, support or respect. Addict phobia creates barriers for those who are afraid of getting labeled and fearful about seeking help. Additionally, addict phobia negatively impacts people struggling to recover daily. Examples of addict phobia include mistaken belief systems about addiction, failure to understand triggers, unrealistic expectations, lack of knowledge about brain chemistry, liver function, relapse processes, resources and recovery options, as well as failure to understand appropriate role of accountability, consistency and structure. Addict phobia makes it possible for individuals and systems to establish (overly rigid or overly permeable) criteria, which can limit or prohibit access to services or successful outcomes to an entire class of people. Addict phobia is a form of oppression in our society.

Alcoholism

A treatable illness brought on by harmful dependence upon alcohol, which is physically and psychologically addictive. As a disease, alcoholism is primary, chronic, progressive and fatal.

Blackout

An amnesia-like period often associated with heavy drinking.

While blackouts impact memory, there is no evidence to support contention that blackouts alter judgment or behavior at the time of occurrence.

Cognitive Impairments

Disruptions in thinking skills such as inattention, memory problems, disruptions in communication, spatial disorientation, problems with sequencing (the ability to follow a set of steps in order to accomplish a task), misperception of time, and perseveration (constant repetition of meaningless or inappropriate words or phrases).

Delirium Tremens (DTs)

When the level of alcohol in the blood drops suddenly and the person becomes delirious as well as tremulous and suffers from hallucinations that are primarily visual but also may be tactile.

Detoxification

The process of providing medical care during the removal of dependence-producing substances from the body so that withdrawal symptoms are minimized and physiological function is safely restored. Treatment includes medication, rest, diet, fluids and nursing care.

Dual Diagnosis

A clinical term referring specifically to patients who meet the diagnostic criteria for an addictive disorder as well as meeting the diagnostic criteria for:

- An organic mental or developmental disorder
- A major psychiatric disorder with or without current symptomology
- A personality disorder or
- A compulsive disorder such as an eating or pathological gambling disorder.

Euphoric Recall

Memories formed under the influence that may be used as inappropriate excuse to minimize, rationalize or deny behavior.

Mentally Ill Chemical Abusers (MICA)

A term used to designate people who have an alcohol or other drug disorder and a markedly severe and persistent mental disorder, such as schizophrenia or bipolar disorder.

Methadone

A synthetic narcotic. It may be used as a substitute for heroin, producing less socially disabling addiction or aiding in withdrawal from heroin.

Relapse

is common in recovery from addiction and not considered treatment failure. As with other chronic illnesses, significant improvement is considered successful treatment even if complete remission or absolute cure is not achieved.

Substance Abuse

a destructive pattern of drug use, including ETOH (alcohol), which leads to clinically significant impairment or distress. Often the substance abuse continues despite significant life problems. When a person exhibits tolerance and withdrawal, the person has progressed from abuse to Addiction (a disease consisting of a number of brain chemistry disorders).

Tolerance

the need for significantly larger amounts of substance to achieve intoxication. Drug effects decrease if the usual amount is taken.

Withdrawal

adverse reaction after a reduction of substance.

THREE CIVIL RIGHTS MOVEMENTS COMPARED

The development of this manual is possible because of all the efforts and struggles throughout history to obtain civil rights for women, victims' rights, and the right of access for persons with disabilities. These three struggles have many similarities, including the recognition that barriers can come in many forms and have been used to limit many different peoples. Currently, all of the groups are still struggling to obtain equal rights, and some are farther along than others.

It was only in 1990, with the passage of the Americans with Disabilities Act (ADA), that people with disabilities gained the basic right to access services that many of us take for granted. Passage of the ADA supported and strengthened organizing efforts and identification of barriers by disability advocates and persons with disabilities. Therefore, it's not surprising that the concerns of women and survivors of domestic violence are just beginning to be addressed on a systemic level.

An individual who is oppressed will have limited options for justice if the oppressed group as a whole has been deprived of human rights. For example, prisoners of war usually don't have a place to file a complaint. As Deaf persons obtained interpreters and access to information, Deaf women had the opportunity and resources to start questioning their more complicated oppressions, as did Deaf people of color, Deaf lesbians and gays, and many others.

The following timeline is a combination of multiple historic struggles from the early 1900s through 1999. It is meant to briefly highlight some important parallels.

Timeline excerpted from: **Women's rights:** "The Path of the Women's Rights Movement— A Timeline of the Women's Rights Movement 1848–1998," <http://www.legacy98.org/timeline>. Copyright 1997-2001 National Women's History Project. All rights reserved.

Victims' rights: *Crime Victims' Rights in America: Historical Overview*, Justice for Deaf Victims Training, ADWAS and Office for Victims of Crime. Compiled by the National Victim Center.

Disability rights: "Disability Social History Timeline," Disability Social History Project, Oakland CA, <http://www.disabilityhistory.org>.

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Women's Rights

1900 *1900* Two-thirds of divorce cases are initiated by the wife; a century earlier, most women lacked the right to sue and were hopelessly locked into bad marriages.

1910 Washington State: Women win the vote.

1917 During WWI, women move into many jobs working in heavy industry in mining, chemical manufacturing, automobile and railway plants. They also run streetcars, conduct trains, direct traffic, and deliver mail.

1917 October 168 National Woman's Party members are arrested and convicted for peacefully picketing the White House for woman suffrage, becoming the first U.S. citizens held as political prisoners. In prison, they staged hunger strikes and were force fed. In response to public outcry, they are eventually released without comment or pardon.

1918 January 8 New York v. Sanger. Margaret Sanger wins her suit in New York to allow doctors to advise their married patients about birth control for health purposes.

1919 The House of Representatives passes the woman suffrage amendment, 304 to 89; the Senate passes it with just two votes to spare, 56 to 25.

Victims' Rights

Disability Rights

1912 Henry H. Goddard publishes *The Kadikak Family*, the best-seller purporting to link disability with immorality and alleging that both are tied to genetics. It advances the agenda of the eugenics movement, which in pamphlets such as *The Threat of the Feeble Minded* creates climate of hysteria allowing for massive human rights abuses of people with disabilities, including institutionalization and forced sterilization.

Women's Rights

1920 *1920* Despite the efforts of a number of black women voters' leagues, when Black women try to register to vote in most Southern states, they face property tax requirements, literacy tests and other obstacles.

1926 Bertha Knight Landes is the first woman elected mayor of a sizable U.S. city (Seattle).

1923 Alice Paul and the National Woman's Party succeed in having a constitutional amendment introduced in Congress which said: *Men and women shall have equal rights throughout the United States and every place subject to its jurisdiction.*

Victims' Rights

Disability Rights

1921 The American Foundation for the Blind (AFB), a non-profit organization recognized as Helen Keller's cause in the United States, is founded.

1927 The U.S. Supreme Court, in *Buck v. Bell*, rules that the forced sterilization of people with disabilities is not a violation of their constitutional rights. The decision removes the last restraints for eugenists advocating that people with disabilities be prohibited from having children. By the 1970s, some 60,000 disabled people are sterilized without consent.

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Women's Rights

1930 *1935* Mary McLeod Bethune organizes the National Council of Negro Women as a lobbying coalition of black women's groups, and serves as president until 1949. The NCNW becomes foremost at fighting job discrimination, racism, and sexism.

1936 *United States v. One Package* declassifies birth control information as obscene. Contraceptive devices can finally be imported to the United States.

Victims' Rights

1932 The National Recovery Act forbids more than one family member from holding a government job, resulting in many women losing their jobs.

Disability Rights

1935 A group in New York City called the League for the Physically Handicapped formed to protest discrimination by the Works Progress Administration (WPA). The league's 300 people—most disabled by polio and cerebral palsy—all had been turned down for WPA jobs. The Home Relief Bureau of New York City was supposed to forward their job requests to the WPA, but was stamping all their applications PH for physically handicapped, as a signal to the WPA not to give these people jobs.

1939 Amid the outbreak of World War II, Hitler orders widespread "mercy killing" of the sick and disabled. The Nazi euthanasia program was code-named *Aktion T4* and was instituted to eliminate "life unworthy of life."

Women's Rights

1940 *1940* 1/5 of white women and 1/3 of black women are wage earners. 60% of the black women are still domestics, compared with 10% of white women. Among Japanese American women workers, almost 38% are in agriculture and 24% are in domestic service.

1941 A massive government and industry media campaign persuades women to take jobs during the war. Almost 7 million women respond, 2 million as industrial "Rosie the Riveters" and 400,000 joining the military.

1943 The wording was revised to what we know today as the Equal Rights Amendment.

1945 The Equal Pay for Equal Work bill is again introduced into Congress (see 1872). It passes in 1963.

Victims' Rights

Disability Rights

1940–1944 In Nazi Germany 908 patients are transferred from Schoenbrunn, an institution for retarded and chronically ill patients, to the euthanasia "installation" at Eglfing-Haar to be gassed. A monument to the victims now stands in the courtyard at Schoenbrunn.

1941 August 3 In Nazi Germany, a Catholic bishop, Clemens von Galen, delivers a sermon in Munster Cathedral attacking the Nazi euthanasia program, calling it "plain murder."

1941 August 23 Hitler suspends *Aktion T4*, which had accounted for nearly a hundred thousand deaths by this time. However the euthanasia program quietly continued using drugs and starvation instead of gassings.

4

Women's Rights

1950

1960 *1960* Women now earn only 60 cents for every dollar earned by men, a decline since 1955. Women of color earn only 42 cents.

1963 The Equal Pay Act, proposed twenty years earlier, establishes equal pay for men and women performing the same job duties. It does not cover domestics, agricultural workers, executives, administrators or professionals.

1963 The report issued by the President's Commission on the Status of Women documents discrimination against women in virtually every area of American life. It makes 24 specific recommendations, some surprisingly far-sighted

Victims' Rights

Women's discussion groups began identifying common issues of sexual abuse and domestic violence.

1964 Title VII of the Civil Rights Act bars employment discrimination by private employers, employment agencies, and unions based on race, sex, and other grounds. To investigate complaints and enforce penalties, it establishes the Equal Employment Opportunity Commission (EEOC), which receives 50,000 complaints of gender discrimination in its first five years.

Disability Rights

1950 The Social Security Amendments of 1950 establish a federal-state program to aid the permanently and totally disabled (APTD). This is a limited prototype for later federal disability assistance programs such as Social Security Disability Insurance.

The Association for Retarded Children of the United States (later renamed the Association for Retarded Citizens and then The Arc) is founded in Minneapolis by representatives of various state association of parents of mentally retarded children.

1961 President Kennedy appoints a special President's Panel on Mental Retardation, to investigate the status of people with mental and develop programs and reforms for its improvement.

The American National Standards Institute, Inc. (ANSI) publishes American Standard Specifications for Making Buildings Accessible to, and Usable by, the Physically Handicapped. This landmark document becomes the basis for all subsequent architectural access codes.

William C. Stokoe, Carl Croneberg, and Dorothy Casterline publish *A Dictionary of American Sign Language* on

Women's Rights

(example: community property in marriages). 64,000 copies are sold in less than a year and talk of women's rights is again respectable.

1964 Patsy Mink (D-HI) is the first Asian-American woman elected to the U.S. Congress.

1966 In response to EEOC inaction on employment discrimination complaints, twenty-eight women found the National Organization for Women (called NOW) to function as a civil rights organization for women.

1967 California becomes the first state to re-legalize abortion.

1967 New York Radical Women is founded. The following year they begin a process of sharing life stories, which becomes known as "consciousness raising." Groups immediately take root coast-to-coast.

1968 The National Abortion Rights Action League (NARAL) is founded.

1968 Shirley Chisholm (D-NY) is first Black woman elected to the U.S. Congress.

Victims' Rights

1965 Lyndon Johnson's Executive Order 11246 takes the 1964 Civil Rights Act a step further, requiring federal agencies and federal contractors to take "affirmative action" in overcoming employment discrimination.

1968 National Welfare Rights organization is formed by activists such as Johnnie Tillmon and Etta Horm. They have 22,000 members by 1969, but are unable to survive as an organization past 1975.

Disability Rights

Linguistic Principles, establishing the legitimacy of American Sign Language and beginning the move away from oralism.

The Autism Society of America is founded by parents of children with autism in response to the lack of services, discrimination against children with autism, and the prevailing view of medical "experts" that autism is a result of poor parenting, as opposed to neurological disability.

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Women's Rights

- 1970** 1970 North American Indian Women's Association is founded.
- 1970 The Comision Feminil Mexicana Nacion is organized to promote Latina rights. Founders include Graciella Olivares, Gracia Molina Pick, Francisco Flores, and Yolanda Nava.
- 1973 In Roe v. Wade, the Supreme Court establishes a woman's right to abortion, effectively canceling the anti-abortion laws of 46 states.
- 1974 Cleveland Board of Education v. LaFleur determines it is illegal to force pregnant women to take maternity leave on the assumption they are incapable of working in their physical condition.
- 1976 Organization of Pan Asian American Women is founded to impact public policy.
- 1977 Congress passes the Hyde Amendment, eliminating federal funding for poor women's abortions. By 1995, only thirteen states still provide public funding for abortions.
- 1979 Owanah Anderson founds and directs the Ohoyo Resource Center to advance the status of American Indian/Alaska Native women.

Victims' Rights

- NOVA formed by activists. National conferences and task forces begin. Several states begin legislative action for victims.
- 1971 The first battered women's shelter opens in the U.S., in Urbana, Illinois, founded by Cheryl Frank and Jacqueline Flenner. By 1979, more than 250 shelters are operating.
- 1971 New York Radical Feminists holds a series of speakouts and a conference on rape and women's treatment by the criminal justice system. Resulting in the establishment of rape crisis centers across the country.
- 1972 The first emergency rape crisis hotline opens in Washington, D.C.
- 1976 In a groundbreaking law, marital rape becomes a crime in Nebraska.
- 1976 Women Against Violence Against Women stages the first major demonstration against pornography, in Los Angeles.

Disability Rights

- Many laws passed granting access for persons with disabilities to governmental agencies.
- 1970 Ed Roberts and his peers at Cowell (UC Berkeley Health Center) formed a group called the Rolling Quads.
- The Rolling Quads form the Disabled Students' Program on the U.C. Berkeley campus.
- 1974 Disabled Women's Coalition founded at UC Berkeley by Susan Sygall and Deborah Kaplan. Other women involved include Kitty Cone, Corbett O'Toole, and Susan Schapiro. The coalition ran support groups, held disabled women's retreats, wrote for feminist publications, and lectured on women and disability.
- National Association of the Deaf did census of Deaf Americans; counted 13.4 million hearing and 1.8 million deaf Americans.
- 1977 *January 1* When Carter's administration took office, the Health, Education, and Welfare Department immediately began revising and watering down the regulations, with no input from the disability community.
- 1977 *April 5* A group of disabled people takes over the San Francisco offices of the Health, Education, and Welfare

Women’s Rights

1980 1981 Sharon Parker and Veronica Collazo found the National Institute for Women of Color. First project: replacing phrase “minority women” with “women of color” in common usage.

1982 Ratification efforts for an Equal Rights Amendment fail despite a solid majority of the public—63%—supporting it. It is promptly reintroduced into Congress.

1984 EMILY’s List (Early Money is Like Yeast: It Makes the Dough Rise) is founded to raise funds for feminist candidates.

1985 Wilma Mankiller becomes first woman installed as principal chief of a major Native American tribe, the Cherokee in Oklahoma.

Victims’ Rights

After many task force recommendations and studies, passage of federal victim and witness protection act of 1982 brings “fair treatment standards” to victims and witnesses at federal level.

1980 New EEOC guidelines list sexual harassment as a form of prohibited sexual discrimination.

1985 Tracey Thurman of Connecticut is first woman to win a civil suit as a battered wife.

1981 Kirchberg v. Feenstra overturns state laws designating a husband “head and master,” having unilateral control of property owned jointly with his wife.

Disability Rights

Department to protest Secretary Joseph Califano’s refusal to sign meaningful regulations for Section 504. The historic demonstrations were successful and the 504 regulations were finally signed.

1980–83 Sears, Roebuck and Co. began selling decoders for closed captioning for television.

National Disabled Women’s Educational Equity Project based at DREDF is established and run by Corbett O’Toole. They did the first national survey on disability and gender, wrote *No More Stares*, and conducted regional training programs for younger disabled women in Pocatello, Eugene and Minneapolis.

National Disabled Women’s Educational Equity Project puts on the first national Conference on Disabled Women’s Educational Equity in Bethesda, MD.

Harilyn Rousso sets up the Networking Project on Disabled Women and Girls at the YWCA in New York City. She produces a book and film titled *Loud, Proud and Female*.

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Women's Rights

1990 *1991* In *Backlash: The Undeclared War Against American Women*, Susan Faludi documents the attacks on women's progress during the last decade, "set off not by women's achievement of full equality but by the increased possibility that they might win it."

1992 Women are now paid 71 cents for every dollar paid to men. The range is from 64 cents for working-class women to 77 cents for professional women with doctorates. Black women earned 65 cents, Latinas 54 cents.

Victims' Rights

1993 Fifty states have revised their laws so that, depending on the degree of additional violence used, husbands can be prosecuted for sexually assaulting their wives.

1994 Every couple applying for a marriage license in California is given information about domestic violence.

1994 The Violence Against Women Act funds services for victims of rape and domestic violence, allows women to seek civil rights remedies for gender-related crimes, provides training to increase police and court officials' sensitivity and a national 24-hour hotline for battered women.

Disability Rights

Americans with Disabilities Act (ADA) of 1991 granted access to persons with disability in the areas of employment, transportation and resources in the community.

1995 The struggle for the rights of people with disabilities in Southern Africa took a giant leap forward with the election and appointment to Parliament, for the first time in the history of the region, of two women disability leaders in South Africa and Zimbabwe. The election of Maria Rantho early in 1995 to the government of Nelson Mandela in South Africa, and of Ronah Moyo in April to the Robert Mugabe government of Zimbabwe marked the beginning of an epoch in the history of people with disabilities.

1995 August 31 The First International Symposium on Issues of Women with Disabilities is held in Beijing, China in conjunction with the Fourth World Conference on Women.

1995 December 26 The organization of people with disabilities in Cuba (ACLIFM) hold their first international conference on disability rights in Havana, Cuba.

**BASIC LEGAL ADVOCACY INFORMATION AND LEGAL
REQUIREMENTS FOR ACCESSIBILITY**

Beginning Steps in Legal Advocacy for Persons with Disabilities

To participate in the legal system, a victim with a disability needs:

- Information about laws regarding domestic violence
- Access to communication services
- Access to 911
- Access to law enforcement
- Access to court systems and legal remedies (e.g., protective orders)
- Access to legal representation
- Access to civil and criminal court at all levels
- Access to court personnel
- Access to court ordered services
- Access to emergency shelter, community and legal advocacy services

The barriers to reaching and receiving these services must be identified and removed in order for any victim, and especially for victims with a disability, to successfully participate in the criminal and civil justice systems. A barrier encountered at any point can abruptly stop the victim with a disability from using the legal system as a resource for safety. There are many barriers that interrupt a victim's efforts to seek safety which can be prevented. Think of this as an ongoing process of discovery. As access to law enforcement improves, you may find unexpected barriers in the prosecutor's office; and, as the prosecutor's office becomes accessible, you discover court system barriers.

Using Interpreters for Accessibility

The Washington state law for interpreters in the justice system (see RCW 2.42 in the Appendix) requires the use of interpreters in all stages of a case when

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communicating with a Deaf victim, perpetrator or witness in a court proceeding. The ADA and Section 504 of the Rehabilitation Act further mandate the use of a sign language interpreter. An interpreter is an “auxiliary aid” and must be qualified and impartial.

Interpreters can receive certification from the Registry of Interpreters for the Deaf and from the National Association for the Deaf (see Appendix for additional contact information). These interpreters have passed tests for competency, and are required to receive ongoing training. Interpreters adhere to a strict code of ethics, demanding total confidentiality.

Family members, advocates, friends, and children of Deaf victims and other persons involved with the Deaf victim should *never* interpret for a Deaf person, as interpreters must be impartial. Safety considerations are also an issue—the Deaf community is a small community that stretches worldwide. It is common for the Deaf community to keep track of its members nationwide. Before hiring an interpreter, check with the victim to make sure that particular person is not allied with the abuser.

Using the ADA for Legal Advocacy

All civil and criminal justice services are required to be accessible by federal law. Advocates should know the basics of the ADA and be able to advocate for access for victims with disabilities at any place in the court system. The federal government has 24-hour helplines to answer most questions about the ADA (see Appendix). In most situations, explaining the barrier to the system to the representatives involved and discussing alternate options creates a satisfactory solution.

One method of systems advocacy includes finding an ally within the system who can help connect you to the right person and understands policies and procedures. Another strategy involves documenting the barriers each time they occur, and joining groups with similar goals.

If the barrier can't be removed by negotiation, and the victim decides that they want to challenge the lack of accessible services, consulting a disability rights

program or an ADA information source is critical when facing system resistance. Because the process for an ADA complaint takes a year and a half or longer, and requires a lot of time and energy, the victim may not want to continue this course of action when in a crisis situation and facing domestic violence issues. Additionally, some victims are not aware of their rights under the ADA, or they may have given up challenging system barriers. It is possible to file a class action under the ADA (without an individual victim coming forward) if an advocate can document a pattern of similar barriers over time. Again, consulting with a disability rights program or an ADA information source is necessary when considering this legal option.

There are additional legal resources regarding disability rights and access in the Appendix of this manual. We encourage you to use the legal resources listed to get assistance while you are learning about these complex issues. The ADA alone is said to “take up a room” of volumes, with all the supporting documents that clarify it. The experts can best tell you how the ADA and other laws apply to an individual victim’s situation. There are many resources to support you in advocating for victims with disabilities that experience discrimination.

Laws Pertaining to Persons with Disabilities in Washington State

In 1984, the state Legislature in Washington passed the Abuse of Vulnerable Adults Law (RCW 74.34) and the Dependent Adults Law (RCW 26.44). In 1995, the Legislature added persons who were dependent and developmentally disabled to RCW 74.34 only. In 1999, the Legislature combined the two statutes under RCW 74.34.

Vulnerable Adult Protection Orders

The Legislature, in RCW 74.34, authorized courts to issue protective orders in cases of abuse, neglect, exploitation, or abandonment of vulnerable adults. In 1999, the Legislature broadened the definition of “vulnerable adult” to include people who are under 60 years old and are not adjudicated incapacitated or are not receiving care in a state-licensed facility, but are receiving care from a state-funded provider. Either the victim, or DSHS on the victim’s behalf, may

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petition the court for such an order (RCW 74.34.110). Violations of the protective order issued under RCW 74.34 require arrest on probable cause for violation of the restraint provisions and impose the same criminal penalties for such a violation of an order issued under RCW 26.50. RCW 74.34 is linked in the statute to RCW 26.50 (Domestic Violence Protection Order) and gives persons who are abused by a caretaker the right to petition for a domestic violence protection order with the same consequences if violated.

RCW 74.34.021 defines vulnerable adults as: “persons receiving services from any individual who for compensation serves as a personal aide to a person who self-directs his or her own care in his or her home,” and further defines in findings (RCW 74.39.007):

- “Self-directed care” means the process in which an adult person who is prevented by a functional disability from performing a manual function related to health care that an individual would otherwise perform for himself or herself, chooses to direct and supervise a paid personal aide to perform those tasks,
- “Personal aide” means an individual, working privately or as an individual provider under contract or agreement with the Department of Social and Health Services, who acts at the direction of an adult person with a functional disability living in his or her own home and provides that person with health care services that a person without a functional disability can perform.

Mandatory Reporting

The mandatory reporting requirements for adult persons with disabilities are broad in their scope and different from what domestic violence advocates are used to in child abuse mandatory reporting situations. Adults with disabilities do not always have the option to decide whether to inform authorities about their experience of abuse. Advocates may find this difficult because most adult victims are allowed to decide when and how they will report abuse independent of anyone else. Even if the adult victim decides to petition for a protection order (under RCW 74.34), the abuse must be reported to state authorities by the professionals named as mandatory reporters regardless of the victim’s

wishes. Domestic violence advocates are not specifically listed as mandatory reporters in the Vulnerable Adult statute. Programs may want to consult with an attorney to develop policies for their agencies. Contacting and developing a relationship with your local Adult Protective Service workers offers an opportunity to:

- provide APS workers with information about the dynamics of domestic violence,
- advocate for a victim’s individual wishes, and
- clarify when to make a report.

RCW 74.34.035—Mandatory Reporting Requirements. RCW 74.34.035 states “When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department. If there is reason to suspect that sexual or physical assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.” The following definitions of the types of abuses that are required to be reported are found in RCW 74.34.035 (1-12) (see Appendix for full text of statute).

Policy changes as recently as 1999 recommended that Adult Protective Service (APS) workers interview victims of abuse or neglect by themselves. The practice of interviewing a victim alone has been standard practice for decades with non-disabled victims.

The Department of Social and Health Services (DSHS) struggles with the issue of monitoring paid caregivers. Most state workers who are responsible for the care of these legally protected adults do not have the training to recognize and respond to domestic violence issues. Practically speaking, this means that vulnerable adult victims would have to seek out the services of APS to get assistance. It is hard for a victim with a disability to reach out for services for their victimization. Advocates should do all they can to assist victims in asking for and receiving services from APS.

Generally, the philosophy governing the investigations include the premise that adults are able to make life decisions for themselves, and that their care, whenever possible, should be self-directed. If the adult does not volunteer for

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services or assistance, the recourse for those working in the area of protection is to seek court intervention, such as guardianship or institutionalization.

What About Guardianship?

Guardianship is a legal relationship between a competent adult and a person over the age of 18, whose disability causes them to be legally declared “incompetent” and become a ward of the state. The disability may be caused by mental illness, developmental disability, accident, age, or other causes.

To be “competent” legally addresses a person’s ability to make informed decisions, and the risk of harm that they may experience due to an inability to provide for themselves or manage their affairs. Guardians must be appointed by the Superior Court. If a person is found to be incompetent, then the guardian is given the right to make decisions on behalf of the best interests of the “ward,” at the same time taking those rights to make decisions away from the ward. Because this involves a serious loss of liberty and dignity, it must be proven that other less restrictive alternatives will not keep the ward from substantial risk of harm. Less restrictive options to guardianship include case management services, property management, protective payees, conservatorship, trusts, and power of attorney.

Additionally, partial guardianship may be granted for specific issues such as financial or medical affairs, and education. For issues involving the civil or criminal justice system, a temporary guardian ad litem (GAL) may be appointed to assist an otherwise legally independent adult through a specific court case. An advocate may ask for a GAL appointment if they think it is in the best interest of the victim. Having a developmental disability is not by itself a reason to declare someone legally incompetent. Also, it is not legally allowable to declare someone incompetent to save money, or because the person acts in ways that seem inappropriate.

Guardians are required to make an initial report that includes a detailed statement of the client’s assets or care needs and the plan to respond to the client’s needs. An annual report documenting the care and activities performed on behalf of the client must be submitted to the court.

Monitoring Guardians. The Washington state branch of the AARP (formerly American Association of Retired Persons) and the Department of Social and Health Services (DSHS) are working together in assisting Washington State Superior Courts to start volunteer guardianship monitoring programs. Volunteers help judges protect incapacitated persons by reviewing records and making home visits.

The AARP's National Guardianship Monitoring Program began in 1988 as a pilot project and spread to courts in half of the United States. In 1998 in Washington state, DSHS began providing volunteers to assist in supervising and monitoring cases for incapacitated persons who are DSHS clients. These volunteers are trained and court-certified. Each volunteer spends two to eight hours a week helping courts with guardianship cases, including duties as record researchers, financial reviewers, and visitors.

Summary of Federal Statutes—Americans with Disabilities Act and Section 504 Rehabilitation Act

Americans with Disabilities Act (ADA)

Excerpted from: National Coalition Against Domestic Violence, 1996. *Open Minds, Open Doors: Technical assistance manual assisting domestic violence service providers to become physically and attitudinally accessible to women with disabilities.* Denver, CO.

The ADA prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications. It also applies to the United States Congress.

To be protected by the ADA, one must have a disability or have a relationship or association with an individual with a disability. An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. The ADA does not specifically name all of the impairments that are covered.

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The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990. The ADA was designed to address the problems of discrimination in both public and private arenas against the estimated 43 million Americans with physical or mental disabilities. The five sections of the ADA are:

Title I: Governs employment provisions.

Title II: Governs public services and public transportation: this section prohibits exclusion of people with disabilities from participating in, or being subjected to, discrimination by a public entity.

Title III: Governs public accommodations and services operated by private employers or individuals including transportation. This section requires accommodation of people with disabilities so that they receive equal enjoyment of goods, services, facilities and accommodations.

Title IV: Requires telecommunications carriers to provide services that permit telephone users with speech or hearing impairments to communicate on an equivalent basis with non-disabled users.

Title V: Provides protection from retaliation against individuals who bring claims under the ADA.

Miscellaneous Provisions: Covers numerous items including attorney fees, coverage of Congress and other legislative agencies, further definition of “illegal use of drugs,” amends the Rehabilitation Act, the use of Alternate Dispute Resolution.

For the purposes of this manual, we will focus primarily on Title III, which is most applicable to private, non-profit human service providers.

The following is excerpted from: U.S. Department of Justice. “Americans with Disabilities Act Requirements Fact Sheet.” USDOJ Civil Rights Division, Coordination and Review Section.

Americans with Disabilities Act Requirements Fact Sheet

Employment

- Employers may not discriminate against an individual with a disability in hiring or promotion if the person is otherwise qualified for the job.
- Employers can ask about one’s ability to perform a job, but cannot inquire if someone has a disability or subject a person to tests that tend to screen out people with disabilities.
- Employers will need to provide “reasonable accommodation” to individuals with disabilities. This includes steps such as job restructuring and modification of equipment.
- Employers do not need to provide accommodations that impose an “undue hardship” on business operations.

Who needs to comply

- All employers with 25 or more employees must comply, effective July 26, 1992.
- All employers with 15-24 employees must comply, effective July 26, 1994.

Transportation

- New public transit buses ordered after August 26, 1990, must be accessible to individuals with disabilities.
- Transit authorities must provide comparable paratransit or other special transportation services to individuals with disabilities who cannot use fixed route bus services, unless an undue burden would result.
- Existing rail systems must have one accessible car per train by July 26, 1995.
- New rail cars ordered after August 26, 1990, must be accessible.
- New bus and train stations must be accessible.
- Key stations in rapid, light, and commuter rail systems must be made accessible by July 26, 1993, with extensions up to 20 years for commuter rail (30 years for rapid and light rail).
- All existing Amtrak stations must be accessible by July 26, 2010.

Public Accommodations

- Private entities such as restaurants, hotels, and retail stores may not discriminate against individuals with disabilities, effective January 26, 1992.
- Auxiliary aids and services must be provided to individuals with vision or hearing impairments or other individuals with disabilities, unless an undue burden would result.
- Physical barriers in existing facilities must be removed, if removal is readily achievable. If not, alternative methods of providing the services must be offered, if they are readily achievable.
- All new construction and alterations of facilities must be accessible.

State and Local Government

- State and local governments may not discriminate against qualified individuals with disabilities.
- All government facilities, services, and communications must be accessible consistent with the requirements of Section 504 of the Rehabilitation Act of 1973.

Telecommunications

- Companies offering telephone service to the general public must offer telephone relay services to individuals who use telecommunications devices for the Deaf (called TTYs) or similar devices.
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General ADA Definitions

Excerpted from: U.S. Department of Justice. “Definitions of Disability,” ADA Regulations and Technical Assistance Materials (<http://www.usdoj.gov/crt/ada/publicat.htm>), updated March 2001.

The ADA has a three-part definition of “disability.” This definition, based on the definition under the Rehabilitation Act, reflects the specific types of discrimination experienced by people with disabilities. Accordingly, it is not the same as the definition of disability in other laws, such as state workers’ compensation laws or other federal or state laws that provide benefits for people with disabilities and disabled veterans.

Under the ADA, an individual with a disability is a person who:

- has a physical or mental impairment that substantially limits one or more major life activities;
 - has a record of such an impairment; or
 - is regarded as having such an impairment.
-

Physical and Mental Impairments

A physical impairment is defined by the ADA as:

“Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine.”

A mental impairment is defined by the ADA as:

“Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.”

Neither the statute nor the regulations list all diseases or conditions that make up “physical or mental impairments,” because it would be impossible to provide a comprehensive list, given the variety of possible impairments.

An impairment under the ADA is a physiological or mental disorder; simple physical characteristics, therefore, such as eye or hair color, left-handedness, or height or weight within a normal range, are not impairments. A physical condition that is not the result of a physiological disorder, such as pregnancy or a predisposition to a certain disease, would not be an impairment. Similarly, personality traits such as poor judgment, quick temper or irresponsible behavior, are not themselves impairments. Environmental, cultural, or economic disadvantages, such as lack of education or a prison record, also are not impairments. Example:

A person who cannot read due to dyslexia is an individual with a disability because dyslexia, which is a learning disability, is an impairment. But a person who cannot read because she dropped out of school is not an individual with a disability, because lack of education is not an impairment.

“Stress” and “depression” are conditions that may or may not be considered impairments, depending on whether these conditions result from a documented physiological or mental disorder. Example:

A person suffering from general “stress” because of job or personal life pressures would not be considered to have an impairment. However, if this person is diagnosed by a psychiatrist as having an identifiable stress disorder, s/he would have an impairment that may be a disability.

A person who has a contagious disease has an impairment. Example:

Infection with the Human Immunodeficiency Virus (HIV) is an impairment. The Supreme Court has ruled that an individual with tuberculosis which affects her respiratory system had an impairment under Section 504 of the Rehabilitation Act.

Substantially Limits

An impairment is a “disability” under the ADA only if it substantially limits one or more major life activities. An individual must be unable to perform, or be significantly limited in the ability to perform, an activity compared to an average person in the general population.

References: TAM I-2.2(a)—The regulations provide three factors to consider in determining whether a person’s impairment substantially limits a major life activity:

1. its nature and severity;
2. how long it will last or is expected to last;
3. its permanent or long term impact, or expected impact.

Examples:

A person with a minor vision impairment, such as 20/40 vision, does not have a substantial impairment of the major life activity of seeing.

A person who can walk for 10 miles continuously is not substantially limited in walking merely because, on the eleventh mile, he or she begins to experience pain, because most people would not be able to walk eleven miles without experiencing some discomfort.

These factors must be considered because, generally, it is not the name of an impairment or a condition that determines whether a person is protected by the ADA, but rather the effect of an impairment or condition on the life of a particular person. Some impairments, such as blindness, deafness, HIV infection or AIDS, are by their nature substantially limiting, but many other impairments may be disabling for some individuals but not for others, depending on the impact on their activities. Example:

Although cerebral palsy frequently significantly restricts major life activities such as speaking, walking and performing manual tasks, an individual with very mild cerebral palsy that only slightly interferes with his ability to speak and has no significant impact on other major life activities is not an individual with a disability under this part of the definition.

Please note: The ADA has been amended several times since its passage in 1990 and is undergoing continuous interpretation in the court systems. Contact your regional DBTAC at 1-800-949-4232 V/TTY for the most up-to-date information.

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Removing Barriers

While barrier removal is a duty, please note the ADA has specified “readily achievable barrier removal,” which means that it is easily accomplishable and able to be carried out without much difficulty or expense. In determining whether an action is readily achievable, consider these factors:

1. Nature and cost of the action;
2. Overall financial resources of the site or sites;
3. The geographic separateness, and the administrative or fiscal relationship of the site to a parent corporation;
4. If applicable, the overall financial resources of any parent corporation;
5. If applicable, the type of operation of any parent corporation (NCADV, 1996).

Examples of readily achievable measures

The following are examples of the steps that may be readily achievable. The list is not intended to be exhaustive, but instead provide an illustration of barrier removal.

- Installing ramps

- Making curb cuts in sidewalks and entrances

- Repositioning shelves

- Rearranging tables, chairs, vending machines, display racks and other furniture

- Repositioning telephones

- Adding raised marking on elevator control buttons

- Installing flashing alarm lights

- Widening doors

- Installing offset hinges to widen doorways

- Eliminating a turnstile or providing an alternate accessible path

- Installing accessible door hardware

- Installing grab bars in toilet stalls

- Rearranging toilet partitions to increase maneuvering space

- Insulating lavatory pipes under sinks to prevent burns

- Installing a raised toilet seat

- Installing a full-length bathroom mirror

- Repositioning a paper towel dispenser in the bathroom

- Creating designated accessible parking spaces

- Installing an accessible paper cup dispenser at an existing inaccessible water fountain

- Removing high-pile, low-density carpet (Myers, 1999)

Section 504 of the Rehabilitation Act of 1973—Handicapped Persons’ Rights Under Federal Law

As part of the Rehabilitation Act of 1973 (Public Law 93-112), Congress enacted Section 504, the first federal civil rights law protecting the rights of handicapped persons. Section 504 states that “no qualified individual with a disability in the United States shall be excluded from, be denied the benefits of, or be subjected to discrimination under” any program or activity that either receives federal financial assistance or is conducted by any Executive agency or the United States Postal Service.

Section 504 is still in effect—regulating public sector entities such as pre-schools, elementary and secondary schools, adult education, community colleges and universities, and state agencies receiving federal assistance for employees or participants (DSHS, police and fire department, hospitals).

Each federal agency has its own set of Section 504 regulations that apply to its own programs. Agencies that provide federal financial assistance also have Section 504 regulations covering entities that receive federal aid. Requirements common to these regulations include reasonable accommodation for employees with disabilities; program accessibility; effective communication with people who have hearing or vision disabilities; and accessible new construction and alterations. Each agency is responsible for enforcing its own regulations. Section 504 may also be enforced through private lawsuits. It is not necessary to file a complaint with a federal agency or to receive a “right-to-sue” letter before going to court.

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For information on how to file Section 504 complaints with the appropriate agency, contact:

Disability Rights Section
Civil Rights Division
U.S. Department of Justice
P.O. Box 66738
Washington, D.C. 20035-6738
(800) 514-0301 (Voice)
(800) 514-0383 (TTY)
www.usdoj.gov/crt/ada/adahom1.html

AGENCY ASSESSMENT AND ORGANIZATIONAL RESPONSIBILITIES

Requirements for Agency Accessibility

We have discussed several federal and state regulations requiring services to be accessible to people with disabilities in the legal advocacy section (“Basic Legal Advocacy Information and Legal Requirements”). Domestic violence programs are further required to accommodate persons with disabilities under the following regulations.

Washington Administrative Code Requirements

Chapter 388-61A of the Washington Administrative Code, under section 388-61A-0160, states: “What written policies and procedures do domestic violence programs need to have?...3. Nondiscrimination relating to staff, clients, and provision of services....”

DSHS Contract Requirements for State-Funded Domestic Violence Programs

The contract states that all domestic violence programs in Washington state are required to be:

- Accessible to persons with disabilities.
- Interpreter Services: In accordance with DSHS Children’s Administration Policy, the Contractor shall provide or arrange for qualified interpretive and/or translation services to Limited English Speaking (LES)/Limited English Proficient (LEP) and/or hearing impaired/deaf persons provided services pursuant to this contract, when interpreter services are necessary.
- Nondiscrimination: The Contractor shall comply with all applicable federal, state, and local nondiscrimination laws and regulations.

Agency Assessment Tools

All remaining pages in section excerpted from: National Coalition Against Domestic Violence, 1996. *Open Minds, Open Doors: Technical assistance manual assisting domestic violence service providers to become physically and attitudinally accessible to women with disabilities*. Denver, CO.

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Access Survey & Planning Guide Implementation Notes

Although some of the accessibility measures outlined in this survey may be costly, many can be instituted at little or no cost. Start with these low or no cost measures first and set realistic timeframes for those that are more complex and costly. Don't try to do everything at once; this will only lead to agency burn-out.

Start by formulating philosophy statements and agency policies, issued by agency leadership, that convey a strong and clear commitment to full accessibility. This sets the stage and context for short and long-term actions at all levels of the organization.

Always be working actively on one or more actions at any particular time that will move you closer to full accessibility. Continue to have an active committee within your organization that has staff, board and volunteer leadership who will continue to remind and monitor the organization, at all levels, on accessibility issues.

Many of these accessibility measures may require long-term fundraising and capital improvements. Set your timeframes for three to five years, but begin now to think about, prioritize and work towards implementation. Once everyone in your organization has a clear vision of where you are going and everyone is thinking and working towards a common vision, you will be closer to reaching your goal.

Recruit women with disabilities to be staff, volunteers and board members. They can create visibility and outreach to other women with disabilities and bring awareness and perspective to your organization about accessibility issues. Establish good working relationships, communicate and network regularly with your local independent living center and other agencies specializing in specific disabilities. They can provide extensive information, support and resources to your organization and the women with disabilities that you are serving.

Don't get discouraged. Doing something is always better than doing nothing. Make the commitment and work slowly and steadily towards full accessibility.

Remember: Accessibility is crucial for the safety and lives of women with disabilities.

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Access Survey and Planning Guide

Ideally, this survey should be completed by a team of agency leaders, including representatives from the staff, board and volunteer ranks. It has been formatted so that your agency can see clearly the areas that need work and then use it as a tool to plan needed actions, timeframes and responsibilities.

If your organization is a shelter, please answer all of the questions in this survey.

If your organization is not a residential program, but clients come to your organization’s facilities, please skip the questions which are marked with an asterisk (*).

If your agency only has telephone contact with clients, please answer questions in Sections I, V, VI, and VII only.

I. Experience

A. Has your organization worked with clients with disabilities?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

B. Do you keep statistics on women with disabilities?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

C. Do you ask in your phone screening if clients have special needs?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

2. Transportation Needs

A. Does your organization have accessible parking designated?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

B. Is your organization located near a bus line?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

C. Does your organization have a referral for a van system, such as Access-A-Ride, to accommodate clients who use electric wheelchairs and therefore cannot use the public bus system?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

3. Safety

A. Is safety information brailled or explained on audio tape (such as security pads, emergency numbers, hand-outs, maps of the building with fire escape routes, etc.)?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

Agency Assessment and Organizational Responsibilities

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B. If important safety information is not taped or reproduced in braille, do you have funds and contacts for brailleing such information?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

C. Do you have a staff member or volunteer who could record this information on audio tape?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

D. Does your alarm system (i.e., smoke alarm, fire alarm, etc.) have visual as well as auditory alarms in each room?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

E. Do you have a system in place to review safety plans for women with cognitive deficits or memory difficulty?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

4.. Building Accessibility

A. Does your building have a flat or ramped entrance with a 32-inch wide doorway?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

B. Is this the safe/client entrance?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

C. Is access needed to upper floors (i.e., access is needed if common rooms, counseling rooms, kitchen, playrooms, etc. are located upstairs)?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

D. If access to upper floors is necessary, do you have a dependable elevator or lift?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

E. At least one accessible bedroom with a 32-inch wide door?*

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

F. Do you have at least one accessible restroom as follows:

32-inch wide doorways to restroom, stall and shower?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

Handrails or grab bars near the toilet and in the shower?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

A flat (roll-in) entrance to the shower area?*

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

G. Are doorways to all rooms, such as offices, common meeting rooms, counseling rooms, playrooms, kitchen and living room 32 inches wide?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

H. Are washing machines front-loading so a woman in a wheelchair can use them?*

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

I. Are the dials on the washing machine on the front of the machine so a woman in a wheelchair can reach them?*

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

J. Are kitchen counters and sinks low enough for a woman in a wheelchair to use them comfortably?*

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

K. Are the dials for the oven/stove on the front of the oven so a woman in a wheelchair can reach them?*

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

L. Are phones lowered enough for a woman in a wheelchair to use them comfortably?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

Agency Assessment and Organizational Responsibilities

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5. Communication

A. Do the phones have amplification or TTY capability?

Yes

No

Action Needed

Time Frame

Est. Cost

Assigned to

B. Does your organization own or rent a TTY?

Yes

No

Action Needed

Time Frame

Est. Cost

Assigned to

C. Have all of your staff and volunteers been trained on TTY etiquette and using the TTY?

Yes

No

Action Needed

Time Frame

Est. Cost

Assigned to

D. Does your organization update these training sessions on a regular basis?

Yes

No

Action Needed

Time Frame

Est. Cost

Assigned to

E. Do you have volunteer interpreters, interpreters on staff, or interpreters on call?

Yes

No

Action Needed

Time Frame

Est. Cost

Assigned to

F. Do you have funding set aside to pay for interpreters?

Yes

No

Action Needed

Time Frame

Est. Cost

Assigned to

6. Attitudinal Accessibility

A. Does your organization have a philosophy statement regarding independent living for women with disabilities?

Yes

No

Action Needed

Time Frame

Est. Cost

Assigned to

B. Does your organization have a policy stating what kinds of care your staff can reasonably expect to provide (such as feeding assistance, dressing, toileting, etc.)?

Yes

No

Action Needed

Time Frame

Est. Cost

Assigned to

C. Do staff members and volunteers know where to contact home health aides and when to do so?*

Yes

No

Action Needed

Time Frame

Est. Cost

Assigned to

D. Does your organization hold disability awareness workshops to educate staff and volunteers about the needs of people with various disabilities?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

E. Are these workshops held on a regular basis?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

F. Does your organization have any staff members, board members, or volunteers with disabilities?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

7. Referrals

A. If your organization is unable to meet the needs of a client with a disability for any reason, are referrals made to other shelters or service providers?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

B. Is your organization networking and communicating on a regular basis with agencies who can assist women with disabilities?

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

8. Medication

A. Do clients have access to medications at all times?*

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

B. Can clients monitor their medications themselves if appropriate?*

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

C. Does your organization have a nurse on staff or access to a nurse?*

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

D. Can you provide personal lockers or lock boxes for medications for women with disabilities?*

<input type="checkbox"/>	<input type="checkbox"/>				
Yes	No	Action Needed	Time Frame	Est. Cost	Assigned to

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Are Your Services and Programs Accessible?

- Do you have a policy stating what kind of care your staff can reasonably expect to provide? Feeding assistance? Dressing? Toileting? Assistance in and out of bed? Does your staff know when to call for home health aides and where to find such services?

- How much assistance can you give a woman who cannot use the telephone or public transportation independently?

- Will you move meetings, counseling sessions or any other social contacts to an accessible location?

- Will you provide meetings for women trying to remain sober?

- Are your written materials in braille or on tape? Is there a reader available? Someone to assist in filling out forms?

- Does your staff know your policy on using interpreters and know how to get an interpreter? Would you consider adding the requirement of being able to communicate fluently in Sign Language to one of your agency positions the next time it becomes vacant?

- Do your agency's medication policies distinguish between prescribed drugs and other drugs in determining whether a client has direct access to their medications?

- Do you routinely advertise your facilities and services as accessible? Is your accessibility noted on all outreach materials and in the phone book?

- Is your staff trained and comfortable working with women with disabilities? Disability awareness training is essential to the success of your program.

- Do you provide ongoing training on various disabilities, their medical aspects and functional limitations? Have speakers with various disabilities come in so that staff can ask questions of someone who is not in a crisis state? All of the literature in the disability/rehabilitation field states that negative attitudes toward persons with disabilities can be overcome through information and exposure to persons with disabilities.

- Are staff members aware of the policies concerning how services are to be provided to persons with disabilities?

- Have you included women with disabilities from your community in the process of developing policies and evaluating your facilities and programs for accessibility?

Organizational Roles and Responsibilities

In every organization, there exists a wide range of responsibilities and duties related to the goal of becoming fully accessible. Each member of the organization must make a conscious and active commitment to achieve this goal by developing an open and accepting attitude toward women with disabilities. It is important that everyone in the organization have a clear picture of their role and clear directives for accomplishing it. The following pages briefly outline the general roles and responsibilities of each member of the organization.

Board of Directors

The Board of Directors plays a crucial role in providing leadership, direction, fundraising, policy formulation and planning which will guide your organization. Hiring practices, personnel policies, anti-discrimination statements, and budgeting decisions are all part of the Board's roles and responsibilities and should reflect a strong commitment to full accessibility for women with disabilities. The Board must not only understand the organization's legal obligations under the ADA, but be willing and committed to comply with the ADA.

The guiding decisions to make accessibility changes must start with the Board. However, it is important that the Board include a mechanism for administrators and direct service staff to have input into these decisions, since the staff will have the challenging job of implementing many of these policies on a daily basis. Some measures that are the responsibility of the Board include:

- Ensure that meetings, hearings, and conferences be held in accessible locations and that auxiliary aids can be provided when needed.
- Formulate nondiscrimination policies that cover the organization's hiring policies and client intake procedures.
- Pass a written policy statement outlining the organization's commitment to full accessibility and communicate it clearly to all staff.
- Take all measures possible to make the organization's facilities physically accessible, and ensure that an ongoing effort is being made to reach all ADA guidelines.

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- Institute ongoing efforts to have representation by persons with disabilities in staff, volunteer and Board positions.
- Ensure that short and long range plans for the organization include strategies that will consistently move the organization towards full accessibility.
- Ensure that the agency budget includes funds that will support capital, personnel and training items that are needed to accomplish full accessibility.

Administrators

Those in administrative and management roles also have a key role to play in influencing how women with disabilities will be accepted—as staff or clients. While the Board of Directors has the responsibility of formulating agency policies, directors and supervisors have the responsibility of ensuring that those policies are translated into procedures and that procedures that create accessible services are followed consistently. If the attitude of administration is strong and supportive of nondiscrimination policies and procedures, direct service staff, outreach staff and volunteers will generally follow this lead. Measures that are usually the responsibility of directors and managers include:

- Ensure that staff hiring procedures reach out to and are inclusive of women with disabilities.
- Provide information and training to staff to enable them to understand and respond appropriately to women with disabilities who are in need of services.
- Prioritize and implement ongoing efforts to move towards attitudinal and physical accessibility and compliance with the ADA.
- Ensure that agency forms, files and record keeping instruments include questions and data collection that include women with disabilities.
- Implement financial decisions that support effective organizational accessibility measures for women with disabilities who are staff as well as clients, i.e., telecommunication devices, ramps, braille signs, interpreters and literature.

- Implement a planning process and a timeline for becoming 100% accessible.
- Encourage and facilitate communication with disability organizations to ensure good working knowledge and relationships with community resources that may assist women with disabilities.
- Include portrayals of women with disabilities in agency literature and publications.
- Formulate emergency evacuation procedures that include correct notification for all women with disabilities.
- Institute mechanisms for comments and complaints from staff, clients and the public to be addressed around issues of organizational accessibility.
- Evaluate and revise agency rules and policies to allow flexibility and support which facilitate needed accommodations for staff and clients with disabilities.

Direct Service Staff and Volunteers

The counselors, caseworkers, crisis line workers, legal advocates, house managers and children's workers are the front-line people who will come in closest contact with women and children with disabilities on a day to day basis. The overall agency attitude as well as the individual's attitude will be most directly communicated to and felt by women and children at this level. It is crucial that the direct service staff have input into the policies and procedures that the Board and administrators are formulating. Because the staff must implement the policies and procedures, the Board and administrators must ensure that they are responsive to the staff in responding to the needs of the women and children they serve.

If complete and accurate information and training are provided to all staff and volunteers on a regular basis, it is more likely that the whole organization will be closer to reaching physical and attitudinal accessible. Responsibilities that fall on the direct service staff are:

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- Participate in regular training sessions pertaining to serving people with disabilities.
- Ask the right questions to allow a woman to acknowledge her or her child's disability and encourage her to ask for the accommodations she will need in order to fully access services.
- Keep accurate and consistent records about the numbers of women and children with disabilities seeking services, the types of disabilities they have and the services provided.
- Participate consistently in networking and communication with disability related organizations to increase understanding of and access to resources for women with disabilities.
- Provide day to day counseling and services to women and children with disabilities.
- Support acceptance of and compliance with organizational policies and procedures.
- Participate in the process of planning for and generating new ideas for continued and better accessibility.
- Institute flexible interpretation of shelter rules to allow for reasonable accommodations that facilitate full participation by women and children with disabilities.

Outreach Staff

The public relations staff, volunteer coordinator, speakers bureau coordinator and other outreach staff play a key role in communicating the message about the accessibility of services. It is important for women with disabilities and those who are in contact with women with disabilities to perceive that the organization is both attitudinally and physically accessible to women and children with disabilities.

It is equally important to let people know the limitations of the organization, if not all measures have been fully implemented, and to communicate the

agency's willingness to assist the individual in identifying and accessing appropriate alternative resources. Outreach staff should:

- Develop materials that encourage and welcome women with disabilities to access needed services.
- Publish accessibility related information regularly in agency newsletters and other publications.
- Display appropriate disability symbols on agency brochures and other outreach materials.
- Implement ongoing efforts to make the community aware of accessibility projects and features being implemented at the agency.
- Facilitate ongoing efforts to get evaluation and feedback from the disabled populations served.
- Schedule disability segments in all regular volunteer trainings and in-services.
- Invite speakers and representatives from disability related organizations to present at training sessions and special events.
- Ensure that all agency events, training sessions and meeting are held at accessible locations and provide reasonable accommodations as needed.

LEARNING ABOUT STATE SERVICES

Many thoughtful recommendations to improve system response to victimization of persons with disabilities served by the Department of Social and Health Services (DSHS) can be found in a recent report by Riveland Associates, *The Protection of Vulnerable Adults in Washington State: Administrative Assessment* (funded by the Department of Social and Health Services). This thirty-two page report details the current challenges facing DSHS as it works to respond to the complex issues facing victims with disabilities. In the words of a law enforcement office quoted in the report:

Protection of vulnerable adults is on the same trend line that protection of children was 15 to 20 years ago. Demographics, visible cases of abuse, and public opinion drove our interests then about children. The same is now starting with vulnerable adults (Riveland Associates, 2000).

The report further states the critical problem areas for serving victims with disabilities. The challenges outlined below offer direction for public policy initiatives and ally building between the disability and domestic violence advocacy communities.

The major problems observed and reported in the total environment of protecting vulnerable adults are in the areas of workforce, policy, communication, and community involvement. In brief:

- *Workforce:* The present-day competition for workers, combined with very modest (compared to private sector) compensation and benefits plans, present major challenges to the recruitment and retention of qualified workers in residential and in-home settings. Similar challenges exist for Adult Protective Service workers and Surveyor and Complaint Investigator positions.
- *Policy:* The philosophy of “self-determination” of adults in determining their lifestyle choices is supported by most persons working in the field. However, there is a lack of policy statement in WAC, RCW or federal law that clarifies for practitioners and the public alike issues as: what is

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neglect; when can or should the “state” step in and “override” self-determination; and what is the appropriate level of regulation for adult family and boarding homes, particularly if the inhabitants are capable of making their own decisions.

- *Communication:* It is reported, and we observed, that internal communications between many organizational entities of DSHS are frequently strained and often non-existent. Too, it is important that the communication patterns with the general public, partners, customers, and policymakers be enhanced.
- *Community Involvement:* As Adult Protection Services increasingly clarifies its mission and sophisticates “best practices,” it would be best served to take an approach that fosters significant community involvement. Local uniqueness may best be addressed through local participation in program development, service delivery, and planning.

Overall, the Aging and Adult Services Administration staff should be commended for the work they do; the standards they have set; and the challenges they have met—yet the biggest challenges are yet to come (Riveland Associates, 2000).

What Services Are Available Under DSHS

The following information was excerpted from the Washington State DSHS website. This information is current as of February 2001. For additional information, visit their website at <http://www.wa.gov/dshs>.

The Aging and Adult Services Administration (AASA)

The Aging and Adult Services Administration (AASA), one of the seven Administrations within DSHS that provide services to Washington residents, provides long-term care services to help seniors and adults with disabilities live independently in their homes, or in other community residential settings such as boarding homes or nursing homes.

Adult Protective Services, a service of the Aging and Adult Services Administration, investigates abuse, neglect or exploitation of any adult who is dependent, developmentally disabled, or vulnerable, and takes action to protect those who are being victimized.

In addition, the Aging and Adult Services Administration plays a vital consumer protection function by licensing nursing homes, boarding homes and adult family homes, and monitoring their quality of care, taking action when care is insufficient, and responding to consumer complaints about these facilities.

Washington state's services to help seniors and adults with disabilities live independently are regarded as among the very best in the nation.

Services of Aging and Adult Services

Services to help seniors and adults with disabilities live in their own homes:

- **Adult Day Care/Adult Day Health.** Social activities, therapies, health education and supervision are provided in a group setting during the day in facilities such as churches, nursing homes, and community centers. (Not available in all communities.)
- **Adult Protective Services.** APS investigates alleged abuse, neglect, exploitation, or abandonment of seniors and other vulnerable adults, and takes action to protect people from further victimization. The vulnerable person must consent to services, and be informed of the right to refuse or withdraw from services. These services are provided without regard to income.
- **Case Management.** Case managers perform comprehensive assessments of the needs of seniors and other vulnerable adults, and develop detailed plans of services. Ongoing follow-up assures services are provided and needs are met.
- **Environmental Modifications.** This program pays for physical adaptations that allow greater independence or enable people to stay in their homes.

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Examples include installing ramps or grab-bars, widening doorways, modifying bathrooms, or installing special electric and plumbing systems to accommodate medical equipment.

- **Health Screening (age 60 or older).** These preventive health measures include a general health assessment, limited physical examination, and selected laboratory tests. (Not available in all communities.)
- **Home Health.** In-home health care (monitoring, treatments, therapies, medications, exercises) authorized by a physician and provided by nurses, therapists, or trained aides, is available.
- **Hospice.** Medical services, home care, social services, and counseling are provided to terminally-ill patients and their families. (Not available in all communities.)
- **Information and Assistance (age 60 or older).** Specialized information about senior services in local communities, and help obtaining needed services is available.
- **Minor Household Repairs (age 60 or older).** Home or apartment repairs/modifications for health and safety can be made. (Not available in all communities.)
- **Personal Care.** This program arranges for help with personal care tasks such as bathing, dressing and grooming, meal preparation, and household chores. Personal care is designed to help people continue to live safely at home.
- **Personal Emergency Response System.** This electronic device allows certain high-risk people to get help in an emergency. The system is connected to a phone; the person may also wear a portable “help” button. When activated, staff at a response center will respond.
- **Respite Care.** This program provides relief for caregivers of adults with disabilities. Respite services can be arranged through home health agen-

cies, adult family homes, adult residential care, social day care, nursing homes, or family, friends, and volunteers.

- **Senior Centers.** These are community facilities where older people can meet, receive services, and participate in recreational activities.
- **Senior Meals (age 60 or if spouse is 60 or older).** Nutritious meals and other dietary services are provided in a group setting or delivered to home-bound persons.
- **Transportation.** Transports seniors and adults with disabilities to and from social services, medical services, meal programs, senior centers, shopping and recreational activities.

Licensing, quality assurance, and consumer protection:

AASA licenses residential and nursing facilities, inspects them periodically, and takes action whenever care is found to be insufficient. AASA also responds to individual complaints about nursing homes, adult family homes or boarding homes. (The Complaint Hotline number is 1-800-562-6078.)

Caregiver Support. Annual training conferences for in-home caregivers (family members, in-home aides, and other providers) teach practical caregiving tips. Topics may include legal and financial planning, medications, understanding depression, and managing anger, resentment and guilt. Family caregiver support is also available from local projects sponsored through Area Agencies on Aging.

Training. AASA works with educators to provide mandated training for paid in-home and residential caregivers. These classes include:

- Fundamentals of Caregiving
- Nurse Delegation
- Mental Health Specialty Training
- Dementia Specialty Training.

Training helps insure that staff are prepared to provide quality care to clients.

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Types of Facilities. When care at home is not possible, the Aging and Adult Services Administration helps families locate and choose among the following types of facilities. Payment for care may include private funding, private insurance, Medicare, Medicaid, or Veterans' Administration funds.

- **Adult Family Homes.** Residential homes licensed to care for two to six people that provide room, board, laundry, necessary supervision, assistance with activities of daily living, personal care, and social services. Some Adult Family Homes also provide nursing services.
- **Boarding Home.** Licensed Boarding Homes contract with the state to provide room and board, help with personal care tasks, and help with medications. Residents may have limited supervision. Some boarding homes offer state-contracted assisted living services, which include private apartments.
- **Nursing Homes.** Provide 24-hour supervised nursing care, personal care, therapy, supervised nutrition, organized activities, social services, room, board, and laundry.
- **Intermediate Care Facilities for the Mentally Retarded.** Provide 24-hour supervised care to people with developmental disabilities. Services include health care, physical and occupational therapy, recreational activities, nutritional management, speech therapy, psychological and psychiatric services, and training in activities of daily living and behavior management.

Nursing facility case management:

Often, someone enters a nursing home for short-term rehabilitation, or improves and no longer needs nursing home care. Aging and Adult Services staff provide ongoing contact to help maintain a patient's residence during a short nursing home stay. Home and Community Services caseworkers also help patients ready to leave a nursing home make arrangements to return home or to another residential care setting.

SAFETY PLANNING

The Zen of Safety Planning by Domestic Violence Advocates

Generally, when a battered woman experiences abuse, she tries to figure out why and how to keep it from happening again. She may work out several strategies to reduce or eliminate the threat of abuse. She may consult with family or friends, or try to talk with her partner. These common strategies are known as “safety plans” to domestic violence advocates, although few battered women would actually use that phrase. Because each battered woman confronts different risks and has different options and resources available, every woman’s safety plan is unique. As would any person making critical decisions, battered women must consider the consequences of following each option (Davies, 1997). Especially for persons with disabilities, the unintended consequences for any identified safety strategy may make the strategy useless or raise unacceptable risks. Figuring out what a battered woman with disabilities needs requires rethinking our traditional approach to safety planning.

The following example provides an opportunity to imagine what additional risks and options are involved with safety planning for a person with disabilities:

A Deaf-Blind woman is safety planning with you. When asked, “What is going on prior to an explosive event?” she shares that when her batterer is escalating in anger, he usually begins by yelling at her in tactile sign language (his hands under her hands so she can feel what he is saying to her in sign language). During this time, she complains that her guide dog is often interrupting the conversation, putting his paws on her legs and nudging her arm with his nose. She feels distracted by the dog and wants him to stop so she can focus on what the batterer says and try to stay safe.

What would you suggest for safety planning? The answer is not on any safety checklist, but if you listen carefully and think about the options available, you may figure out that the victim should follow the dog’s clue that danger is close, and even use it as an excuse to get away from the abuser—for example, “Oh, I’d better go walk the dog.”

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Learning to Recognize and Create New Options for Safety

Safety planning is always an individualized process. For a woman with a disability, it is even more varied and individualized. Because perpetrators are very calculated in targeting the abuse to the individual, they will most likely target their abusive behaviors to limit the victim's access to safety. For example, many abusers damage or disable the telephone to prevent calls for help. A Deaf victim often has her TTY damaged, leaving her abuser access to the hearing phone, while isolating her. A woman who is quadriplegic may have the phone put out of her reach.

Try to offer creative options, avoiding rigid ideas about how things should be done. There are a hundred or more ways to use a spoon, and just as many different things to use it on. During safety planning, the more options you can create together to get around a barrier, the better the victim will be able to problem-solve in a crisis situation.

Provide ample time to understand the individual's situation and plan for safety accordingly. Many situations you encounter will be new; be prepared to brainstorm creative solutions for safety to fit the individual's ability and resources. The situations may be more complex, and the time for discussion could be slower; therefore, allow for plenty of time to discuss all of the factors. Safety planning should be ongoing and repetitive because practicing is important for some people. The use of role plays and visual models, as well as reviewing problem-solving strategies addressing different scenarios, will help generalize safe thinking.

The victim's mobility and function levels must be considered during safety planning. Alternative methods for getting around and seeking help should be brainstormed and different ways for getting things done. For example, pretending to need emergency medical attention to get to a hospital and ask for help, using elbows to scoot down the hallway to neighbors, or setting up a code word to use with a caseworker during a visit to signal trouble.

Aids and devices should have back-up systems or back-up plans. Since the abuser frequently targets these items, knowing alternatives to their use or having a hidden back-up plan can be life-saving.

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Strategizing the Response to Danger

Skills can be developed to assist the victim in responding to and seeking help when in danger. It can be as simple as noticing a change in behavior or routine. In one case, the victim's seeing eye dog had developed a close bond with her abuser, and the abuser had gradually taken over the duties of caring for and playing with the dog in the home. If the victim left the house, she always knew when her abuser was following her or watching her, because the dog would become extremely excited and forget her training.

Communications aids can be developed for safety; in one instance, a person who had multiple disabilities was working at a "sheltered workshop" where her abuser also was permitted to work. Both victim and abuser had limited vocational choices. The victim was unable to readily verbally communicate, but was able to put on a red hat if she felt unsafe. This allowed her supervisor to monitor the situation closely.

Take the time to review initial safety planning options—don't take anything for granted. For some victims you may need to practice safety planning strategies. For example, with some victims you may want to ask if it is difficult to say "no" with a stern expression instead of a smile, or if they feel unsure about how or when to call 911.

The ability to evaluate what information is safe to disclose may be challenging for some victims with cognitive issues. Safety planning options must include choices that match the skill level of the victim. For example, if a victim is unable to keep from disclosing the address of the confidential shelter, other alternatives should be developed that preserve the confidentiality of the shelter and the safety of the victim.

Sample Safety Plans for Persons with Disabilities

The following materials are examples of safety plans written for persons with disabilities. The materials address three different steps in planning: preparing to leave, safety planning for and responding to an explosive incident, and leaving the situation (Myers, 1999).

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Preparing to Leave

Adapted from: Stellar, 1998. "Checklist for persons with disabilities: What to take with you when you leave an abusive relationship." Austin, TX: Safe Place-Domestic Violence and Sexual Assault Survival Center.

- Change your payee on your SSI/SSDI benefits to someone other than the batterer.

- Open a savings account in your name and have your benefit check(s) directly deposited into that account. Try to save money and transfer money from any joint account you have with the batterer into your new account.

- Make plans for your personal care needs with someone other than the batterer; ask more than one friend for help to prevent one person from becoming overwhelmed.

- Contact your caseworker (if you have one), independent living center or other disability organization to identify additional benefits you may be entitled to after leaving the batterer.

- Secure a post office box in your own name and hide the key or give it to someone you trust.

- Get together money, an extra set of keys, medications, spare medical supplies and adaptive equipment and clothes for you and your children. Leave these items with a friend.

- Identify friends, family, religious community members and others who would let you stay with them or lend you money to leave.

- Make sure that your vehicle and any adaptations are in working order. Keep the gas tank at least half full so you can leave at any time.

- If you use special transportation services to escape or seek assistance, give the transit company the name of a place you regularly frequent but the different address of the place you want to go to. Therefore, the batterer will not get suspicious.

- If you are not currently using special transportation service, consider applying for it.

- Call the domestic violence shelter in your area to discuss safety planning, your needs and explain to them about your disability. If the shelter is full, ask to be put on a waiting list and call daily to check the status. If the shelter is inaccessible, ask them to give you the number of the nearest accessible shelter. Safety planning is very important at this time, so ask the shelter to help you strategize.

- Keep the number of the shelter with you or memorize it. Keep change on your person for calling from a phone booth.

- Call disability service providers in your area (e.g., independent living centers, disability rights organization, support groups). Learn your rights as a person with disabilities.

- Contact area Adult Protective Services and tell them that your health and safety are at stake.

Safety Planning for and Responding to an Explosive Incident

Adapted from: Stellar, 1998. "Checklist for persons with disabilities: What to take with you when you leave an abusive relationship." Austin, TX: Safe Place-Domestic Violence and Sexual Assault Survival Center.

Planning

- Even though an abuser's tactics are unpredictable, watch for cues you have previously experienced to reduce your risk of injury and danger.

- If possible, ask the caretaker or attendant to perform personal care tasks at a later time.

- If you experience periods when your abuser is cooperative or helpful, ask them to complete extra tasks, such as laundry or organizing personal paperwork, allowing easy access to these items in an emergency.

- Routinely ask your caretaker/partner to help you out of bed early in the day. It is easier to respond to an emergency when you are mobile and rested.

- Increase your access to mobility aids whenever possible. Keep your cane or walker close by or move to your wheelchair. Think about alternate ways to be mobile if these are taken away.

- Secure an extra cordless or cellular phone that is always with you; tuck it by your side in your wheelchair or on a walker or in a scooter basket. Try to keep the additional phone secret from the abuser; it may help to turn off the ringer. Program 911 and other safety numbers into the speed dial of the phone.

- Practice exiting your home or how you will get to a phone.

- Talk to the police when you are not in immediate danger. Inform them of your situation and ask them to drive past your home a couple of times during the evening or as regularly as possible. Let them know you have a disability.

- Plan ahead for where you will go, if you have to leave.

Responding

- When you feel afraid, try to stay close to a phone and call 911 for assistance.

- During an incident, try to move yourself away from rooms that have any possible weapons, like the kitchen and bathroom. Try to stay near an exit.

- If possible, look for an exit and/or yell for help.

- Ask others to call 911 during an incident. Memorize or keep the phone number of a contact that will call the police if they hear any disturbances coming from your home.

- Or, use a code word or phrase that tells your children, family, support workers, neighbors, or friends to call 911.

- If a situation is dangerous, consider giving the abuser what they want in order to calm them down.

- If the abuser cannot be stopped, focus on staying alive and protecting yourself.

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What To Take When Leaving An Abusive Relationship: Checklist For Persons With Disabilities

Adapted from: Stellar, 1998. "Checklist for persons with disabilities: What to take with you when you leave an abusive relationship." Austin, TX: Safe Place-Domestic Violence and Sexual Assault Survival Center.

No time to prepare and you must leave as quickly as possible

- Medication
 - Assistive Devices
 - Any information about services and financial benefits
 - Caseworker name and phone number
 - Existence of and information about legal guardian
-

Time to prepare

Identification

- Driver's license or state ID card
- Birth certificates (yours and your children's)
- Social Security card
- Social Security award letter
- Proof of disability
- Food stamps/AFDC card
- Insurance, Medicaid, and/or clinic card

Important Services and Medical Information and Resources

- Adaptive equipment (e.g., wheelchairs, shower bench, crutches, communications device, hearing aid batteries)
- Medications/prescriptions
- Urological supplies
- Names and phone numbers of home health agencies, caseworkers and other disability service providers to assist in coordinating services for you
- Legal guardianship information

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- Phone numbers of friends or past attendants (who might be willing to help with personal care tasks during transition period and also provide you with emotional support)
- Fixed route bus pass, mobility ID card or special transit ID card

Money

- Money and/or credit cards/ATM card
- Bank books/account information/checkbook

Legal Papers

- Lease/house payment information/deed to the house
- Car registration/car insurance papers
- Health/life insurance papers
- Medical records/doctor's orders
- Children's school records/shot records
- Work permits (green card, visa)
- Passport
- Divorce papers
- Child custody papers
- Protective orders

Miscellaneous Items

- House/car keys
 - Medications
 - Small objects to sell
 - Jewelry
 - Address book
 - Pictures (of you, your children and the abuser)
 - Children's small, favorite toy
 - Toiletries/diapers
-

BUILDING ALLIANCES

What Is an Ally?

An ally is a group or individual with whom you share like attitudes, beliefs, and vision. An alliance should be mutually beneficial, with both sides learning and teaching in a cooperative information and resource exchange. There should be a commitment over time to communicate and work together towards a common mission. Excellence in advocacy for persons with disabilities is impossible without ally building. There are really two complex professional fields of study needed for this work. There are books inches thick that detail thousands of different parts of the body that can be affected by disability and disease. You need not know everything about all persons with disabilities. But you can:

- Know the basics,
- Know how to ask the victim what they need,
- And you can have allies built-in to help you problem-solve.

When a victim who is quadriplegic comes to you seeking shelter, it is not the time to find the resources you need for emergency chore services. Ideally you will know that before you need the information.

Find out what the resources are in your area. Domestic violence programs can start by calling DSHS and OCVA to find leads to the resources available in your area (or see contacts listed in the Appendix). Call and ask for someone to come out for a site visit to your shelter or facility. Ask them for a review of your services and sites. Ask them what other resources are available for support and information. Ask them to be on your board of directors or your planning/program committees.

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There are several caveats to the use of allies in the disability profession:

1. Danger of abuser getting information

- There is a small-town feeling among disability workers. There is a perception (often true) that “everyone knows everyone else” in this community. If you are calling for consultation on an individual victim, check with the victim to make sure she is comfortable that all disability service providers you coordinate with are not linked to the abuser.
- Make sure that the service provider can prevent inadvertent slips of information from their office to the abuser.
- Make sure that there are separate caseworkers in place if the abuser and victim both use the same disability services and that they are responsible in scheduling and logistics so that the victim remains safe.

2. The victim may have several reasons for not wanting her disability service providers to know her personal abuse situation.

- This is her decision and must be respected. This situation becomes difficult for a victim if the abuse she has experienced must be reported (see “Basic Legal Advocacy” section for information on mandatory reporting).
- As an advocate, when consulting with disability providers about a particular victim’s experience, be careful how much you reveal about their identity. It is very easy for persons in the disability field to guess who you are talking about even without any specific information.

The Team Approach to Advocating for Victims with Disabilities

In a meeting of some of the best professionals from the disability advocacy and domestic violence advocacy communities, a great deal of groundwork had to be done before the group could work as a whole in examining the needs of victims with disabilities. Both groups have similar visions of self-determination for all individuals, but they come from very different perspectives, and have not spent much time talking with each other.

The disability advocates were distrustful of the services provided by domestic violence shelters, and these fears are based on some bad experiences they have had with shelters and legal systems. They wanted training themselves so that they could provide services to victims in crisis in an accessible manner.

Domestic violence advocates wanted to provide services, but were a bit overwhelmed at the high incidence of abuse of persons with disabilities and the amount of work that needs to be done to make services accessible to everyone.

Neither group of advocates has been serving victims with disabilities systematically and effectively, but each group felt it was the best resource for victims who are disabled. Each profession has a hard task, and usually does it alone, but alone has not been enough; we are going to have to work together to find the best practices for victims with disabilities.

Combining Resources

This is a model to provide advocacy, making the most of resources available for victims with disabilities. The domestic violence advocates and disability advocates need to develop long-term relationships to provide appropriate for victims who are disabled.

The advocate needs to be able to get accurate information on both domestic violence issues and disability issues in order to provide the best possible services to the victim with a disability.

Co-advocacy teams can be developed on a case-by-case basis. The victim needs to be involved in selecting who should be on the team and what the team should do in its work together. A possible scenario looks like this:

- Victim with a disability
- Workplace supervisor
- Developmental disability caseworker
- Department of Vocational Rehabilitation worker
- Domestic violence advocate from community advocacy or shelter program

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- Group home supervisor or other chosen representative
- Legal advocate from prosecutor's office

The victim should facilitate or choose the facilitator, and also set the agenda.

The tasks of the team might include:

- Clarifying roles and expectations, dividing duties
- Identification of duplicated efforts, and boundary issues
- Safety planning (seamless)
- Discussion of issues only as requested by victim

The team could meet once, or many times, and should have a clear purpose. Releases of information should be in place.

Identify Possible Resources/Stakeholders

We need to be prepared, no matter which door the victim enters, to provide excellent and accessible support to victims with disabilities.

By identifying your local resources in the disability community, you will be gaining valuable information and support about other resources available for persons with disabilities that you can use.

You can also work towards identifying resources to fill the gaps in your services and facilities. For example, is there a wheelchair accessible room in another facility or private home that could serve as an option if your shelter has a steep stairway and is not wheelchair accessible?

Compare Visions and Understand Potential Allies/Stakeholders to Further Define the Problem with Broader Input

Domestic violence and disability advocates have similar if not identical visions. The majority philosophy and guiding principal in both professions holds that all persons should live in the least restrictive environment possible and be

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afforded access to all that they choose of what society has to offer. Both fields believe strongly in an individual's basic human rights to live unoppressed and free from harm. Empowerment and self-determination are values held high in both fields.

Develop Solutions to Problems with Allies/Stakeholders

When we have a chance to form coalitions and forge a common understanding of each other's fields, we will open up many opportunities for increased safety options for victims with disabilities.

Implement Solutions

Training should offer opportunities to forge new solutions and set in place mechanisms to implement these solutions.

We are hoping to develop connections that will be long-lasting and develop into co-advocacy teams combining the best practices of service with the goal of safety for the victim and completely accessible services.

Gather Feedback and Evaluate

As we remove barriers, new ones will appear. This is a natural long-term process of discovering new options.

If we are ready to discuss outcomes to this new field of work, then we will find new problems, re-implement, and re-evaluate solutions. It is an ongoing process. We will need to study more to find the model practices of service, and develop model prevention techniques designed for a broader audience, including persons with a wide range of disabilities.

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Community Organizing and Linkages Worksheet

Excerpted from: Asian Pacific Islander Women and Family Safety Center, 2000. *Organizing with Passion: Domestic Violence organizing in communities of color and rural communities*. Praxis - Rural Technical Assistance on Violence Against Women in Partnership with the Violence Against Women Office, Office of Justice Programs.

Here is a worksheet to assist in your specific community organizing and planning process:

Identify the Issues

- What do you and your co-workers complain about?
 - What do the women you work with complain about?
 - What is your dream or vision?
 - What is it you are committed to?
-

Identify the Stakeholders

- Who do you think could help address this issue?
 - Who do the women you work with believe could help?
 - Who else cares about this issue at your agency?
 - At other agencies, groups, institutions?
 - Identify groups, agencies, institutions (for example, the community health clinic and Spanish radio program).
 - Identify individuals (for example, a certain teacher).
-

Identify the Help Needed

- What resources are needed to address this issue (besides money)?
 - Who has these resources?
-

Understand Potential Allies

- What are their mission and goals?
 - How does your agency and your issue relate to their mission/goals? (Be very specific.)
 - How would helping you help them? (Be very specific.)
 - Do you understand how they operate and make decisions?
 - Do you understand what they are afraid of?
-

Develop a Plan

- Identify steps to build relationship and trust (at least one year).
 - Who else can help you do this?
 - What specific actions can you take for the biggest impact, given your limited time/energy?
 - How will your approach be culturally appropriate, accessible and flexible?
 - How will you prevent burnout?
 - Is this project repeatable (annual march, vigil, religious service, etc.)?
-

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U.S. Department of Justice. "Definitions of Disability," ADA Regulations and Technical Assistance Materials (<http://www.usdoj.gov/crt/ada/publicat.htm> updated March 2001).

FURTHER READING AND RESOURCES

Web Sites

www.cavnet.org
www.boystown.org/research/abused.html
www.quasar.ualberta.ca/ddc/ddb/sobleymansell.html
www.psych-health.com/death.html
www.psych-health.com/tony.html
www.vh.org/Welcome/UIHC/UIHCMedDepts/Peds/ChildAbuse/DHSAdult.html
www.realtime.net/austinrapecrisis/HTML/psac.htm
www.pcepd.gov
www.icdi.wvu.edu/tech/ada.htm
www.adapt.org/jt.htm
www.usdoj.gov/crt/ada/qandaeng.htm (ADA Q&A page)
www.dshs.gov/2disa.html (*For People with Disabilities* homepage)
<http://www.hc-sc.gc.ca/hppb/familyviolence/html/disabl/1disabl.htm>
(Canadian report on violence and people with disabilities)

Organizations (National and Washington State)

ADA Information Line

(800) 514-0301
(800) 514-0383 TDD
www.usdoj.gov/crt/ada/adahom1.htm
The U.S. Department of Justice answers questions about the ADA and provides free publications by mail and fax through its ADA Information Line; publications may also be viewed or downloaded at its website.

Access USA—Braille Services

P.O. Box 160
242 James Street
Clayton, NY 13624
(613) 995-148
(800) 263-2750
Braille translation for all types of copying, translation, and printing services.

*Further
Reading and
Resources*
WEBSITES
ORGANIZATIONS

*Further
Reading and
Resources*

ORGANIZATIONS

Alzheimer's Association
919 N. Michigan Avenue, Suite 1000
Chicago, IL 60611
(800) 272-3900
(312) 335-8700
(312) 335-8882 TTY
Information, referral and support.

American Association of the Deaf-Blind
814 Thayer Avenue, Suite 302
Silver Spring, MD 20910
(301) 588-6545 TTY

American Association on Mental Retardation (AAMR)
1719 Kalorama Road NW
Washington, DC 20009
(202) 387-1968
Safeguard the rights of and enhance the quality of life for individuals with developmental disabilities, their friends and family members. Call for information regarding the local chapter in your area.

American Diabetes Association (ADA) National Center
1660 Duke Street
Alexandria, VA 22314
(800) 232-3472
(703) 549-1500

American Epilepsy Society (AES)
638 Prospect Avenue
Hartford, CT 06105
(203) 586-7505

American Foundation for the Blind (AFB)
15 West 16th Street
New York, NY 10011
(212) 620-2000

American Paralysis Association (APA)
500 Morris Avenue
Springfield, NJ 07081
Spinal Cord Injury Hotline: (800) 526-3456
Mobility Impairment: (800) 225-0292

American Parkinson Disease Association (APDA)

60 Bay Street
Staten Island, NY 10301
(800) 223-2732
(718) 981-8001

Information, referral and support.

American Printing House for the Blind (APH)

1839 Frankfort Avenue
P.O. Box 6085
Louisville, KY 40206
(800) 223-1839
(502) 895-2405

Information and referral, telephone tape, braille translation, talking books.

American Psychiatric Association (APA)

Division of Public Affairs
1400 K Street NW
Washington, DC 20005
(202) 682-6220

American Sickle Cell Anemia Association (ASCAA)

10300 Carnegie Avenue
Cleveland, OH 44106
(216) 229-8600

Information, referral and support groups.

American Spinal Injury Association (ASIA)

345 East Superior Street, Room 1436
Chicago, IL 60611
(312) 908-6207

Arthritis Foundation

1314 Spring Street NW
Atlanta, GA 30309
(404) 872-7100

Asthma and Allergy Foundation of America/N.E. Chapter

220 Boylston St.
Chestnut Hill, MA 02167
(617) 965-7771
(617) 965-8886 (Fax)

Asthma and allergy information, referral, patient education and support group programs, outreach support, research.

*Further
Reading and
Resources*

ORGANIZATIONS

*Further
Reading and
Resources*

ORGANIZATIONS

CDC National AIDS Hotline
American Social Health Association
P.O. Box 13827
Research Triangle Park, NC 27709
(800) 342-2437 V/TTY

Center for Research on Women With Disabilities
Department of Physical Medicine and Rehabilitation
Baylor College of Medicine
6910 Fannin, Suite 310 South
Houston, TX 77030
(713) 797-6282 V
(713) 797-0716 TTY

Central Washington Service Center for the Deaf and Hard of Hearing
303 S. 12th Avenue
Yakima, WA 98902-3112
(509) 452-9826 TTY
(509) 452-9823 V

Clearinghouse on Disability Information
Office of Special Education and Rehabilitative Services
Department of Education
Room 3132, Switzer Building
Washington, DC 20202-2524
(202) 205-8241 V/TTY
(202) 205-8723 V/TTY

Commission on Mental and Physical Disability Law
American Bar Association
1800 M Street NW, Suite 200 South
Washington, DC 20036-5886
(202) 331-2240
(202) 331-3884 TTY

Community Service Center for the Deaf & Hard of Hearing
1609 19th Avenue
Seattle, WA 98122
(206) 322-4996 V/TTY
(206) 720-3251 Fax
(877) 301-0006 V/TTY [from outside King Co.]

Cystic Fibrosis Foundation (CFF)

6931 Arlington Road
Bethesda, MD 20814
(800) 344-4823
(301) 951-4422

Information and referral.

*Further
Reading and
Resources*

ORGANIZATIONS

Deaf and Hard of Hearing Services, Office of

Department of Social and Health Services
P.O. Box 45300

Olympia, WA 98504-5301

(360) 902-8000 V/TTY

(360) 753-0699 TTY

curtigl@dshs.wa.gov

Offers programs for children and youth who are deaf or heard of hearing.

Disability and Business Technical Assistance Centers (DBTACs)

(800) 949-4232 V/TTD

www.icdi.wvu.edu/tech/ada.htm

The National Institute on Disability and Rehabilitation Research (NIDRR) of the U.S. Department of Education has funded a network of grantees throughout the nation to provide information, training, and technical assistance to agencies and businesses regarding their responsibilities and duties under the ADA. Your call to the above toll-free number will be routed to the DBTAC in your region.

Domestic Violence Initiative for Women with Disabilities

P.O. Box 300535

Denver, CO 80203

(303) 839-5510 V/TTY

Dystonia Medical Research Foundation

One East Wacker Drive, Suite 2430

Chicago, IL 60601

(312) 755-0198

Equal Justice Coalition

Association for Community Advocacy

NEW Center Building

1100 Main St., Suite 205

Ann Arbor, MI 48104

(734) 662-1256

Contact: Marsha Katz or Dohn Hoyle

The project educates people with developmental disabilities, their families and service providers about their rights under the ADA and other laws as they apply to the criminal justice system.

*Further
Reading and
Resources*

ORGANIZATIONS

Equal Justice Project

Temple University, Ritter Hall Annex
Philadelphia, PA 19122

(215) 204-1123
www.temple.edu/inst_disabilities

Contact: Lisa Sonneborn

This project has developed two sets of curricula: one for lawyers, psychologists, law enforcement officers and corrections personnel, and one for people with mental retardation and their advocates in the community. The project has a statewide network of leaders in the areas of law, psychology, law enforcement, corrections, advocacy, and self-advocacy who are able to provide resources for those assisting defendants, witnesses or victims with mental retardation.

Head Injury Hotline

212 Pioneer Building
Seattle, WA 98104
(206) 621-8558

Huntington's Disease Society of America (HDSA)

140 West 22nd Street, 6th Floor
New York, NY 10011
(800) 345-4372
(212) 242-1968

Provide information, referral and support.

Ileitis and Colitis Foundation

17 Avery Sq.
Needham, MA 02194
(617) 449-0324

Information, referral and support.

Information Center for Individuals with Disabilities (ICID)

Fort Point Place
27-43 Wormwood Street
Boston, MA 02210-1606
(617) 727-5540
(800) 462-5015

Information and referral to resources providing products and services for people with disabilities.

Institute for Rehabilitation and Research (TIRR)

Independent Living Research Utilization

2323 South Shepard, Suite 1000

Houston, TX 77019

(713) 797-5283

The center products audiovisuals, curricula, training materials, and journal articles; provides technical assistance; conducts conferences; and performs needs assessments.

*Further
Reading and
Resources*

ORGANIZATIONS

Institute on Alcohol, Drugs, and Disability (IADD)

1801 East Cotati Avenue

Rohnert Park, CA 94928

(707) 664-2677

(707) 664-2958 TTY

International Polio Network (IPN)

5100 Oakland Avenue, Suite 206

St. Louis, MO 63110

(314) 534-0475

Job Accommodation Network (JAN)

West Virginia University

P.O. Box 6080

Morgantown, West Virginia 26506-6080

Accommodation Info: (800) 526-7234 V/TTY

ADA Info: (800) 232-9675

<http://www.jan.wvu.edu/>

Louis Braille Center

320 Dayton Street, Suite 125

Edmonds, WA 98020-3590

(425) 776-4042 V/TTY

LRS Library Reproduction Service

1977 S. Los Angeles Street

Los Angeles, CA 90011-1096

(213) 749-2463

(800) 255-5002

Large print reproductions of any and all education materials.

Lupus Foundation of America—Mass. Chapter

425 Watertown St.

Newton, MA 02158

(617) 332-9014

Information, referral and support.

*Further
Reading and
Resources*

ORGANIZATIONS

Multiple Sclerosis Information

(800) 624-8236
Muscular Dystrophy Association (MDA)
3300 East Sunrise Drive
Tucson, AZ 85718
(602) 529-2000
(800) 223-6666

National Association of the Deaf

814 Thayer Avenue
Silver Spring, MD 20910-4500
(301) 587-1788 V
(301) 587-1789 TTY
(301) 587-1791 Fax
<http://www.nad.org>

National Advisory Group on Justice

Public Interest Law Center of Philadelphia (PILCOP)
125 S. Ninth St., Suite 700
Philadelphia, PA 19107
(215) 627-3183
Contact: Liz Obermayer

Self Advocates Becoming Empowered (SABE) and PILCOP have established a national advisory group governed by self-advocates and linked to active local self-advocacy groups in four states to enable self-advocates locally and increasingly at a national level to positively influence police policies and practices and encourage fair treatment for people with developmental disabilities in the criminal justice system.

National Council on Disability

1331 F Street NW, 10th Floor
Washington, DC 20004
(202) 272-2004
(202) 272-2074 TTY

National Council on Independent Living

2111 Wilson Blvd., Suite 405
Arlington, VA 22201
(703) 525-3406
(703) 525-3407 TTY
Locate your nearest Center for Independent Living.

National Guardianship Association

1604 N. Country Club Road
Tucson, AZ 85716-3102
(520) 881-6561
(520) 326-2467 TDD

*Further
Reading and
Resources*

ORGANIZATIONS

National Information Center on Deafness (NICD)

Gallaudet University
800 Florida Avenue NE
Washington, DC 20002
(202) 651-5051
(202) 651-5052 TTY

National Institute on Disability and Rehabilitation Research

U.S. Department of Education
400 Maryland Avenue SW
Washington, DC 20202
(202) 205-8134
(202) 205-5479 TTY

National Mental Health Association (NMHA)

1021 Prince Street
Alexandria, VA 22314
(800) 969-NMHA
(703) 684-7722
Information and referral.

National Multiple Sclerosis Society

733 3rd Avenue, 6th Floor
New York, NY 10017
(800) FIGHTMS
(212) 986-3240
Information, referral and support.

National Organization for Victim Assistance

1757 Park Road NW
Washington, DC 20010
(202) 232-6682
(202) 464-2255 (Fax)
Email: nova@try-nova.org
<http://www.try-nova.org>

*Further
Reading and
Resources*

ORGANIZATIONS

National Organization on Disability

910 Sixteenth Street NW

Washington, DC 20006

(800) 248-2253

National Paralysis Foundation

(800) 925-CURE

National Rehabilitation Information Center

8455 Colesville Road, Suite 935

Silver Spring, MD 20910-3319

(800) 227-0216

(301) 588-9284 V/TTY

National Self-Help Clearinghouse

Graduate School and University Center

25 West 43rd Street, Room 620

New York, NY 10036

(212) 642-2944

National Spinal Cord Injury Association

(800) 926-9629

National Women's Health Network

1325 G Street NW (Lower Level)

Washington, DC 20005

(202) 347-1140

National Women's Health Resource Center

2440 M Street NW, Suite 600

Washington, DC 20037

National Organization on Disability

910 16th Street NW, Suite 600

Washington, DC 20006

(800) 248-2253 (referral line)

Paralyzed Veterans of America

(202) 872-1300

Personal Safety Awareness Center

Resource Lending Library Listing of Materials

Austin Rape Crisis Center

(512) 445-5776 x210

Perspectives

365 Woodford Street
Portland, ME 04103
(207) 772-7305

Braille text with quick turnaround.

*Further
Reading and
Resources*

ORGANIZATIONS

President's Committee on Employment of People with Disabilities

1331 F Street NW
Washington, DC 20004
(202) 376-6200
(202) 376-6205 TTY

Registry of Interpreters for the Deaf, Inc.

333 Commerce Street
Alexandria, VA 22314
(703) 838-0030 V
(703) 838-0459 TTY
(703) 838-0454 Fax

RESNA Technical Assistance Project

1700 N. Moore Street, Suite 1540
Arlington, VA 22209-1903
(703) 524-6686
(703) 524-6630 (Fax)
(703) 524-6639 TTY

Contracts for technical assistance services in each state.

Sight Line Productions

505 Paradise Road, Suite 200
Swampscott, MA 01901
(617) 595-9800

Large print materials.

Society for Disability Studies

American Foundation for the Blind
15 West 16th Street
New York, NY 10011
(212) 620-2140

Southwest Washington Center of the Deaf & Hard of Hearing

1715 Broadway Street
Vancouver, WA 98663
(360) 695-9720 TTY
(360) 695-3364 V
(360) 695-2706 Fax

*Further
Reading and
Resources*

ORGANIZATIONS

Spina Bifida Association of America (SBAA)

590 MacArthur Blvd., Suite 250

Washington, DC 20007

(800) 621-3141

(301) 944-3285

Information, referral and support.

Tacoma Area Coalition of Individuals with Disabilities

6315 S. 19th Street

Tacoma, WA 98466

(253) 565-9000 V

(253) 565-3486 TTY

(877) 53-TACID V

(877) 551-3323 TTY

tacid@tacid.org

Tourette Syndrome Association (TSA)

42-40 Bell Blvd.

Bayside, NY 11361

(800) 237-0717

Information and referral services, support groups.

United Cerebral Palsy

(800) 872-5827

Information, referral and support.

Wider Opportunities for Women

1325 G Street NW (Lower Level)

Washington, DC 20005

(202) 638-3143

WRY CRIPS—Disabled Women's Theater

San Francisco Women's Centers

P.O. Box 21474

Oakland, CA 94620

(510) 601-5819

PUBLICATIONS—ARTICLES AND BOOKS

Further
Reading and
ResourcesARTICLES
AND BOOKS

- Aiello, D. and L. Capkin. (1984). "Services for Disabled Victims: Elements and Standards." *Response* (Fall), pp. 14-16.
- American Bar Association, Commission on Mental & Physical Disability Law. (1994). *Into the Jury Box: A Disability Accommodation Guide for State Courts*. [Cost: \$15, (800) 285-2221]
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Further Reading and Resources

ARTICLES AND BOOKS

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*Further
Reading and
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ARTICLES
AND BOOKS

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JOURNALS,
MAGAZINES AND
NEWSLETTERS

PUBLICATIONS—JOURNALS, MAGAZINES AND NEWSLETTERS

Abilities

Canadian Abilities Foundation
College Park, 444 Yonge Street
Toronto, Ontario M5B 2H4
Canada

ABLED

12211 Fondren, Suite 703
Houston, TX 77035
(713) 726-1132

The Disability Rag

Avocado Press
Box 145
Louisville, KY 40201
(502) 459-5343

Dykes, Disability & Stuff

P.O. Box 8773
Madison, WI 53708

Independent Living

Equal Opportunity Publications
150 Motor Parkway, Suite 420
Hauppauge, NY 11788
(516) 273-8743

It's Okay

Phoenix Counsel Inc.
1 Springbank Drive
St. Catharine's, Ontario L2S 2K1
Canada
(905) 688-2935 (Fax)

Journal of Disability Policy Studies

Department of Rehabilitation Education and Research
346 North West Avenue
Fayetteville, AR 72701
(501) 575-3656 V/TTY

Journal of Rehabilitation
National Rehabilitation Association
633 South Washington Street
Alexandria, VA 22314
(703) 836-0805
(703) 836-0849 TTY

Kaleidoscope
United Disability Services
326 Locust Street
Akron, OH 44302
(216) 762-9755

Mainstream
P.O. Box 370598
San Diego, CA 92137
(619) 234-3138

New Mobility
Miramar Communications, Inc.
23815 Stuart Ranch Road
P.O. Box 8987
Malibu, CA 90265
(800) 543-4116
(310) 317-4522
(310) 317-9644 (Fax)

Resourceful Woman
Health Resource Center for Women with Disabilities
Rehabilitation Institute of Chicago
345 East Superior Street, Room 683
Chicago, IL 60611
(312) 908-4744

Through the Looking Glass
801 Peratta Avenue
Berkeley, CA 94707
(510) 525-8138

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Reading and
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VIDEOS

VIDEOS

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES RESOURCES

DSHS
Resources

Child Protective Services Fact Sheet: An explanation of the CPS process, plus selected data on the number of referrals and types of child abuse. Requires Adobe Acrobat to read. <http://www.wa.gov/dshs/mediareleases/CPSfacts.pdf>

Guide for Mandated Reporters: DSHS has produced a 21-minute training video on reporting child abuse and neglect for those required to report called “Making A CPS Referral, A Guide For Mandated Reporters.” The new video/CD-ROM discusses who is mandated to report and how to make a report. Copies of both the video and CD-ROM formats are available in English at no charge at local libraries, at the state library in Olympia and at DSHS Division of Children and Family Services (DCFS) offices statewide. More information about the training video can be found at:

<http://www.wa.gov/dshs/mediareleases/pr01038.shtml>

To view a digitized version of the video online, go to:

<http://www.dshs.wa.gov/geninfo/dcfspub.html>

(requires free RealPlayer software).

Call 1-866-ENDHARM to report abuse/neglect: DSHS has announced a new toll-free phone number, 1-866-ENDHARM (1-866-363-4276), that makes it easier for neighbors and community members to report suspected abuse or neglect, and will connect you to the right Department of Social and Health Services (DSHS) office to make your report. The answering service operates seven days per week, 24 hours per day. People legally required to report suspected abuse or neglect (mandatory reporters) should continue to call 911 or 1-800-562-5624.

**DSHS
Resources**

Selected DSHS toll-free phone numbers:

Please use one of the program-specific numbers listed below, or call DSHS Constituent Services at 1-800-737-0617 for Washington State information.

Aging and Adult Services Administration

www.aasa.dshs.wa.gov

1-800-422-3263 (voice)

1-800-737-7931 (TDD)

Abuse/neglect reporting for adults in their own homes

REGION 1

(Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens and Whitman Counties)

1-800-459-0421

REGION 2

(Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla and Yakima Counties)

1-800-822-2097

REGION 3

(Island, San Juan, Skagit, Snohomish and Whatcom Counties)

1-800-487-0416

REGION 4

(King County)

1-800-346-9257

REGION 5

(Kitsap and Pierce Counties)

1-800-442-5129

REGION 6

(Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum Counties)

1-800-462-4957

Statewide Abuse & Neglect Reports for Adults in Facilities

1-800-562-6078 (voice)

1-800-737-7931 (TTY)

Children's Administration

Phone Directory for Child Protective Services (CPS) and Family Reconciliation Services (FRS): <http://www.wa.gov/dshs/ca/cpsfrs.html>
CA Constituent Relations: 1-800-723-4831
Child Abuse & Neglect Reports: 1-800-562-5624
Child Care Resource & Referral: 1-800-446-1114
Foster Parent/Adoptive Parenting Information: 1-888-794-1794

*DSHS
Resources*

Economic Services Administration

Community Services Division Constituent Relations: 1-800-865-7801
Child Support Community Relations: 1-800-457-6202

Health & Rehabilitation Services Administration

Division of Alcohol & Substance Abuse: 1-877-301-4557
Division of Developmental Disabilities: <http://www.wa.gov/dshs/ddd/>
Mental Health Division: 1-888-713-6010
Office of Deaf & Hard of Hearing
1-800-422-7930 (voice)
1-800-422-7941 (TTY)
Division of Vocational Rehabilitation: 1-800-637-5627

Juvenile Rehabilitation Administration

For information and assistance about JRA, please use the blue pages in your local phone directory to contact the JRA regional office nearest you.
Headquarters Office: 1-360-902-7805

Management Services Administration

DSHS Board of Appeals: 1-877-351-0002
Social Services Payment System
1-800-523-2301 (general information)
1-888-461-8855 (billing information)
Division of Access & Equal Opportunity
1-800-521-8060 (voice)
1-800-521-8061 (TTY)
1-800-766-5407 (Region 1 & 2)

Medical Assistance Administration

Medical Assistance Customer Support Center
1-800-562-3022

*DSHS
Resources*

If you have questions about services provided by programs administered by DSHS, please contact the address or phone number below. Contact information is also updated and provided on the DSHS website.

DSHS Constituent Services
PO Box 45130
Olympia, WA 98504-5130
1-800-737-0617 for Washington State information only

The following is an alphabetical list of DSHS programs and the administration they fall under.

DSHS Programs and Services

KEY to DSHS Administrations:

AASA Aging and Adult Services Administration
CA Children's Administration
ESA Economic Services Administration
HRSA Health and Rehabilitative Services Administration
JRA Juvenile Rehabilitation Administration
MSA Management Services Administration
MAA Medical Assistance Administration

A

Adoption Services (CA)
Aggression Replacement Training (JRA)
Administrative Services (MSA)
Adult Day Care (AASA)
Adult Family Homes (AASA)
Adult Protective Services (AASA)
Aging & Adult Services Administration (AASA)
Alcohol & Substance Abuse, Division of (HRSA)
Alcohol Treatment (HRSA)

B

Basic Health Plan (MAA or HCA—
external Web site)
Basic Training Camp (JRA)
Behavior Rehabilitation Services (CA)
Boarding Homes (AASA)

C

Camp Outlook (JRA)
Case Management for Senior & Vulnerable
Adults (AASA)
Chemical Dependency Disposition Alternative
(JRA)
Child Abuse & Neglect (CA)
Child Care Provider Licensing (CA)
Child Care Resource & Referral Agencies (CA)

Child Care, Seasonal (CA)
Child Care Services (CA)
Child Care for Teen Parents (CA)
Child Care Training (CA)
Child Care (Working Connections Child Care)
(ESA)
Child Protective Services (CA)
Child Study & Treatment Center (HRSA)
Child Support Services (ESA)
Children's Administration (CA)
Children's Health Insurance Program (MAA)
Community Juvenile Accountability Act (JRA)
Community Programs for Juvenile Offenders
(JRA)
Community Services Offices (ESA)
Complaint Hotline for Nursing Homes, Adult
Family Homes & Boarding Homes (AASA)
Constituent Services (MSA)
Consumer Protection (AASA)
Crime Victim/Witness Notification Program
(MSA)

D

Deaf & Hard of Hearing, Office of (HRSA)
 Developmental Disabilities, Division of (DDD)
 (HRSA)
 Diversion from Welfare (ESA)
 Diversion Programs for Juvenile Offenders (JRA)
 Diversity (MSA)
 Domestic Violence Services for Victims (CA)
 Drug Abuse Treatment (HRSA)

E

Eastern State Hospital (HRSA)
 Echo Glen Children’s Center (JRA)
 Economic Assistance Services (ESA)
 Work First
 General Assistance—Unemployable
 Emergency Assistance (ESA)
 Employee Services (MSA)
 Equal Opportunity (MSA)
 Environmental Modifications (AASA)

F

Family Assistance Program (MAA)
 Family Reconciliation Services (CA)
 Food Stamps (ESA)
 Foster Care, Specialized (CA)
 Foster Parent Training (CA)
 Foster Home Licensing & Placement (CA)
 Fraud Investigations (MSA)
 Functional Family Therapy (JRA)

G

General Assistance - Unemployable (ESA)
 Green Hill Training School (JRA)
 Group Homes (Specialized Foster Care) (CA)

H

Health & Rehabilitative Services Administration
 (HRSA)
 Health Care (MAA)
 Health Care Authority (HCA site—
 external Web site)
 Health Screening for Seniors & Other Adults
 (AASA)
 Home-based Services
 For Children (CA)
 For Seniors & Other Adults (AASA)
 Home Health Care for Seniors & Other Adults
 (AASA)
 Hope Centers (CA)
 Hospice (AASA)
 Household Repairs for Seniors (AASA)

I

Immigrant Services (ESA)
 Indian Policy & Support Services Program (MSA)
 Infant Toddler Early Intervention Program (HRSA)
 Intermediate Care Facilities for Mentally
 Retarded (AASA)
 Intervention Programs for Juvenile Offenders
 (JRA)

J

Juvenile Institutions (JRA)
 Juvenile Rehabilitation Administration (JRA)

L

Lands & Buildings (MSA)
 Licensing
 Child Care Providers (CA)
 Nursing Homes (AASA)
 Adult Family Homes (AASA)
 Boarding Homes (AASA)

M

Management Services Administration (MSA)
 Maple Lane School (JRA)
 Medicaid (MAA)
 Medical Assistance Administration (MAA)
 Mental Health, Division of (HRSA)
 Mission Creek Youth Camp (JRA)
 Multi-Systemic Therapy (JRA)

N

Naselle Youth Camp (JRA)
 Nursing Home Licensing & Consumer Protection
 (AASA)

P

Parole Services for Juvenile Offenders (JRA)
 Personal Care for Senior & Other Adults (AASA)
 Personal Emergency Response System (AASA)

R

Refugee Medical Assistance Program (MAA)
 Refugee Services (ESA)
 Research & Data Analysis Division (MSA)
 Residential Habitation Centers (HRSA)
 Respite Care
 For Seniors & Other Adults (AASA)
 For Foster Parents (CA)
 Responsible Living Skills Program (CA)

DSHS Resources

S

Senior Abuse, Protection & Prevention (AASA)
Senior Centers (AASA)
Senior Information & Assistance (AASA)
Senior Meals (AASA)
Senior Services (AASA)
Sex Offender Disposition Alternative (JRA)
Special Commitment Center (HRSA)
Supplemental Security Income (SSI) (ESA)

T

Telecommunications Relay Services (HRSA)
Telephone Assistance Program (ESA)
Transportation for Seniors & Other Adults
(AASA)
Also see WorkFirst (ESA)

V

Victim/Witness Notification Program (MSA)
Vocational Rehabilitation, Division of (HRSA)

W

Western State Hospital (HRSA)
Work Source
HRSA/DVR
ESA/WorkFirst
WorkFirst (ESA)

Y

Youth Camps for Juvenile Offenders (JRA)

UNITED NATIONS DECLARATION ON
THE RIGHTS OF DISABLED PERSONS

Proclaimed by General Assembly resolution 3447 (XXX) of 9 December 1975

*United
Nations
Declarations*

The General Assembly,

Mindful of the pledge made by Member States, under the Charter of the United Nations to take joint and separate action in co-operation with the Organization to promote higher standards of living, full employment and conditions of economic and social progress and development,

Reaffirming its faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

Recalling the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the Declaration on the Rights of Mentally Retarded Persons, as well as the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and other organizations concerned,

Recalling also Economic and Social Council resolution 1921 (LVIII) of 6 May 1975 on the prevention of disability and the rehabilitation of disabled persons,

Emphasizing that the Declaration on Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

Bearing in mind the necessity of preventing physical and mental disabilities and of assisting disabled persons to develop their abilities in the most varied fields of activities and of promoting their integration as far as possible in normal life,

Aware that certain countries, at their present stage of development, can devote only limited efforts to this end,

Proclaims this Declaration on the Rights of Disabled Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1. The term "disabled person" means any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capabilities.

United Nations Declarations

2. Disabled persons shall enjoy all the rights set forth in this Declaration. These rights shall be granted to all disabled persons without any exception whatsoever and without distinction or discrimination on the basis of race, colour, sex, language, religion, political or other opinions, national or social origin, state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family.
3. Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.
4. Disabled persons have the same civil and political rights as other human beings; paragraph 7 of the Declaration on the Rights of Mentally Retarded Persons applies to any possible limitation or suppression of those rights for mentally disabled persons.
5. Disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible.
6. Disabled persons have the right to medical, psychological and functional treatment, including prosthetic and orthetic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the processes of their social integration or reintegration.
7. Disabled persons have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions.
8. Disabled persons are entitled to have their special needs taken into consideration at all stages of economic and social planning.
9. Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative or recreational activities. No disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than that required by his or her condition or by the improvement which he or she may derive therefrom. If the stay of a disabled person in a specialized establishment is indispensable, the environment and living conditions therein shall be as close as possible to those of the normal life of a person of his or her age.

10. Disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature. 11. Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensable for the protection of their persons and property. If judicial proceedings are instituted against them, the legal procedure applied shall take their physical and mental condition fully into account.

12. Organizations of disabled persons may be usefully consulted in all matters regarding the rights of disabled persons.

13. Disabled persons, their families and communities shall be fully informed, by all appropriate means, of the rights contained in this Declaration.

**UNITED NATIONS PRINCIPLES FOR THE PROTECTION OF
PERSONS WITH MENTAL ILLNESS AND THE IMPROVEMENT OF
MENTAL HEALTH CARE**

Adopted by General Assembly resolution 46/119 of 17 December 1991

Application

These Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

Definitions

In these Principles:

“Counsel” means a legal or other qualified representative;

“Independent authority” means a competent and independent authority prescribed by domestic law;

“Mental health care” includes analysis and diagnosis of a person’s mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;

“Mental health facility” means any establishment, or any unit of an establishment, which as its primary function provides mental health care;

“Mental health practitioner” means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;

“Patient” means a person receiving mental health care and includes all persons who are admitted to a mental health facility;

“Personal representative” means a person charged by law with the duty of repre-

United Nations Declarations

senting a patient's interests in any specified respect or of exercising specified rights on the patient's behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;

"The review body" means the body established in accordance with Principle 17 to review the involuntary admission or retention of a patient in a mental health facility.

General limitation clause

The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

Principle 1

Fundamental freedoms and basic rights

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.
2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.
3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.
4. There shall be no discrimination on the grounds of mental illness.
"Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of these Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.
5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interest.

Principle 2

Protection of minors

Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

Principle 3

Life in the community

Every person with a mental illness shall have the right to live and work, as far as possible, in the community.

Principle 4

Determination of mental illness

1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.
2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.

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3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in diagnosing mental illness.
4. A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.
5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

**UNITED NATIONS DECLARATION ON THE RIGHTS OF
MENTALLY RETARDED PERSONS**

Proclaimed by General Assembly resolution 2856 (XXVI) of 20 December 1971

The General Assembly,

Mindful of the pledge of the States Members of the United Nations under the Charter to take joint and separate action in co-operation with the Organization to promote higher standards of living, full employment and conditions of economic and social progress and development,

Reaffirming faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

Recalling the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and other organizations concerned,

Emphasizing that the Declaration on Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

Bearing in mind the necessity of assisting mentally retarded persons to develop their abilities in various fields of activities and of promoting their integration as far as possible in normal life,

Aware that certain countries, at their present stage of development, can devote only limited efforts to this end,

Proclaims this Declaration on the Rights of Mentally Retarded Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1. The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.
 2. The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.
 3. The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.
 4. Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.
 5. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.
 6. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.
 7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.
- Relevant Statute
References and Commentary

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Chapter 2.42 RCW Interpreters in Legal Proceedings

RCW 2.42.010 Legislative Declaration Intent.

It is hereby declared to be the policy of this state to secure the constitutional rights, of deaf persons and of other persons who, because of impairment of hearing or speech are unable to readily understand or communicate the spoken English language, and who consequently cannot be fully protected in legal proceedings unless qualified interpreters are available to assist them.

RCW 2.42.050 Oath.

Every qualified interpreter appointed under this chapter in a judicial or administrative proceeding shall, before beginning to interpret, take an oath that a true interpretation will be made to the person being examined of all the proceedings in a manner which the person understands, and that the interpreter will repeat the statements of the person being examined to the court or other agency conducting the proceedings, to the best of the interpreter's skill and judgment.

[1989 c 358 § 14; 1985 c 389 § 20; 1973 c 22 § 5.]

NOTES:

Rules of court: ER 604.

Severability — 1989 c 358: See note following RCW 2.43.010.

RCW 2.42.110 Definitions.

As used in this chapter, the following terms have the meanings indicated unless the context clearly requires otherwise.

(1) "Impaired person" means a person who, because of a hearing or speech impairment, cannot readily understand or communicate in spoken language; and includes persons who are deaf, deaf and blind, speech impaired, or hard of hearing.

(2) "Qualified interpreter" means a visual language interpreter who is certified by the state or is certified by the registry of interpreters for the deaf to hold the comprehensive skills certificate or both certificates of interpretation and transliteration, or an interpreter who can readily translate statements of speech impaired persons into spoken language.

(3) "Intermediary interpreter" means a hearing impaired interpreter who holds a reverse skills certificate by the state or is certified by the registry of interpreters for the deaf with a reverse skills certificate, who meets the requirements of RCW 2.42.130, and who is able to assist in providing an accurate interpretation

between spoken and sign language or between variants of sign language by acting as an intermediary between a hearing impaired person and a qualified hearing interpreter.

RCWs

(4) “Appointing authority” means the presiding officer or similar official of any court, department, board, commission, agency, licensing authority, or legislative body of the state or of any political subdivision.

[1991 c 171 § 1; 1985 c 389 § 11.]

RCW 2.42.120 Appointment, pay.

(1) If a hearing impaired person is a party or witness at any stage of a judicial or quasi-judicial proceeding in the state or in a political subdivision, including but not limited to civil and criminal court proceedings, grand jury proceedings, proceedings before a magistrate, juvenile proceedings, adoption proceedings, mental health commitment proceedings, and any proceeding in which a hearing impaired person may be subject to confinement or criminal sanction, the appointing authority shall appoint and pay for a qualified interpreter to interpret the proceedings.

(2) If the parent, guardian, or custodian of a juvenile brought before a court is hearing impaired, the appointing authority shall appoint and pay for a qualified interpreter to interpret the proceedings.

(3) If a hearing impaired person participates in a program or activity ordered by a court as part of the sentence or order of disposition, required as part of a diversion agreement or deferred prosecution program, or required as a condition of probation or parole, the appointing authority shall appoint and pay for a qualified interpreter to interpret exchange of information during the program or activity.

(4) If a law enforcement agency conducts a criminal investigation involving the interviewing of a hearing impaired person, whether as a victim, witness, or suspect, the appointing authority shall appoint and pay for a qualified interpreter throughout the investigation. Whenever a law enforcement agency conducts a criminal investigation involving the interviewing of a minor child whose parent, guardian, or custodian is hearing impaired, whether as a victim, witness, or suspect, the appointing authority shall appoint and pay for a qualified interpreter throughout the investigation. No employee of the law enforcement agency who has responsibilities other than interpreting may be appointed as the qualified interpreter.

(5) If a hearing impaired person is arrested for an alleged violation of a criminal law the arresting officer or the officer’s supervisor shall, at the earliest possible time, procure and arrange payment for a qualified interpreter for any notification of rights, warning, interrogation, or taking of a statement. No employee of the law

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enforcement agency who has responsibilities other than interpreting may be appointed as the qualified interpreter.

(6) Where it is the policy and practice of a court of this state or of a political subdivision to appoint and pay counsel for persons who are indigent, the appointing authority shall appoint and pay for a qualified interpreter for hearing impaired persons to facilitate communication with counsel in all phases of the preparation and presentation of the case.

[1985 c 389 § 12.]

RCW 2.42.130 Source of interpreters, qualifications.

(1) If a qualified interpreter for a hearing impaired person is required, the appointing authority shall request a qualified interpreter and/or an intermediary interpreter through the department of social and health services, office of deaf services, or through any community center for hearing impaired persons which operates an interpreter referral service. The office of deaf services and these community centers shall maintain an up-to-date list or lists of interpreters that are certified by the state and/or by the registry of interpreters for the deaf.

(2) The appointing authority shall make a preliminary determination, on the basis of testimony or stated needs of the hearing impaired person, that the interpreter is able in that particular proceeding, program, or activity to interpret accurately all communication to and from the hearing impaired person. If at any time during the proceeding, program, or activity, in the opinion of the hearing impaired person or a qualified observer, the interpreter does not provide accurate, impartial, and effective communication with the hearing impaired person the appointing authority shall appoint another qualified interpreter. No otherwise qualified interpreter who is a relative of any participant in the proceeding may be appointed.

[1991 c 171 § 2; 1985 c 389 § 13.]

RCW 2.42.140 Intermediary interpreter, when.

If the communication mode or language of the hearing impaired person is not readily interpretable, the interpreter or hearing impaired person shall notify the appointing authority who shall appoint and pay an intermediary interpreter to assist the qualified interpreter.

[1985 c 389 § 14.]

2.42.150 Waiver of right to interpreter.

(1) The right to a qualified interpreter may not be waived except when: (a) A hearing impaired person requests a waiver through the use of a qualified interpreter; (b) The counsel, if any, of the hearing impaired person consents;

and (c) The appointing authority determines that the waiver has been made knowingly, voluntarily, and intelligently.

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(2) Waiver of a qualified interpreter shall not preclude the hearing impaired person from claiming his or her right to a qualified interpreter at a later time during the proceeding, program, or activity.

2.42.160 Privileged communications.

(1) A qualified and/or intermediary interpreter shall not, without the written consent of the parties to the communication, be examined as to any communication the interpreter interprets under circumstances where the communication is privileged by law.

(2) A qualified and/or intermediary interpreter shall not, without the written consent of the parties to the communication, be examined as to any information the interpreter obtains while interpreting pertaining to any proceeding then pending.

RCW 2.42.170 Fee.

A qualified and/or intermediary interpreter appointed under this chapter is entitled to a reasonable fee for services, including waiting time and reimbursement for actual necessary travel expenses. The fee for services for interpreters for hearing impaired persons shall be in accordance with standards established by the department of social and health services, office of deaf services.

[1991 c 171 § 4; 1985 c 389 § 17.]

RCW 2.42.180 Visual recording of testimony.

At the request of any party to the proceeding or on the appointing authority's initiative, the appointing authority may order that the testimony of the hearing impaired person and the interpretation of the proceeding by the qualified interpreter be visually recorded for use in verification of the official transcript of the proceeding.

In any judicial proceeding involving a capital offense, the appointing authority shall order that the testimony of the hearing impaired person and the interpretation of the proceeding by the qualified interpreter be visually recorded for use in verification of the official transcript of the proceeding.

[1985 c 389 § 18.]

RCW 49.60.010 Purpose of chapter.

This chapter shall be known as the “law against discrimination”. It is an exercise of the police power of the state for the protection of the public welfare, health, and peace of the people of this state, and in fulfillment of the provisions of the Constitution of this state concerning civil rights. The legislature hereby finds and declares that practices of discrimination against any of its inhabitants because of race, creed, color, national origin, families with children, sex, marital status, age, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a disabled person are a matter of state concern, that such discrimination threatens not only the rights and proper privileges of its inhabitants but menaces the institutions and foundation of a free democratic state. A state agency is herein created with powers with respect to elimination and prevention of discrimination in employment, in credit and insurance transactions, in places of public resort, accommodation, or amusement, and in real property transactions because of race, creed, color, national origin, families with children, sex, marital status, age, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a disabled person; and the commission established hereunder is hereby given general jurisdiction and power for such purposes.

* * *

RCW 49.60.030 Freedom from discrimination — Declaration of civil rights.

(1) The right to be free from discrimination because of race, creed, color, national origin, sex, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a disabled person is recognized as and declared to be a civil right. This right shall include, but not be limited to:

- (a) The right to obtain and hold employment without discrimination;
- (b) The right to the full enjoyment of any of the accommodations, advantages, facilities, or privileges of any place of public resort, accommodation, assemblage, or amusement;
- (c) The right to engage in real estate transactions without discrimination, including discrimination against families with children;
- (d) The right to engage in credit transactions without discrimination;
- (e) The right to engage in insurance transactions or transactions with health maintenance organizations without discrimination: PROVIDED, That a practice which is not unlawful under RCW 48.30.300, 48.44.220, or 48.46.370 does

not constitute an unfair practice for the purposes of this subparagraph; and

(f) The right to engage in commerce free from any discriminatory boycotts or blacklists. Discriminatory boycotts or blacklists for purposes of this section shall be defined as the formation or execution of any express or implied agreement, understanding, policy or contractual arrangement for economic benefit between any persons which is not specifically authorized by the laws of the United States and which is required or imposed, either directly or indirectly, overtly or covertly, by a foreign government or foreign person in order to restrict, condition, prohibit, or interfere with or in order to exclude any person or persons from any business relationship on the basis of race, color, creed, religion, sex, the presence of any sensory, mental, or physical disability, or the use of a trained dog guide or service animal by a disabled person, or national origin or lawful business relationship: PROVIDED HOWEVER, That nothing herein contained shall prohibit the use of boycotts as authorized by law pertaining to labor disputes and unfair labor practices.

(2) Any person deeming himself or herself injured by any act in violation of this chapter shall have a civil action in a court of competent jurisdiction to enjoin further violations, or to recover the actual damages sustained by the person, or both, together with the cost of suit including reasonable attorneys' fees or any other appropriate remedy authorized by this chapter or the United States Civil Rights Act of 1964 as amended, or the Federal Fair Housing Amendments Act of 1988 (42 U.S.C. Sec. 3601 et seq.).

(3) Except for any unfair practice committed by an employer against an employee or a prospective employee, or any unfair practice in a real estate transaction which is the basis for relief specified in the amendments to RCW 49.60.225 contained in chapter 69, Laws of 1993, any unfair practice prohibited by this chapter which is committed in the course of trade or commerce as defined in the Consumer Protection Act, chapter 19.86 RCW, is, for the purpose of applying that chapter, a matter affecting the public interest, is not reasonable in relation to the development and preservation of business, and is an unfair or deceptive act in trade or commerce.

RCW 49.60.040 Definitions.

As used in this chapter:

(1) "Person" includes one or more individuals, partnerships, associations, organizations, corporations, cooperatives, legal representatives, trustees and receivers, or any group of persons; it includes any owner, lessee, proprietor, manager, agent, or employee, whether one or more natural persons; and further includes any political or civil subdivisions of the state and any agency or instrumentality of the state or of any political or civil subdivision thereof;

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- (2) “Commission” means the Washington state human rights commission;
- (3) “Employer” includes any person acting in the interest of an employer, directly or indirectly, who employs eight or more persons, and does not include any religious or sectarian organization not organized for private profit;
- (4) “Employee” does not include any individual employed by his or her parents, spouse, or child, or in the domestic service of any person;
- (5) “Labor organization” includes any organization which exists for the purpose, in whole or in part, of dealing with employers concerning grievances or terms or conditions of employment, or for other mutual aid or protection in connection with employment;
- (6) “Employment agency” includes any person undertaking with or without compensation to recruit, procure, refer, or place employees for an employer;
- (7) “Marital status” means the legal status of being married, single, separated, divorced, or widowed;
- (8) “National origin” includes “ancestry”;
- (9) “Full enjoyment of” includes the right to purchase any service, commodity, or article of personal property offered or sold on, or by, any establishment to the public, and the admission of any person to accommodations, advantages, facilities, or privileges of any place of public resort, accommodation, assemblage, or amusement, without acts directly or indirectly causing persons of any particular race, creed, color, sex, national origin, or with any sensory, mental, or physical disability, or the use of a trained dog guide or service animal by a disabled person, to be treated as not welcome, accepted, desired, or solicited;
- (10) “Any place of public resort, accommodation, assemblage, or amusement” includes, but is not limited to, any place, licensed or unlicensed, kept for gain, hire, or reward, or where charges are made for admission, service, occupancy, or use of any property or facilities, whether conducted for the entertainment, housing, or lodging of transient guests, or for the benefit, use, or accommodation of those seeking health, recreation, or rest, or for the burial or other disposition of human remains, or for the sale of goods, merchandise, services, or personal property, or for the rendering of personal services, or for public conveyance or transportation on land, water, or in the air, including the stations and terminals thereof and the garaging of vehicles, or where food or beverages of any kind are sold for consumption on the premises, or where public amusement, entertainment, sports, or recreation of any kind is offered with or without charge, or where medical service or care is made available, or where the public gathers, congregates, or assembles for amusement, recreation, or public purposes, or public halls, public

elevators, and public washrooms of buildings and structures occupied by two or more tenants, or by the owner and one or more tenants, or any public library or educational institution, or schools of special instruction, or nursery schools, or day care centers or children's camps: PROVIDED, That nothing contained in this definition shall be construed to include or apply to any institute, bona fide club, or place of accommodation, which is by its nature distinctly private, including fraternal organizations, though where public use is permitted that use shall be covered by this chapter; nor shall anything contained in this definition apply to any educational facility, columbarium, crematory, mausoleum, or cemetery operated or maintained by a bona fide religious or sectarian institution;

(11) "Real property" includes buildings, structures, dwellings, real estate, lands, tenements, leaseholds, interests in real estate cooperatives, condominiums, and hereditaments, corporeal and incorporeal, or any interest therein;

(12) "Real estate transaction" includes the sale, appraisal, brokering, exchange, purchase, rental, or lease of real property, transacting or applying for a real estate loan, or the provision of brokerage services;

(13) "Dwelling" means any building, structure, or portion thereof that is occupied as, or designed or intended for occupancy as, a residence by one or more families, and any vacant land that is offered for sale or lease for the construction or location thereon of any such building, structure, or portion thereof;

(14) "Sex" means gender;

(15) "Aggrieved person" means any person who: (a) Claims to have been injured by an unfair practice in a real estate transaction; or (b) believes that he or she will be injured by an unfair practice in a real estate transaction that is about to occur;

(16) "Complainant" means the person who files a complaint in a real estate transaction;

(17) "Respondent" means any person accused in a complaint or amended complaint of an unfair practice in a real estate transaction;

(18) "Credit transaction" includes any open or closed end credit transaction, whether in the nature of a loan, retail installment transaction, credit card issue or charge, or otherwise, and whether for personal or for business purposes, in which a service, finance, or interest charge is imposed, or which provides for repayment in scheduled payments, when such credit is extended in the regular course of any trade or commerce, including but not limited to transactions by banks, savings and loan associations or other financial lending institutions of whatever nature, stock brokers, or by a merchant or mercantile establishment which as part of its ordinary business permits or provides that payment for purchases of property or service therefrom may be deferred;

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(19) “Families with children status” means one or more individuals who have not attained the age of eighteen years being domiciled with a parent or another person having legal custody of such individual or individuals, or with the designee of such parent or other person having such legal custody, with the written permission of such parent or other person. Families with children status also applies to any person who is pregnant or is in the process of securing legal custody of any individual who has not attained the age of eighteen years;

(20) “Covered multifamily dwelling” means: (a) Buildings consisting of four or more dwelling units if such buildings have one or more elevators; and (b) ground floor dwelling units in other buildings consisting of four or more dwelling units;

(21) “Premises” means the interior or exterior spaces, parts, components, or elements of a building, including individual dwelling units and the public and common use areas of a building;

(22) “Dog guide” means a dog that is trained for the purpose of guiding blind persons or a dog that is trained for the purpose of assisting hearing impaired persons;

(23) “Service animal” means an animal that is trained for the purpose of assisting or accommodating a disabled person’s sensory, mental, or physical disability.

RCW 49.60.050 Commission created.

There is created the “Washington state human rights commission,” which shall be composed of five members to be appointed by the governor with the advice and consent of the senate, one of whom shall be designated as chairperson by the governor.

[1985 c 185 § 3; 1981 c 338 § 9; 1957 c 37 § 5; 1955 c 270 § 2. Prior: 1949 c 183 § 4, part; Rem. Supp. 1949 § 7614-23, part.]

* * *

RCW 49.60.060 Membership of commission.

One of the original members of the commission shall be appointed for a term of one year, one for a term of two years, one for a term of three years, one for a term of four years, one for a term of five years, but their successors shall be appointed for terms of five years each, except that any individual chosen to fill a vacancy shall be appointed only for the unexpired term of the member whom the individual succeeds.

A member shall be eligible for reappointment.

A vacancy in the commission shall be filled within thirty days, the remaining members to exercise all powers of the commission.

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Any member of the commission may be removed by the governor for inefficiency, neglect of duty, misconduct or malfeasance in office, after being given a written statement of the charges and an opportunity to be heard thereon.

[1985 c 185 § 4; 1955 c 270 § 3. Prior: 1949 c 183 § 4, part; Rem. Supp. 1949 § 7614-23, part.]

* * *

RCW 49.60.172 Unfair practices with respect to HIV infection.

(1) No person may require an individual to take an HIV test, as defined in **chapter 70.24 RCW**, as a condition of hiring, promotion, or continued employment unless the absence of HIV infection is a bona fide occupational qualification for the job in question.

(2) No person may discharge or fail or refuse to hire any individual, or segregate or classify any individual in any way which would deprive or tend to deprive that individual of employment opportunities or adversely affect his or her status as an employee, or otherwise discriminate against any individual with respect to compensation, terms, conditions, or privileges of employment on the basis of the results of an HIV test unless the absence of HIV infection is a bona fide occupational qualification of the job in question.

(3) The absence of HIV infection as a bona fide occupational qualification exists when performance of a particular job can be shown to present a significant risk, as defined by the board of health by rule, of transmitting HIV infection to other persons, and there exists no means of eliminating the risk by restructuring the job.

(4) For the purpose of this chapter, any person who is actually infected with HIV, but is not disabled as a result of the infection, shall not be eligible for any benefits under the affirmative action provisions of **chapter 49.74 RCW** solely on the basis of such infection.

(5) Employers are immune from civil action for damages arising out of transmission of HIV to employees or to members of the public unless such transmission occurs as a result of the employer's gross negligence.

[1988 c 206 § 903.]

NOTES:

Severability — 1988 c 206: See **RCW 70.24.900**.

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**RCW 49.60.174 Evaluation of claim of discrimination—
Actual or perceived HIV infection.**

(1) For the purposes of determining whether an unfair practice under this chapter has occurred, claims of discrimination based on actual or perceived HIV infection shall be evaluated in the same manner as other claims of discrimination based on sensory, mental, or physical disability; or the use of a trained dog guide or service animal by a disabled person.

(2) Subsection (1) of this section shall not apply to transactions with insurance entities, health service contractors, or health maintenance organizations subject to RCW 49.60.030(1)(e) or 49.60.178 to prohibit fair discrimination on the basis of actual HIV infection status when bona fide statistical differences in risk or exposure have been substantiated.

(3) For the purposes of this chapter, “HIV” means the human immunodeficiency virus, and includes all HIV and HIV-related viruses which damage the cellular branch of the human immune system and leave the infected person immunodeficient.

[1997 c 271 § 6; 1993 c 510 § 8; 1988 c 206 § 902.]

NOTES:

Severability — 1993 c 510: See note following RCW 49.60.010.

Severability — 1988 c 206: See RCW 70.24.900.

* * *

RCW 49.60.400 Affirmative action, discrimination prohibited.

(1) The state shall not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, public education, or public contracting.

(2) This section applies only to action taken after December 3, 1998.

(3) This section does not affect any law or governmental action that does not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin.

(4) This section does not affect any otherwise lawful classification that:

(a) Is based on sex and is necessary for sexual privacy or medical or psychological treatment; or

(b) Is necessary for undercover law enforcement or for film, video, audio, or theatrical casting; or

(c) Provides for separate athletic teams for each sex.

- (5) This section does not invalidate any court order or consent decree that is in force as of December 3, 1998.
- (6) This section does not prohibit action that must be taken to establish or maintain eligibility for any federal program, if ineligibility would result in a loss of federal funds to the state.
- (7) For the purposes of this section, “state” includes, but is not necessarily limited to, the state itself, any city, county, public college or university, community college, school district, special district, or other political subdivision or governmental instrumentality of or within the state.
- (8) The remedies available for violations of this section shall be the same, regardless of the injured party’s race, sex, color, ethnicity, or national origin, as are otherwise available for violations of Washington antidiscrimination law.
- (9) This section shall be self-executing. If any part or parts of this section are found to be in conflict with federal law, the United States Constitution, or the Washington state Constitution, the section shall be implemented to the maximum extent that federal law, the United States Constitution, and the Washington state Constitution permit. Any provision held invalid shall be severable from the remaining portions of this section.
- [1999 c 3 § 1 (Initiative Measure No. 200, approved November 3, 1998).]

Chapter 74.34 RCW Abuse of Vulnerable Adults

RCW 74.34.005 Findings.

The legislature finds and declares that:

- (1) Some adults are vulnerable and may be subjected to abuse, neglect, financial exploitation, or abandonment by a family member, care provider, or other person who has a relationship with the vulnerable adult;
- (2) A vulnerable adult may be home bound or otherwise unable to represent himself or herself in court or to retain legal counsel in order to obtain the relief available under this chapter or other protections offered through the courts;
- (3) A vulnerable adult may lack the ability to perform or obtain those services necessary to maintain his or her well-being because he or she lacks the capacity for consent;
- (4) A vulnerable adult may have health problems that place him or her in a dependent position;

(5) The department and appropriate agencies must be prepared to receive reports of abandonment, abuse, financial exploitation, or neglect of vulnerable adults;

(6) The department must provide protective services in the least restrictive environment appropriate and available to the vulnerable adult.

[1999 c 176 § 2.]

NOTES:

Findings — Purpose—1999 c 176: “The legislature finds that the provisions for the protection of vulnerable adults found in chapters 26.44, 70.124, and 74.34 RCW contain different definitions for abandonment, abuse, exploitation, and neglect. The legislature finds that combining the sections of these chapters that pertain to the protection of vulnerable adults would better serve this state’s population of vulnerable adults. The purpose of chapter 74.34 RCW is to provide the department and law enforcement agencies with the authority to investigate complaints of abandonment, abuse, financial exploitation, or neglect of vulnerable adults and to provide protective services and legal remedies to protect these vulnerable adults.” [1999 c 176 § 1.]

Severability—1999 c 176: “If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.” [1999 c 176 § 36.]

Conflict with federal requirements—1999 c 176: “If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state.” [1999 c 176 § 37.]

RCW 74.34.020 Definitions.

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) “Abandonment” means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

(2) “Abuse” means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm,

pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

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- (a) “Sexual abuse” means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.
- (b) “Physical abuse” means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.
- (c) “Mental abuse” means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.
- (d) “Exploitation” means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.
- (3) “Consent” means express written consent granted after the vulnerable adult or his or her legal representative has been fully informed of the nature of the services to be offered and that the receipt of services is voluntary.
- (4) “Department” means the department of social and health services.
- (5) “Facility” means a residence licensed or required to be licensed under chapter 18.20 RCW, boarding homes; chapter 18.51 RCW, nursing homes; chapter 70.128 RCW, adult family homes; chapter 72.36 RCW, soldiers’ homes; or chapter 71A.20 RCW, residential habilitation centers; or any other facility licensed by the department.
- (6) “Financial exploitation” means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person’s profit or advantage.
- (7) “Individual provider” means a person under contract with the department to provide services in the home under chapter 74.09 or 74.39A RCW.

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(8) “Mandated reporter” is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to **chapter 18.130 RCW**.

(9) “Neglect” means (a) a pattern of conduct or inaction by a person or entity with a duty of care to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that avoids or prevents physical or mental harm or pain to a vulnerable adult; or (b) an act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult’s health, welfare, or safety.

(10) “Permissive reporter” means any person, employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults.

(11) “Protective services” means any services provided by the department to a vulnerable adult with the consent of the vulnerable adult, or the legal representative of the vulnerable adult, who has been abandoned, abused, financially exploited, neglected, or in a state of self-neglect. These services may include, but are not limited to case management, social casework, home care, placement, arranging for medical evaluations, psychological evaluations, day care, or referral for legal assistance.

(12) “Self-neglect” means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult’s physical or mental health, and the absence of which impairs or threatens the vulnerable adult’s well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an individual provider when the neglect is not a result of inaction by that agency or individual provider.

(13) “Vulnerable adult” includes a person:

(a) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or

(b) Found incapacitated under **chapter 11.88 RCW**; or

(c) Who has a developmental disability as defined under **RCW 71A.10.020**; or

(d) Admitted to any facility; or

(e) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under **chapter 70.127 RCW**; or

(f) Receiving services from an individual provider.

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[1999 c 176 § 3; 1997 c 392 § 523; 1995 1st sp.s. c 18 § 84; 1984 c 97 § 8.]

NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—
1999 c 176: See notes following **RCW 74.34.005**.

Short title—Findings—Construction—Conflict with federal requirements—
Part headings and captions not law—1997 c 392: See notes following
RCW 74.39A.009.

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s.
c 18: See notes following **RCW 74.39A.030**.

RCW 74.34.021 Vulnerable adult—Definition.

For the purposes of this chapter, the term “vulnerable adult” includes persons receiving services from any individual who for compensation serves as a personal aide to a person who self-directs his or her own care in his or her home under chapter 336, Laws of 1999.

[1999 c 336 § 6.]

NOTES:

Finding — Intent — 1999 c 336: See note following **RCW 74.39.007**.

RCW 74.34.025 Limitation on recovery for protective services and benefits.

The cost of benefits and services provided to a vulnerable adult under this chapter with state funds only does not constitute an obligation or lien and is not recoverable from the recipient of the services or from the recipient’s estate, whether by lien, adjustment, or any other means of recovery.

[1999 c 176 § 4; 1997 c 392 § 304.]

NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—1999 c
176: See notes following **RCW 74.34.005**.

Short title — Findings — Construction — Conflict with federal requirements —
Part headings and captions not law — 1997 c 392: See notes following **RCW
74.39A.009**.

**RCW 74.34.035 Reports—Mandated and permissive—Contents—
Confidentiality.**

(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department. If there is reason to suspect that sex-

ual or physical assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

(2) Permissive reporters may report to the department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited, or neglected.

(3) No facility, as defined by this chapter, agency licensed or required to be licensed under **chapter 70.127 RCW**, or facility or agency under contract with the department to provide care for vulnerable adults may develop policies or procedures that interfere with the reporting requirements of this chapter.

(4) Each report, oral or written, must contain as much as possible of the following information:

- (a) The name and address of the person making the report;
- (b) The name and address of the vulnerable adult and the name of the facility or agency providing care for the vulnerable adult;
- (c) The name and address of the legal guardian or alternate decision maker;
- (d) The nature and extent of the abandonment, abuse, financial exploitation, neglect, or self-neglect;
- (e) Any history of previous abandonment, abuse, financial exploitation, neglect, or self-neglect;
- (f) The identity of the alleged perpetrator, if known; and
- (g) Other information that may be helpful in establishing the extent of abandonment, abuse, financial exploitation, neglect, or the cause of death of the deceased vulnerable adult.

(5) Unless there is a judicial proceeding or the person consents, the identity of the person making the report under this section is confidential.

[1999 c 176 § 5.]

NOTES:

Findings—Purpose—Severability—Conflict with federal requirements — 1999 c 176: See notes following RCW 74.34.005.

RCW 74.34.040 Reports—Contents—Identity confidential.

The reports made under *RCW 74.34.030 shall contain the following information if known:

- (1) Identification of the vulnerable adult;
- (2) The nature and extent of the suspected abuse, neglect, exploitation, or abandonment;

- (3) Evidence of previous abuse, neglect, exploitation, or abandonment;
- (4) The name and address of the person making the report; and
- (5) Any other helpful information.

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Unless there is a judicial proceeding or the person consents, the identity of the person making the report is confidential.

[1986 c 187 § 2; 1984 c 97 § 10.]

NOTES:

*Reviser's note: RCW 74.34.030 was repealed by 1999 c 176 § 35.

RCW 74.34.050 Immunity from liability.

(1) A person participating in good faith in making a report under this chapter or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding under this chapter is immune from liability resulting from the report or testimony. The making of permissive reports as allowed in this chapter does not create any duty to report and no civil liability shall attach for any failure to make a permissive report as allowed under this chapter.

(2) Conduct conforming with the reporting and testifying provisions of this chapter shall not be deemed a violation of any confidential communication privilege. Nothing in this chapter shall be construed as superseding or abridging remedies provided in **chapter 4.92 RCW**.

[1999 c 176 § 6; 1997 c 386 § 34; 1986 c 187 § 3; 1984 c 97 § 11.]

NOTES:

Findings — Purpose — Severability — Conflict with federal requirements — 1999 c 176: See notes following **RCW 74.34.005**.

Application — Effective date — 1997 c 386: See notes following **RCW 74.14D.010**.

RCW 74.34.053 Failure to report—False reports—Penalties.

(1) A person who is required to make a report under this chapter and who knowingly fails to make the report is guilty of a gross misdemeanor.

(2) A person who intentionally, maliciously, or in bad faith makes a false report of alleged abandonment, abuse, financial exploitation, or neglect of a vulnerable adult is guilty of a misdemeanor.

[1999 c 176 § 7.]

NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—1999 c 176: See notes following **RCW 74.34.005**.

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RCW 74.34.063 Response to reports—Timing—Reports to law enforcement agencies—Notification to licensing authority.

- (1) The department shall initiate a response to a report, no later than twenty-four hours after knowledge of the report, of suspected abandonment, abuse, financial exploitation, neglect, or self-neglect of a vulnerable adult.
- (2) When the initial report or investigation by the department indicates that the alleged abandonment, abuse, financial exploitation, or neglect may be criminal, the department shall make an immediate report to the appropriate law enforcement agency. The department and law enforcement will coordinate in investigating reports made under this chapter. The department may provide protective services and other remedies as specified in this chapter.
- (3) The law enforcement agency or the department shall report the incident in writing to the proper county prosecutor or city attorney for appropriate action whenever the investigation reveals that a crime may have been committed.
- (4) The department and law enforcement may share information contained in reports and findings of abandonment, abuse, financial exploitation, and neglect of vulnerable adults, consistent with RCW 74.04.060, 42.17.310, and other applicable confidentiality laws.
- (5) The department shall notify the proper licensing authority concerning any report received under this chapter that alleges that a person who is professionally licensed, certified, or registered under Title 18 RCW has abandoned, abused, financially exploited, or neglected a vulnerable adult.

[1999 c 176 § 8.]

NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—1999 c 176: See notes following RCW 74.34.005.

RCW 74.34.067 Investigations—Interviews—Ongoing case planning—Conclusion of investigation.

- (1) Where appropriate, an investigation by the department may include a private interview with the vulnerable adult regarding the alleged abandonment, abuse, financial exploitation, neglect, or self-neglect.
- (2) In conducting the investigation, the department shall interview the complainant, unless anonymous, and shall use its best efforts to interview the vulnerable adult or adults harmed, and, consistent with the protection of the vulnerable adult shall interview facility staff, any available independent sources of relevant information, including if appropriate the family members of the vulnerable adult.

- (3) The department may conduct ongoing case planning and consultation with:
- (a) Those persons or agencies required to report under this chapter or submit a report under this chapter;
 - (b) consultants designated by the department; and
 - (c) designated representatives of Washington Indian tribes if client information exchanged is pertinent to cases under investigation or the provision of protective services. Information considered privileged by statute and not directly related to reports required by this chapter must not be divulged without a valid written waiver of the privilege.
- (4) The department shall prepare and keep on file a report of each investigation conducted by the department for a period of time in accordance with policies established by the department.
- (5) If the department determines that the vulnerable adult has suffered from abuse, neglect, self-neglect, abandonment, or financial exploitation, and lacks the ability or capacity to consent, and needs the protection of a guardian, the department may bring a guardianship action under **chapter 11.88 RCW** as an interested person.
- (6) When the investigation is completed and the department determines that an incident of abandonment, abuse, financial exploitation, neglect, or self-neglect has occurred, the department shall inform the vulnerable adult of their right to refuse protective services, and ensure that, if necessary, appropriate protective services are provided to the vulnerable adult, with the consent of the vulnerable adult. The vulnerable adult has the right to withdraw or refuse protective services.
- (7) The department may photograph a vulnerable adult or their environment for the purpose of providing documentary evidence of the physical condition of the vulnerable adult or his or her environment. When photographing the vulnerable adult, the department shall obtain permission from the vulnerable adult or his or her legal representative unless immediate photographing is necessary to preserve evidence. However, if the legal representative is alleged to have abused, neglected, abandoned, or exploited the vulnerable adult, consent from the legal representative is not necessary. No such consent is necessary when photographing the physical environment.
- (8) When the investigation is complete and the department determines that the incident of abandonment, abuse, financial exploitation, or neglect has occurred, the department shall inform the facility in which the incident occurred, consistent with confidentiality requirements concerning the vulnerable adult, witnesses, and complainants.

[1999 c 176 § 9.]

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NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—1999 c 176: See notes following RCW 74.34.005.

RCW 74.34.070 Cooperative agreements for services.

The department may develop cooperative agreements with community-based agencies providing services for vulnerable adults. The agreements shall cover: (1) The appropriate roles and responsibilities of the department and community-based agencies in identifying and responding to reports of alleged abuse; (2) the provision of case-management services; (3) standardized data collection procedures; and (4) related coordination activities.

[1999 c 176 § 10; 1997 c 386 § 35; 1995 1st sp.s. c 18 § 87; 1984 c 97 § 13.]

NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—1999 c 176: See notes following RCW 74.34.005.

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

RCW 74.34.080 Injunctions.

If access is denied to an employee of the department seeking to investigate an allegation of abandonment, abuse, financial exploitation, or neglect of a vulnerable adult by an individual, the department may seek an injunction to prevent interference with the investigation. The court shall issue the injunction if the department shows that:

- (1) There is reasonable cause to believe that the person is a vulnerable adult and is or has been abandoned, abused, financially exploited, or neglected; and
- (2) The employee of the department seeking to investigate the report has been denied access.

[1999 c 176 § 11; 1984 c 97 § 14.]

NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—1999 c 176: See notes following RCW 74.34.005.

RCW 74.34.090 Data collection system—Confidentiality.

The department shall maintain a system for statistical data collection, accessible for bona fide research only as the department by rule prescribes. The identity of any person is strictly confidential.

[1984 c 97 § 15.]

RCW 74.34.095 Confidential information—Disclosure.

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(1) The following information is confidential and not subject to disclosure, except as provided in this section:

- (a) A report of abandonment, abuse, financial exploitation, or neglect made under this chapter;
- (b) The identity of the person making the report; and
- (c) All files, reports, records, communications, and working papers used or developed in the investigation or provision of protective services.

(2) Information considered confidential may be disclosed only for a purpose consistent with this chapter or as authorized by **chapter 18.20, 18.51, or 74.39A RCW**, or as authorized by the long-term care ombudsman programs under federal law or state law, **chapter 43.190 RCW**.

(3) A court or presiding officer in an administrative proceeding may order disclosure of confidential information only if the court, or presiding officer in an administrative proceeding, determines that disclosure is essential to the administration of justice and will not endanger the life or safety of the vulnerable adult or individual who made the report. The court or presiding officer in an administrative hearing may place restrictions on such disclosure as the court or presiding officer deems proper.

[2000 c 87 § 4; 1999 c 176 § 17.]

NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—1999 c 176: See notes following **RCW 74.34.005**.

RCW 74.34.110 Protection of vulnerable adults—Petition for protective order.

An action known as a petition for an order for protection of a vulnerable adult in cases of abandonment, abuse, financial exploitation, or neglect is created.

- (1) A vulnerable adult may seek relief from abandonment, abuse, financial exploitation, or neglect, or the threat thereof, by filing a petition for an order for protection in superior court.
- (2) A petition shall allege that the petitioner is a vulnerable adult and that the petitioner has been abandoned, abused, financially exploited, or neglected, or is threatened with abandonment, abuse, financial exploitation, or neglect by respondent.
- (3) A petition shall be accompanied by affidavit made under oath stating the specific facts and circumstances which demonstrate the need for the relief sought.

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(4) A petition for an order may be made whether or not there is a pending lawsuit, complaint, petition, or other action between the parties.

(5) A petitioner is not required to post bond to obtain relief in any proceeding under this section.

(6) An action under this section shall be filed in the county where the petitioner resides; except that if the petitioner has left the residence as a result of abandonment, abuse, financial exploitation, or neglect, or in order to avoid abandonment, abuse, financial exploitation, or neglect, the petitioner may bring an action in the county of either the previous or new residence.

(7) The filing fee for the petition may be waived at the discretion of the court.

[1999 c 176 § 12; 1986 c 187 § 5.]

NOTES:

Findings — Purpose — Severability — Conflict with federal requirements — 1999 c 176:

See notes following RCW 74.34.005.

RCW 74.34.120 Protection of vulnerable adults — Hearing.

The court shall order a hearing on a petition under RCW 74.34.110 not later than fourteen days from the date of filing the petition. Personal service shall be made upon the respondent not less than five court days before the hearing. If timely service cannot be made, the court may set a new hearing date. A petitioner may move for temporary relief under **chapter 7.40 RCW**.

[1986 c 187 § 6.]

RCW 74.34.130 Protection of vulnerable adults—Judicial relief.

The court may order relief as it deems necessary for the protection of the petitioner, including, but not limited to the following:

- (1) Restraining respondent from committing acts of abandonment, abuse, neglect, or financial exploitation;
- (2) Excluding the respondent from petitioner's residence for a specified period or until further order of the court;
- (3) Prohibiting contact by respondent for a specified period or until further order of the court;
- (4) Prohibiting the respondent from knowingly coming within, or knowingly remaining within, a specified distance from a specified location;
- (5) Requiring an accounting by respondent of the disposition of petitioner's income or other resources;

(6) Restraining the transfer of property for a specified period not exceeding ninety days; and

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(7) Requiring the respondent to pay the filing fee and court costs, including service fees, and to reimburse the petitioner for costs incurred in bringing the action, including a reasonable attorney's fee.

Any relief granted by an order for protection, other than a judgment for costs, shall be for a fixed period not to exceed one year. The clerk of the court shall enter any order for protection issued under this section into the judicial information system.

[2000 c 119 § 27; 2000 c 51 § 2; 1999 c 176 § 13; 1986 c 187 § 7.]

NOTES:

Reviser's note: This section was amended by 2000 c 51 § 2 and by 2000 c 119 § 27, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Application—2000 c 119: See note following RCW 26.50.021.

Findings—Purpose—Severability—Conflict with federal requirements—1999 c 176: See notes following RCW 74.34.005.

RCW 74.34.140 Protection of vulnerable adults—Execution of protective order.

When an order for protection under RCW 74.34.130 is issued upon request of the petitioner, the court may order a peace officer to assist in the execution of the order of protection.

[1986 c 187 § 8.]

RCW 74.34.145 Protection of vulnerable adults—Notice of criminal penalties for violation—Enforcement under RCW 26.50.110.

(1) An order for protection of a vulnerable adult issued under this chapter which restrains the respondent or another person from committing acts of abuse, prohibits contact with the petitioner, excludes the person from any specified location, or prohibits the person from coming within a specified distance from a location, shall prominently bear on the front page of the order the legend: VIOLATION OF THIS ORDER WITH ACTUAL NOTICE OF ITS TERMS IS A CRIMINAL OFFENSE UNDER CHAPTER 26.50 RCW AND WILL SUBJECT A VIOLATOR TO ARREST.

(2) Whenever an order for protection of a vulnerable adult is issued under this chapter, and the respondent or person to be restrained knows of the order, a violation of a provision restraining the person from committing acts of abuse,

RCWs prohibiting contact with the petitioner, excluding the person from any specified location, or prohibiting the person from coming within a specified distance of a location, shall be punishable under **RCW 26.50.110**, regardless of whether the person is a family or household member as defined in **RCW 26.50.010**.

[2000 c 119 § 2.]

NOTES:

Application—2000 c 119: See note following **RCW 26.50.021**.

RCW 74.34.150 Protection of vulnerable adults—Department may seek relief.

The department of social and health services, in its discretion, may seek relief under **RCW 74.34.110** through **74.34.140** on behalf of and with the consent of any vulnerable adult. Neither the department of social and health services nor the state of Washington shall be liable for failure to seek relief on behalf of any persons under this section.

[1986 c 187 § 9.]

RCW 74.34.160 Protection of vulnerable adults—Proceedings are supplemental.

Any proceeding under **RCW 74.34.110** through **74.34.150** is in addition to any other civil or criminal remedies.

[1986 c 187 § 11.]

RCW 74.34.165 Rules.

The department may adopt rules relating to the reporting, investigation, and provision of protective services in in-home settings, consistent with the objectives of this chapter.

[1999 c 176 § 18.]

NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—1999 c 176: See notes following **RCW 74.34.005**.

RCW 74.34.170 Services of department discretionary—Funding.

The provision of services under **RCW *74.34.030**, **74.34.040**, **74.34.050**, and ****74.34.100** through **74.34.160** are discretionary and the department shall not be required to expend additional funds beyond those appropriated.

[1986 c 187 § 10.]

NOTES:

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Reviser's note:

*(1) RCW 74.34.030 was repealed by 1999 c 176 § 35.

***(2) RCW 74.34.100 was recodified as RCW 74.34.015 pursuant to 1995 1st sp.s. c 18 § 89, effective July 1, 1995. RCW 74.34.015 was subsequently repealed by 1999 c 176 § 35.

RCW 74.34.180 Retaliation against whistleblowers and resident — Remedies — Rules.

(1) An employee or contractor who is a whistleblower and who as a result of being a whistleblower has been subjected to workplace reprisal or retaliatory action, has the remedies provided under **chapter 49.60 RCW. RCW 4.24.500 through 4.24.520**, providing certain protection to persons who communicate to government agencies, apply to complaints made under this section. The identity of a whistleblower who complains, in good faith, to the department or the department of health about suspected abandonment, abuse, financial exploitation, or neglect by any person in a facility, licensed or required to be licensed, or care provided in a facility or in a home setting, by any person associated with a hospice, home care, or home health agency licensed under **chapter 70.127 RCW** or other in-home provider, may remain confidential if requested. The identity of the whistleblower shall subsequently remain confidential unless the department determines that the complaint was not made in good faith.

(2)(a) An attempt to expel a resident from a facility, or any type of discriminatory treatment of a resident who is a consumer of hospice, home health, home care services, or other in-home services by whom, or upon whose behalf, a complaint substantiated by the department or the department of health has been submitted to the department or the department of health or any proceeding instituted under or related to this chapter within one year of the filing of the complaint or the institution of the action, raises a rebuttable presumption that the action was in retaliation for the filing of the complaint.

(b) The presumption is rebutted by credible evidence establishing the alleged retaliatory action was initiated prior to the complaint.

(c) The presumption is rebutted by a review conducted by the department that shows that the resident or consumer's needs cannot be met by the reasonable accommodations of the facility due to the increased needs of the resident.

(3) For the purposes of this section:

(a) "Whistleblower" means a resident or a person with a mandatory duty to report under this chapter, or any person licensed under Title 18 RCW, who in

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good faith reports alleged abandonment, abuse, financial exploitation, or neglect to the department, or the department of health, or to a law enforcement agency;

(b) “Workplace reprisal or retaliatory action” means, but is not limited to: Denial of adequate staff to perform duties; frequent staff changes; frequent and undesirable office changes; refusal to assign meaningful work; unwarranted and unsubstantiated report of misconduct under **Title 18 RCW**; letters of reprimand or unsatisfactory performance evaluations; demotion; denial of employment; or a supervisor or superior encouraging coworkers to behave in a hostile manner toward the whistleblower. The protections provided to whistleblowers under this chapter shall not prevent a facility or an agency licensed under **chapter 70.127 RCW** from: (i) Terminating, suspending, or disciplining a whistleblower for other lawful purposes; or (ii) for facilities licensed under **chapter 70.128 RCW**, reducing the hours of employment or terminating employment as a result of the demonstrated inability to meet payroll requirements. The department shall determine if the facility cannot meet payroll in cases in which a whistleblower has been terminated or had hours of employment reduced because of the inability of a facility to meet payroll; and

(c) “Reasonable accommodation” by a facility to the needs of a prospective or current resident has the meaning given to this term under the federal Americans with disabilities act of 1990, 42 U.S.C. Sec. 12101 et seq. and other applicable federal or state antidiscrimination laws and regulations.

(4) This section does not prohibit a facility or an agency licensed under **chapter 70.127 RCW** from exercising its authority to terminate, suspend, or discipline any employee who engages in workplace reprisal or retaliatory action against a whistleblower.

(5) The department shall adopt rules to implement procedures for filing, investigation, and resolution of whistleblower complaints that are integrated with complaint procedures under this chapter.

(6)(a) Any vulnerable adult who relies upon and is being provided spiritual treatment in lieu of medical treatment in accordance with the tenets and practices of a well-recognized religious denomination may not for that reason alone be considered abandoned, abused, or neglected.

(b) Any vulnerable adult may not be considered abandoned, abused, or neglected under this chapter by any health care provider, facility, facility employee, agency, agency employee, or individual provider who participates in good faith in the withholding or withdrawing of life-sustaining treatment from a vulnerable adult under **chapter 70.122 RCW**, or who acts in accordance with **chapter**

7.70 RCW or other state laws to withhold or withdraw treatment, goods, or services.

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(7) The department, and the department of health for facilities, agencies, or individuals it regulates, shall adopt rules designed to discourage whistleblower complaints made in bad faith or for retaliatory purposes.

[1999 c 176 § 14; 1997 c 392 § 202.]

NOTES:

Findings — Purpose — Severability — Conflict with federal requirements — 1999 c 176: See notes following RCW 74.34.005.

Short title—Findings—Construction—Conflict with federal requirements—Part headings and captions not law—1997 c 392: See notes following RCW 74.39A.009.

RCW 74.34.200 Abandonment, abuse, financial exploitation, or neglect of a vulnerable adult—Cause of action for damages—Legislative intent.

(1) In addition to other remedies available under the law, a vulnerable adult who has been subjected to abandonment, abuse, financial exploitation, or neglect either while residing in a facility or in the case of a person residing at home who receives care from a home health, hospice, or home care agency, or an individual provider, shall have a cause of action for damages on account of his or her injuries, pain and suffering, and loss of property sustained thereby. This action shall be available where the defendant is or was a corporation, trust, unincorporated association, partnership, administrator, employee, agent, officer, partner, or director of a facility, or of a home health, hospice, or home care agency licensed or required to be licensed under **chapter 70.127 RCW**, as now or subsequently designated, or an individual provider.

(2) It is the intent of the legislature, however, that where there is a dispute about the care or treatment of a vulnerable adult, the parties should use the least formal means available to try to resolve the dispute. Where feasible, parties are encouraged but not mandated to employ direct discussion with the health care provider, use of the long-term care ombudsman or other intermediaries, and, when necessary, recourse through licensing or other regulatory authorities.

(3) In an action brought under this section, a prevailing plaintiff shall be awarded his or her actual damages, together with the costs of the suit, including a reasonable attorney's fee. The term "costs" includes, but is not limited to, the reasonable fees for a guardian, guardian ad litem, and experts, if any, that may be necessary to the litigation of a claim brought under this section.

[1999 c 176 § 15; 1995 1st sp.s. c 18 § 85.]

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NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—1999 c 176: See notes following RCW 74.34.005.

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

RCW 74.34.205 Abandonment, abuse, or neglect—Exceptions.

(1) Any vulnerable adult who relies upon and is being provided spiritual treatment in lieu of medical treatment in accordance with the tenets and practices of a well-recognized religious denomination may not for that reason alone be considered abandoned, abused, or neglected.

(2) Any vulnerable adult may not be considered abandoned, abused, or neglected under this chapter by any health care provider, facility, facility employee, agency, agency employee, or individual provider who participates in good faith in the withholding or withdrawing of life-sustaining treatment from a vulnerable adult under chapter 70.122 RCW, or who acts in accordance with chapter 7.70 RCW or other state laws to withhold or withdraw treatment, goods, or services.

[1999 c 176 § 16.]

NOTES:

Findings—Purpose—Severability—Conflict with federal requirements—1999 c 176: See notes following RCW 74.34.005.

RCW 74.34.210 Order for protection or action for damages—Standing—Jurisdiction.

A petition for an order for protection or an action for damages under this chapter may be brought by the plaintiff, or where necessary, by his or her family members and/or guardian or legal fiduciary, or as otherwise provided under this chapter. The death of the plaintiff shall not deprive the court of jurisdiction over a petition or claim brought under this chapter. Upon petition, after the death of the vulnerable person, the right to initiate or maintain the action shall be transferred to the executor or administrator of the deceased, for the benefit of the surviving spouse, child or children, or other heirs set forth in chapter 4.20 RCW.

[1995 1st sp.s. c 18 § 86.]

NOTES:

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

RCW 74.34.900 Severability—1984 c 97.

If any provision of this act or its application to any person or circumstance is

held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

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[1984 c 97 § 18.]

RCW 74.34.901 Severability—1986 c 187.

If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

[1986 c 187 § 12.]

*Washington
State
Programs*

WASHINGTON STATE DOMESTIC VIOLENCE PROGRAMS

Alphabetized by city

State of Washington Domestic Violence Hotline: 1-800-562-6025 V/TTY

Washington State Relay System: 711

Washington State Coalition Against Domestic Violence: 1402 Third Ave,
Suite 406, Seattle, WA 98101 206-389-2515 V 206-389-2900 TTY

Program	Business Line	Crisis Line
Eastside Domestic Violence Program PO Box 6398 Bellevue, WA 98008	(425) 562-8840	(800) 827-8840
Whatcom Crisis Services Domestic Violence Program 1407 Commercial Bellingham, WA 98225	(360) 671-5714	(360) 734-7271
Lummi Family Services 1790 Bayon Rd Bellingham, WA 98226	(360) 738-3959	
Lummi Victims of Crime 2616 Kwina Rd Bellingham, WA 98226	(360) 384-2285	(360) 384-2285
Womencare Shelter 2217 Woburn St Bellingham, WA 98226	(360) 671-8539	(360) 734-3438
ALIVE - YWCA PO Box 559 Bremerton, WA 98337	(360) 876-1608	(360) 479-1980
St. James Domestic Violence Advocacy Program 1134 Columbia St Cathlamet, WA 98612	(360) 795-8612	(360) 414-9702
Human Response Network PO Box 337 Chehalis, WA 98532	(360) 748-6601	(360) 748-6601
Families in Crisis PO Box 1324 Chehalis, WA 98532	(360) 807-6187	
Women's Center, Inc. 1010 Ironwood Dr, Suite 101 Coeur d'Alene, ID 83814	(208) 664-9303	(208) 664-1443
Family Support Center 320 N Main Colville, WA 99114	(509) 684-8421	(509) 684-6139
Family Crisis Network/Tribal Office PO Box 47 Cusick, WA 99119	(509) 445-0550	
Family Resource Center PO Box 1130 Davenport, WA 99122	(509) 725-4358	(509) 725-4357

Program	Business Line	Crisis Line
Inland Counseling Network PO Box 30 Dayton, WA 99328	(509) 382-2527	(509) 382-2527
Family Violence Program Nooksak Tribe PO Box 157 Deming, WA 98244	(360) 592-5176	
DV/SA Services of the San Juans PO Box 1516 Eastsound, WA 98245	(360) 376-5979	
ASPEN of CWCMH 220 West 4th Ave Ellensburg, WA 98926	(509) 925-9384	(509) 925-9384
Snohomish County Center for Battered Women PO Box 7 Everett, WA 98206	(425) 259-2827	(425) 252-2873
Forks Abuse Program PO Box 1775 Forks, WA 98331	(360) 374-6411	(360) 374-2273
Ft. Lewis Family Advocacy Program ACS/AFZH-PAW-C, Bldg. 5218 Fort Lewis, WA 98433	(253) 967-7166	
Domestic Violence Center of Grays Harbor 2306 Sumner Ave Hoquiam, WA 98550	(360) 538-0733	(800) 818-2194
Emergency Support Shelter PO Box 877 Kelso, WA 98626	(360) 425-1176	(360) 636-8471
Columbia Basin Domestic Violence Services 5917 W Clearwater Kennewick, WA 99336	(509) 735-2271	
Quileute Tribe Domestic Violence Program PO Box 279 La Push, WA 98350	(360) 374-4340	(360) 374-9020
YWCA of Lewiston, ID/Clarkston, WA 300 Main St Lewiston, ID 83501	(208) 743-1535	(800) 669-3176
YWCA - Pathways for Women 6027 208 St SW Lynnwood, WA 98036	(425) 774-9843	
Tulalip Tribes Domestic Violence Program 6221 23rd Ave NE Marysville, WA 98271	(360) 651-3284	
Family Advocacy Building 170 McCord AFB, WA 98438	(253) 982-3684	
E. Lewis Co. Domestic Violence Services PO Box 1133 Morton, WA 98356	(360) 496-5134	(360) 498-3039

*Washington
State
Programs*

Appendix

<i>Washington State Programs</i>	Program	Business Line	Crisis Line
	New Hope DV/SA Services PO Box 1057 Moses Lake, WA 98837	(509) 764-8402	(509) 765-1717
	Our Place/Nuestro Lugar PO Box 1394 Moses Lake, WA 98837	(509) 765-1214	(509) 760-3899
	Skagit DV & SA Services PO Box 301 Mount Vernon, WA 98273	(360) 336-9591	
	Crisis Support Network 2 Appelo Lane Naselle, WA 98638	(360) 484-7191	(800) 435-7276
	Makah Family Services Domestic Violence Program PO Box 115 Neah Bay, WA 98357	(360) 645-3120	
	Family Crisis Network PO Box 944 Newport, WA 99156	(509) 447-2274	(509) 447-5483
	CADA - Citizens Against Domestic and Sexual Abuse PO Box 190 Oak Harbor, WA 98277	(360) 675-7781	(360) 675-2232
	Safeplace PO Box 1605 Olympia, WA 98507	(360) 786-8754	(360) 754-6300
	Address Confidentiality Program PO Box 257 Olympia, WA 98507	(360) 753-2972	(800) 822-1065
	Washington Coalition of Sexual Assault Programs 2415 Pacific Ave. SE, C-10 Olympia, WA 98501	(360) 754-7583	
	The Support Center PO Box 3639 Omak, WA 98841	(509) 826-3221	(888) 826-3221
	Healthy Families of Clallam County Domestic Violence/Sexual Assault 1914 W 18th St Port Angeles, WA 98363	(360) 452-3811	(360) 452-4357
	Lower Elwha Tribe Domestic Violence Program 2851 Lower Elwha Rd Port Angeles, WA 98363	(360) 452-8471	
	Domestic Violence/Sexual Assault Program of Jefferson County PO Box 743 Port Townsend, WA 98368	(360) 385-5291	
	Alternatives to Violence of the Palouse PO Box 37 Pullman, WA 99163	(509) 332-0552	(509) 332-4357
	Connections/Ferry County Community Services 42 Klondike Rd Republic, WA 99166	(509) 775-3331	

Program	Business Line	Crisis Line
Adams County Resource Center PO Box 424 Ritzville, WA 99169	(509) 659-4225	(509) 660-1067
Alcohol/Drug 24 Hour Help Line PO Box 18317 Seattle, WA 98118	(206) 722-3703	(800) 562-1240
New Beginnings for Battered Women & Their Children PO Box 75152 Seattle, WA 98125	(206) 783-4520	
Northwest Network of Bisexual, Trans & Lesbian Survivors of Abuse PO Box 20398 Seattle, WA 98102	(206) 568-7777	(206) 568-7777
Ina Maka Family Program, United Indians of All Tribes Foundation 1945 Yale Place E Seattle, WA 98102	(206) 325-0070	(800) 871-7954
Salvation Army Catherine Booth House PO Box 20128 Seattle, WA 98102	(206) 442-8383	
Broadview Emergency Shelter and Transitional Housing Program PO Box 31151 Seattle, WA 98103	(206) 622-3108	(206) 622-4933
CHAYA PO Box 12917 Seattle, WA 98111	(206) 275-2493	
Communities Against Rape & Abuse 801 23rd Ave S, #G1 Seattle, WA 98144	(206) 322-4856	
Jewish Family Services, Project Dvora 1601 16th Ave Seattle, WA 98122	(206) 461-3240	
East Cherry YWCA 2820 E Cherry St Seattle, WA 98122	(206) 568-7843	(206) 461-4438
YWCA - Seattle/King Co. 1118 5th Ave Seattle, WA 98101	(206) 490-4354	
Seattle Indian Health Board, Domestic Violence Program PO Box 3364 Seattle, WA 98114	(206) 324-9360	
Refugee Women's Alliance - (REWA) 3004 S Alaska St Seattle, WA 98108	(206) 721-3846	
Abused Deaf Women's Advocacy Services (ADWAS) 2627 Eastlake Ave E Seattle, WA 98102	(206) 726-0093	(206) 236-3134
Asian & Pacific Islander Women & Family Safety Center PO Box 14047 Seattle, WA 98114	(206) 467-9976	
Consejo Counseling & Referral Service 3808 S Angeline Seattle, WA 98118	(206) 461-4880	

*Washington
State
Programs*

Appendix

<i>Washington State Programs</i>	Program	Business Line	Crisis Line
	Upper Skagit Tribe Domestic Violence Program 25880 Sig Wig Wise Sedro Wooley, WA 98284	(360) 336-9591	
	Squaxin Island Tribe Domestic Violence Program SE 70 Squaxin Lane Shelton, WA 98584	(360) 427-9006	
	Skokomish Tribe Domestic Violence Program W 80 Tribal Center Rd Shelton, WA 98584	(360) 426-4740	
	South Puget Inter-Tribal Planning Agency 2750 SE Old Olympic Hwy Shelton, WA 98584	(360) 426-3990	
	Turning Pointe PO Box 2014 Shelton, WA 98584	(360) 426-1216	
	Spokane County Domestic Violence Consortium 1425 N Washington, Suite 209 Spokane, WA 99201	(509) 487-6783	(509) 326-2255
	YWCA - Alternatives to Domestic Violence Program 829 W. Broadway Spokane, WA 99201	(509) 327-9534	(509) 326-2255
	Skamania County Council on Domestic Violence & Sexual Assault PO Box 477 Stevenson, WA 98648	(509) 427-4210	(877) 427-4210
	Lower Valley Crisis & Support Services PO Box 93 Sunnyside, WA 98944	(509) 837-6689	(509) 837-6689
	Centro Latino SER 1208 S 10th St Tacoma, WA 98405	(253) 572-7717	
	Korean Women's Association 125 E 96th St Tacoma, WA 98445	(253) 535-4202	
	YWCA Tacoma/Pierce County Women's Support Shelter 405 S Broadway Tacoma, WA 98402	(253) 383-3263	(253) 383-2593
	Puyallup Tribe Family Violence Prevention Program 3308 Centennial Way NE Tacoma, WA 98422	(253) 573-7947	
	Quinault Indian Nation Domestic Violence Program PO Box 189 Taholah, WA 98587	(360) 276-8215	
	Family and Domestic Violence, Yakama Nation Social Services PO Box 151 Toppenish, WA 98948	(509) 865-5121	

Program	Business Line	Crisis Line	<i>Washington State Programs</i>
DAWN-Domestic Abuse Women's Network PO Box 88007 Tukwila, WA 98138	(425) 656-4305	(425) 656-7867	
Kalispel Tribe Domestic Violence Program PO Box 39 Usk, WA 99180	(509) 445-1147		
YWCA SafeChoice 3609 Main St Vancouver, WA 98663	(360) 696-0167	(360) 695-0501	
YWCA - Walla Walla 213 S First St Walla Walla, WA 99362	(509) 525-2570	(509) 529-9922	
Spokane Tribe Domestic Violence Program PO Box 100 Wellpinit, WA 99040	(509) 258-7502		
DSV Crisis Center/Phoenix Place PO Box 2704 Wenatchee, WA 98807	(509) 663-7446	(509) 663-7446	
Programs for Peaceful Living PO Box 1486 White Salmon, WA 98672	(509) 493-1533	(800) 866-9372	
Yakima YWCA Family Crisis Program 15 North Naches Ave Yakima, WA 98901	(509) 248-7796	(509) 248-7796	

This list is current as of March 2003.

