



**BARBARA FAYE WAXMAN FIDUCCIA PAPERS
ON WOMEN AND GIRLS WITH DISABILITIES 2011
CENTER FOR WOMEN POLICY STUDIES**

March 2011

**Women, Disability and Violence:
Strategies to Increase Physical and Programmatic Access to Victims' Services for
Women with Disabilities**

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"Few people with physical disabilities come to the domestic violence/sexual assault program and shelter. Are we alienating this population? What's a way to draw them in? Maybe we don't have a large population with physical disabilities in need here. But maybe not."

Staff member, domestic violence/sexual
assault service provider

Many studies conducted in the United States, Australia, Canada, and the United Kingdom corroborate a high occurrence of physical, emotional, sexual, and disability-specific abuse among women with disabilities. As this staff member's observation reflects, however, there exists little evidence that large numbers of women with disabilities attempt to access shelters and other domestic violence/sexual assault programs and services when they are victimized.¹ Why don't the majority of women with disabilities who experience such abuse show up, seeking services? What might be done to encourage them to do so in greater numbers?

Women with disabilities who are also the victims/survivors of domestic violence and/or sexual abuse often find themselves occupying a position between two parallel service networks. Domestic violence service providers are usually skilled at discussing sensitive issues surrounding violence and abuse. However, they are less likely to have significant experience assisting clients with disabilities. This inexperience often extends to a lack of familiarity with the best ways to create an environment welcoming to women with disabilities or to reach out to members of the disabled community to advertise available services. On the other hand, disability service providers are quite

proficient at helping individuals with disabilities access a range of community services. They typically offer referrals to services involving housing, utilities, health care, and job training. Yet staff members often possess little training on how to identify abuse or on what steps they should take when they suspect abuse is taking place.

As a result, a woman with a disability who has also experienced domestic abuse may find herself with no clear place to turn for help. She may not know about her local domestic violence service providers. If she does go to them, she may feel unwelcome if she and staff have difficulties communicating with one another about the abuse or about accommodations relating to her disability. But if she goes to her disability service provider for assistance with other living issues, the topic of domestic violence might never come up. If she does mention it, staff may be unprepared, though willing, to help.

The most obvious solution would be to build bridges between these service networks, so that in any given community a disabled woman who is a victim of domestic violence will be directed towards an integrated network of services that can offer both solutions and hope, no matter where she makes her first point of contact. Such collaborative efforts to bring together multiple agencies to address this problem have already begun. The advantages of sharing existing resources and expertise in order to meet the needs of a population whose identities intersect across lines of gender, violence, and disability are clear. However, while there are strengths inherent within existing service provision, there are also barriers and challenges to overcome.

On the whole, domestic violence/sexual assault service providers and disability service providers recognize the need for inter-agency collaboration and support its goals.² Despite such support, however, Zweig, Schlichter, and Burt recorded that only slightly more than half of the agencies they surveyed reported successful collaborations. The barriers that prevented success can be divided into three broad categories. First, domestic violence service providers sometimes expressed insensitivity or frustration toward women whose disabilities made communication more challenging or otherwise increased the difficulty of providing services to them. Second, some disability service providers misunderstood the complex dynamics of domestic violence, sexual assault, and the needs of victims/survivors, resulting in a tendency to dismiss domestic violence issues and victims as not requiring serious attention. Finally, in some situations, agencies simply failed to follow through on promises made during the initial inter-agency meetings or failed to adhere to the agreed upon guidelines for collaboration.³

Given the stresses under which many community service providers operate, such misunderstandings and insufficient follow-through should come as no surprise. It is an unfortunate truth that service providers are often short of the funds, time, and personnel they need to be able to help their

constituencies to the degree that they would wish. Staffers strive to do the best they can with limited resources, working with people who may face severe challenges. Under these already tense circumstances, attempts to identify and assist the underserved population of women with disabilities who are also victims of domestic abuse can often be perceived as an accusation that one or more agencies are failing to help those in need. Such perceptions lead quite easily to resentment. Anecdotal evidence abounds of heated arguments across conference tables, with representatives from each side walking away in anger and frustration.⁴

No matter which set of statistics a researcher consults, the degree of domestic violence against women with disabilities is unacceptably high. These victims and survivors of domestic violence need access to services. Between 2006 and 2009, the Boise State University Gender Studies Program partnered with the Idaho State Independent Living Council and the Idaho Coalition Against Sexual and Domestic Violence to investigate the strengths of, and barriers to, services for women with disabilities who become victims of domestic violence in one predominantly rural state in the Intermountain West.⁵ The goal of this collaborative effort was to work toward equal access to services for all victims and survivors of domestic violence, regardless of level of ability and no matter where a victim or survivor first attempted to access such services. This article utilizes information from this research to glean insights and offer specific strategies to forge more effective multi-agency collaborations that should be replicable and useful to service providers, policymakers, activists, and women with disabilities who are victims or survivors.

This article strives to balance fairly and effectively the voices and needs of individuals with disabilities with those of service providers who provide either disability or domestic violence/sexual assault services.⁶ As previously noted, however, the dedicated individuals and organizations that provide domestic violence and disability services across the United States are already stretched thin dealing with the client populations with which they are familiar. It is common for advocates to place blame and guilt upon themselves because they cannot do enough, given the limited resources at their disposal. Adding another constituency to the existing burden may seem to some like too much to ask of these service networks and the people who run them.

Yet the need demands that we ask. Ask, not accuse. There is little to be gained by pointing fingers. No single organization or individual in any community is responsible for the stark reality of the current situation. But these organizations and individuals can take on the responsibility of helping change this situation. In truth, it is unlikely that anyone else has the dedication or the expertise to do so. The intent of this article is to highlight opportunities for positive change, hopefully in a way that will help empower service providers as well as victims and survivors with disabilities.

Intersections of Gender, Violence, and Disability

Approximately 15 percent of women in the United States identify as having at least one disability.⁷ Over a decade ago, women with disabilities identified abuse and violence as their top priority issue to confront.⁸ More recently, staff at an overwhelming majority of Independent Living Centers studied by Swedlund and Nosek “identified abuse as an important issue among their consumers.”⁹

Annually, intimate partners physically abuse over three million women, and approximately one third of US women will be physically abused by their partners at some point during their lives. These numbers increase when non-physical forms of abuse are included. An estimated eight to 12 million women in the U.S.—regardless of ability—are considered at risk for abuse by a partner at some point in their lifetimes.

The extent of abuse among the general population of women has been well documented over the last four decades. Researchers worldwide have explored the causes and the individual and societal impacts of such violence. The effectiveness of various types of services and programs to assist victims and survivors has also been extensively investigated.¹⁰

Despite a large amount of information and analysis on fully-abled women, domestic violence and/or sexual abuse, impacts, and interventions, we know relatively little about the intersections of gender, abuse, and disability.¹¹ Discussions integrating feminist and disability theory are in their nascent stages but advancing in sophistication.¹² Critics describe studies that attempt to quantify rates of abuse among women with disabilities as flawed for a variety of reasons, including problematic definitions of what constitutes abuse or disability; insufficient data collected by law enforcement, hospitals, and service providers; methodological limitations; and the cultural stigma attached to both individuals with disabilities and victims/survivors of domestic violence.¹³

Despite the critiques—many of them valid—a consensus has emerged around certain issues. Thanks to research completed within the last fifteen years, women with disabilities are generally recognized as at least equally as likely if not more likely to experience physical abuse as their fully-abled counterparts. Women with disabilities experience sexual abuse at rates higher than the general population of women.¹⁴ Abusers generally continue their abuse of women with disabilities over longer periods of time than with fully-abled women, and women with disabilities are more likely to be abused by multiple perpetrators.¹⁵ Recognizing that individuals with disabilities are not a homogenous group—any more than fully-abled women are—researchers are refining their approaches to break down results by category of disability and include additional intersections of race/ethnicity, immigrant status, economic

class, and education levels with gender, abuse, and disability to identify subgroups at increased risk.¹⁶

Many researchers agree that the incidence of abuse among women with disabilities is probably higher than official statistics report.¹⁷ Reasons for this phenomenon include the existence of forms of disability-specific abuse of which law enforcement personnel, health care workers, and service providers are not trained or required to recognize or record.¹⁸ L'Institut Roeher described such disability-specific forms of abuse as including, but not limited to: the administration of medications; physical restraint or denial of mobility; denial of assistive technologies; denial of necessities and neglect; threatening forms of communication; financial exploitation; and, emotional or psychological abuse that focuses on the victim's disability.¹⁹

As with the abuse of all women, power differentials exist between the woman with a disability and the perpetrator of such abuse. What distinguishes disability-specific abuse from the vulnerabilities experienced by all women, according to Nosek, Howland, and Hughes, is the extent to which abuse is correlated to a woman's disability.²⁰ Also, some actions that would be identified as abuse against a fully-abled woman are not classified as abuse when perpetrated against a woman with a disability.²¹

Statistics also likely underreport the incidence of abuse against women with disabilities because abuse occurs in disability-specific environments. When seeking to identify abuse and abusers of women with disabilities, the net needs to be cast more widely than usual, beyond spouses and intimate partners as abusers. Inquiries should include the possibility of abuse by Personal Care Attendants and other at-home caregivers, transportation providers, and medical professionals in clinical settings.²²

In addition to being at increased risk for particular types of violence perpetrated in disability-specific environments and settings, scholarship suggests that violence against women with disabilities may impact such women differently than fully-abled women.²³ While the fully-abled population generally considers disability as a protection against abuse, Nosek, Howland, Hughes, and Foley discuss how the experience of disability often "reduces a woman's emotional and physical defenses," thus leaving her more vulnerable to abuse and its consequences.²⁴

Additionally, some women with disabilities may not have been educated to recognize what is happening to them as abuse or may not be physically or cognitively able to report the abuse. Often, women with disabilities—especially women with mental health diagnoses or developmental disabilities—who report abuse are less likely to be believed than are fully-abled women who report abuse.²⁵

Even if a woman with a disability is able to recognize and report what is happening to her as abuse, she may be reluctant to report the violence and seek services. Almost twenty years ago, Andrews and Veronen found that

only 10 percent of victims with disabilities tried to access shelter services.²⁶ I have found no subsequent study indicating substantial increases in attempts to access domestic violence/sexual assault services by women with disabilities.

The broad facts, then, are clear enough: women with disabilities face an unacceptably high risk and incidence of interpersonal violence. The question remains as to why women with disabilities who are victimized do not request domestic violence/sexual assault services more frequently, either from domestic violence/sexual assault or disability service providers. Researchers into domestic violence and sexual assault have identified many barriers that inhibit women in general from seeking services. Such barriers include fear of losing custody of children, fear of escalation in violence, financial concerns, isolation, and loss of self-esteem due to abuse. Women with disabilities also experience these concerns, albeit in different manifestations. Consider the situation of a woman with a mental health disability who is being abused. As commonly occurs in such situations, her abuser threatens her with loss of custody of their children. An added dimension exists due to the woman's disability, however, as the abuser threatens that no one in authority will believe this woman's accusations of abuse because of her diagnosis and no judge would award custody to a woman with a mental illness.

Certain barriers, however, tend to be more specific to women with disabilities who are victimized. Many women with disabilities lack information on domestic violence/sexual assault services available in their area. Some worry that they will not be believed if they report abuse. As researchers in Oregon report: "Key informants and service providers who work with these individuals [persons with developmental disabilities, physical disabilities, or mental illness] said that rights are often not enforced for these populations because the victims are not taken seriously."²⁷

Some women with disabilities are unwilling to leave abusive environments because of their dependence on caregivers. They fear not having their basic needs met or being placed in more restrictive environments. Many such women express their perceptions that they are powerless to escape situations of interpersonal violence.²⁸

Moreover, if a woman with a disability overcomes such barriers and requests assistance, scholarship demonstrates she is less likely than a fully-abled woman to receive appropriate services from either domestic violence/sexual assault or disability service providers for a variety of reasons – systemic, financial, programmatic, and attitudinal. I reiterate that the intent here is not to place blame on any victims/survivors, agencies or individuals but simply to identify barriers to women with disabilities seeking services for domestic violence/sexual assault.

Regarding the victims/survivors, research reveals that women with disabilities find it more difficult to speak about their experiences and needs than fully-abled women when seeking services. Some women with disabilities

communicate in ways unfamiliar to service personnel, so staff members and volunteers may not comprehend attempts to disclose abuse and ask for particular types of assistance. Many women with disabilities have also been socialized to comply with caregivers rather than disagree and state alternative requests.²⁹ Extra effort needs to be made to welcome this population of women in ways that would build trust on their terms and facilitate effective communication and service provision and usage.

Regarding service providers, what services will be offered to a woman with a disability who has been victimized? Although a great deal of research on service interventions has been published in the last thirty years, Maria Barile contended that women with disabilities have been largely absent within such discussions.³⁰ It should not be surprising then, that the majority of domestic violence/sexual assault service providers seldom explicitly include issues particular to women with disabilities in their planning, service philosophies, written policies, and programming. Conversely, disability service providers rarely prioritize gendered and domestic violence issues in their planning, philosophies, policies, and programming.³¹

Domestic violence/sexual assault service providers strive to provide services to all victims and survivors and may recognize the serious problem of abuse of women with disabilities. They tend to do so, however, through the lens of traditional understandings of domestic violence/sexual assault theory. For example, Lloyd and Emery explain the dynamics and manifestations of domestic abuse as rooted in the gendered need of men to exercise power over women. They identify traditional risk patterns for the extension of male power and control over women, how victims forgive and forget, and how the very ways the general populace talks about and understands relationships through socially constructed understandings of relationships, intimacy, and love contribute to traditional patterns of interpersonal violence.³² Lloyd and Emery target poor communication and problem solving skills as being at the core of cycles of interpersonal violence. Service providers subsequently construct tools and programming around fully-abled understandings of intimacy, communication, and problem solving to address issues to break the patterns identified by the general theories.³³

Are such theories on the dynamics of abuse and concomitant services adequate to meet the service needs of women with disabilities should they become victimized? In all likelihood, no. As discussed above, while similarities may be present in abuse and its roots, there are important differences in the contexts of abuse or in the barriers women with disabilities face in getting services. If these differences go unrecognized by service providers, cases of abuse may remain unrevealed or victims/survivors may be unable to get appropriate services.³⁴ To follow through on the example above, women with disabilities face challenges with communication and problem

solving across a range of disabilities and social contexts that traditional programming would likely not address.

The unintended consequence of such gaps in coverage is that women with disabilities who become victims of interpersonal violence will likely be underserved by traditional programming.³⁵ Zweig, Schlichter and Burt comment that “it is striking how few programs provide services that address multiple issues.”³⁶ Complex, interwoven sets of factors involving gender, disability, and both the nature and long-term impacts of abuse arise on a case-by-case basis when attempting to serve women with disabilities who are victims or survivors.³⁷ Intervention strategies that prove effective with fully-abled women, therefore, may not aid women with disabilities in the same manner. Moreover, services that assist a particular population of victims who are women with disabilities may not be appropriate for other individuals with disabilities.

Service providers and women with disabilities perceive accessibility of services across these multiple issues quite differently. Only a minority of shelters are fully accessible by the standards of the ADA, and domestic violence/sexual assault service providers typically overestimate their accessibility.³⁸ For example, providers may in good conscience report their organization as being fully accessible if their only accommodation is that wheelchairs can access their facility. Over-reporting accessibility is usually not intentional and likely results from limited understanding about what constitutes full physical and programmatic accessibility.³⁹

Accessibility of services includes physical accessibility of service providers’ facilities but also entails broader issues of attitudes, atmosphere, inclusivity, and ability to be referred to, and participate in, the variety of available programs and services appropriate to the individual’s needs.⁴⁰ For example, at both domestic violence/sexual assault and disability service providers, do intake materials include questions that would lead to the disclosure of interpersonal violence, particularly disability-specific forms of abuse?⁴¹ At domestic violence/sexual assault service providers, are services and referrals appropriate and accessible based on a victim/survivor’s level of cognitive ability? Can Personal Care Assistants (PCAs) or service animals be accommodated? Are written materials available in large-print or audio formats? What assistive technologies or assisted communications options exist?⁴² Disability service providers frequently possess limited understanding of interpersonal violence issues. They may look for signs of physical abuse among their clients, but do they know to look for emotional, sexual or disability-specific abuse?⁴³ Some disability service providers report that they do not think they need to screen for potential abuse or that they do not believe it is their responsibility to do so.⁴⁴

As this study revealed, virtually all service providers explain that they try to serve everyone who walks through their doors and will get clients

whatever they need while at the same time reporting that few women with disabilities who are victims or survivors of domestic violence or sexual assault seek services or accommodations from their organizations. Individuals with disabilities, on the other hand, had no reticence about discussing the many factors which had discouraged them from asking for needed accommodations or even seeking or following through with referrals and services.⁴⁵

Financial constraints also limit the ability of domestic violence/sexual assault and disability service providers to provide equal access to services for victims and survivors⁴⁶ as both types of service providers are historically underfunded.⁴⁷ Another barrier is insufficient awareness and understanding of the complex intersections between gender, violence and disability among staff, executive directors and board members. Misinformation and misperceptions about violence and disability directly impact service providers' ability to provide equal access to services. For example, victims and service providers recognize that the attitudes of service providers are key to ensure that victims receive appropriate assistance. Despite this acknowledgment, however, pervasive attitudes that stigmatize victims of abuse as well as individuals with disabilities exist among service providers. This produces discomfort in serving women with disabilities who seek services for abuse. Indeed, because of these attitudinal barriers, women with disabilities generally are offered less support than are fully-abled women.⁴⁸ Such discrimination and stigma contribute to increased risk of abuse and create barriers to "effective means of escape or redress when they are harmed."⁴⁹ Provision of services is sometimes not seen as a right for women with disabilities (as it generally is for fully-abled women) but as charity.⁵⁰

Women with disabilities confront such barriers and often choose not to overcome them. As one woman with a disability from the present study explained, "I think some of it is not so much the service provider as the attitude that's behind it. I don't think there's an awareness of how to deal with victims, survivors, overcomers [with disabilities] . . . So then they come at you with questions and sometimes . . . there's this judgment that's behind it . . . that's one thing that's really difficult." Another study participant said that: "The judgment makes you so you don't want to go in and talk about it, because you know people aren't going to be compassionate."⁵¹

In sum, women with disabilities face unacceptably high risks, incidence, and impacts of domestic violence. Challenges exist in providing victims and survivors equal access to the services they need. Their disabilities may make the signs of abuse more difficult to recognize. The service needs of women with disabilities may also differ from those of fully-abled women. Women with disabilities are also likely to underutilize existing services or to attempt to access them at different points of entry than fully-abled women. Simply put, addressing the needs of women with disabilities who are also victims of domestic abuse cannot be accomplished by doing more of what is

already being done to help people with disabilities or survivors of domestic violence; it requires new types of awareness, training, and outreach.

Discussion and Analysis of Research Findings: Strategies to Increase Physical and Programmatic Access to Victims' Services for Women with Disabilities

This research offers suggestions to overcome such challenges, bringing domestic violence/sexual assault service providers, disability service providers, and women with disabilities together more productively to work toward equal access to services for all victims and survivors of domestic violence, regardless of level of ability and no matter where a victim or survivor first attempts to access such services.⁵² This analysis endeavors to suggest practices that respect the quality of services already provided, the overloaded nature of such service work, and the strained budgets of organizations. I reiterate that the intent is not to blame either service providers or victims/survivors but simply to offer practical strategies to increase choices and access to programs and services.

Three communities were selected from within different regions of a rural state in the Intermountain West.⁵³ Each community is a mid-sized, predominantly rural city or town,⁵⁴ and each community contained at least one domestic violence/sexual assault service provider and one disability service provider. Communities were chosen based on factors such as pre-existing relationships and/or collaborative work between these providers; service providers' stated willingness to work with one another to create attitudinal and systemic change within their own organizations as well as across organizational boundaries; and community demographics.

Focus group and interview questions addressed the following issues:

- What resources and services do disability and domestic violence/sexual assault service providers currently have available for women with disabilities who have experienced violence?
- What do women with disabilities know about such services in their communities?
- To what extent do organizational policies, procedures and protocols at the service organizations hinder or promote meeting the particular needs of women with disabilities who are victims or survivors of domestic violence or sexual assault?
- What barriers exist for service providers which hinder them from providing services and which might be minimized or overcome?
- What barriers and facilitators to utilizing services exist for women with disabilities, which could be minimized or overcome?

- What relationships currently exist among service providers that could be fostered to better serve women with disabilities who become victims? What is the history of these relationships?⁵⁵

Separate focus groups and individual interviews were conducted in each community with staff and Executive Directors of the domestic violence/sexual assault service providers; staff and Executive Directors of disability service providers; and women with disabilities.

This analysis uses information gleaned from the focus groups and interviews to formulate strategies to encourage more effective multi-agency collaborations between domestic violence/sexual assault and disability service providers. The goal of fostering such successful relationships is to increase access to services to all victims and survivors of domestic violence, regardless of level of ability and no matter where a victim or survivor first attempted to access such services.

A strength emerging from this research is that disability and domestic violence/sexual assault service providers are already experienced at multi-agency collaborations with outside service providers – just not with one another. In all three communities studied, both types of service providers presently participate in networks of individuals and organizations that provide a multitude of different services to women. Advocates within this web successfully share information and resources with one another and refer clients to get what they need. Executive Directors of disability service providers spoke with pride that, “my staff know about every service in town.” Disability advocates tended to view themselves as “generalists,” or as first points of contact for clients with disabilities and they subsequently refer those clients to appropriate community services. Staff and Executive Directors of domestic violence/sexual assault service providers exhibited similar confidence in their knowledge of, and connections to, a multiplicity of local outside services. In contrast to the disability “generalists,” their extensive knowledge was understandably more targeted to resources aimed at serving victims and survivors of domestic violence and sexual assault.

Conversations with staff members about the history and successes of their multi-agency collaborations proved lengthy. “Collaborating works for us,” one staff member concluded. “Connections to other organizations are our strength,” an Executive Director stated. These multi-agency collaborations take many forms, both formal and informal. Some staff members and Executive Directors serve on the boards of other agencies. Other organizations report that they “invite agencies to come and meet us, or we go out and meet them.” Most service providers try to increase their community presence with other organizations and potential clients through exhibits at various types of fairs, summits and conferences.

While staff at both types of service providers in each community could describe an intricate web of multi-agency connections, rarely did they mention interagency connections with one another as a part of their networks. For example, while domestic violence/sexual assault staff in one community studied were aware of the disability service provider's existence, their awareness was limited to the organization's name, address and phone number.⁵⁶ Few reciprocal referrals were being made between the organizations, and little combined advocacy was occurring. Similarly, disability service providers in all three communities mentioned referring clients for domestic violence/sexual assault services, but noted that these organizations were not the service providers with which they enjoyed frequent, regular, and collaborative relationships. And while such staff reported on their efforts to visit outside programs to "share what we do and find out about what they do," they noted "but not with the domestic violence/sexual assault service provider."

The implications for women with disabilities who seek services for abuse are obvious. An individual who sought services would be offered a different set of uncoordinated options depending on which service provider she consulted. Research results bore this out. While service providers reported that they referred clients to a range of community resources regularly, women with disabilities in each community expressed frustration about their efforts to gain information about available resources and access services that met their needs. Women described the gradual process through which they learned, bit by bit, what services were available. They criticized what they perceived as insufficient coordination and interagency knowledge among service providers. Many focus group participants described how they discovered a disability or domestic violence/sexual assault organization or service by "luck" or "chance." As one woman with a disability observed, "Why was it so hard? You have to make so many calls and phone calls and stuff. . . .It was confusing and tiring. . . .So many people and so many different opinions..."⁵⁷ Focus group participants asked service providers to devise a more centralized, simple, equitable system "with people who know how resources overlap and interconnect." Services -- both domestic violence/sexual assault and disability--"need to be connected immediately" in "wrap-around services for that client."

Such inconsistent access to services and incomplete information constitute a significant impediment to usage of services and help explain why, as the domestic violence/sexual assault staff member observed at the beginning of this article, so few women with disabilities seem to seek services for these types of abuse. Advocates were aware that the current situation did not necessarily constitute the most effective and efficient way to provide services to clients, and could create confusion for both service providers and clients. One staff member commented: "Let's come up with one

comprehensive, consistent, non-contradictory plan to help a client rather than all these different tentacles coming off an octopus.”

In addition to previous experience working in multi-agency collaborations, two other strengths will stand domestic violence/sexual assault and disability service providers in good stead as they attempt to construct more productive relationships with one another and equal access to services for women with disabilities: similarities in philosophy and enthusiasm for service. Participants in each focus group and interview, whether with disability or domestic violence/sexual assault service providers, shared the same basic convictions and goals, albeit expressed in different terms. Each organizational philosophy centered around wanting people to be offered choices to better their circumstances -- with providers’ respect for each individual’s dignity and right to choose. For example, when asked to describe her philosophy of service provision, one Executive Director at a domestic violence/sexual assault service provider identified her top priority as providing the resources to meet clients’ needs so that the client does not feel she has to return to an abuser: “If I can eliminate this and say, ‘No, no. I can help you with that. I can take care of that.’ Then she doesn’t have a reason to go back. But, if you want to go back because you want to go back, that’s fine. That’s your choice. But I don’t want a woman to leave here saying she has to go back because we can’t give her something she needs.”

Both domestic violence/sexual assault and disability service providers empower women, respect their right to choose, and endeavor to create safe, supportive spaces in which clients can make such choices. Similar to the domestic violence/sexual assault philosophy described above, disability service providers attempt to lay out options and resources from which clients can select. It is then the client’s prerogative whether to make a choice and to act. Their goal, according to staff, is not for an advocate to “fix” a client’s life. Staff members respect client choices rather than imposing their own vision of what a client’s life should look like.

Women with disabilities expressed how important each of these values – dignity, self-empowerment, choice and respect -- was to them when they were seeking services for domestic violence/sexual assault. Focus group participants asked for services to be provided without judgment and with respect for individual choice. Perhaps most importantly, they asked that individuals with disabilities be consulted about the types of choices to be offered by both domestic violence/sexual assault and disability service providers.⁵⁸ As one participant said, “The only way things are going to change is if each and every one of us who has lived through this kind of situation does something to contribute to the change of the way things are now.”

Additionally, staff at both types of organizations exhibit caring, enthusiastic, positive “can do” attitudes toward serving clients. They are willing to pursue more fruitful connections with one another that will assist in

creating effective multi-agency collaborations to better serve women. “We are quite a ways from the ideal, but it could be good!” a staff member at one disability service provider said optimistically. A staff member at a domestic violence/sexual assault organization described one aspect of her work: “We listen, and let people know they are loved” while a disability advocate detailed how she and her co-workers provide “hugs and Kleenexes” as they lay out choices for their clients. “I’ll call anyone,” another disability staff member commented, displaying energy and commitment to the work and to clients.

Overall, service providers in each community studied expressed a commitment to build bridges between organizations and with communities to offer women with disabilities who are victimized a larger, more coordinated array of choices. Both disability and domestic violence/sexual assault advocates generally recognized the benefits of creating a greater degree of interagency collaboration and requested more network overlap of communication, referrals, resources and services with those of the other type of service provider. Executive Directors and staff suggested various measures to increase network overlaps, which will be discussed in greater detail below, along with the suggestions forwarded by women with disabilities. These shared values, commitment to the work, caring attitudes, and enthusiasm should provide an important foundation upon which to forge such connections.

But, as discussed above, it is not as simple a process as making a few phone calls and meeting around a table. Many efforts to create sustained multi-agency collaborations to address these issues have failed. What can be done to increase their chances of success?

Facilitation

Outside facilitation greatly increases the chances of success of cross-disciplinary multi-agency collaborations, particularly in the early stages. After three years of multi-agency collaborative work, it became clear that an outside facilitator could smooth communications, broker compromises, and ease tensions among service providers and with women with disabilities to keep each party at the table.⁵⁹ The facilitator should be someone trusted by both domestic violence/sexual assault and disability service providers. The facilitator should be educated (or willing to be) about both domestic violence/sexual assault and disability but should not be an individual who already is strongly invested in either domestic violence/sexual assault or disability service work or who has strong personal ties to the Executive Director or staff of one of the domestic violence/sexual assault or disability service providers. These criteria allow the facilitator to be perceived (to as great a degree as is realistically possible) as an un-invested, impartial party who will not unfairly favor any constituency during proceedings. Policy

makers should fund such outside facilitation, since hiring an outside facilitator may be beyond the budgetary capacity of agencies already strapped for funds. As an alternative, a practical option is for service providers to solicit an experienced facilitator from among their network of community contacts. A possible barter could be worked out in which the facilitator mediates between the domestic violence/sexual assault and disability service providers in return for a similar service performed for the facilitator's organization in the future.⁶⁰

First Things First

Although service providers may feel motivated to plunge right in with reciprocal referrals, meetings, and cross-trainings, it is best to hold off and spend time laying foundations for future collaborative work to decrease the possibility of future conflicts between organizations. Previous studies have emphasized the importance of patience and persistence since long-lasting, meaningful change to pre-existing attitudes and modes of service provision is a long process.⁶¹ If the end result is greater access to services for all victims and survivors of domestic violence, regardless of level of ability and no matter where a victim or survivor first attempted to access such services, the extra time is justified.

Initially, designated representatives from each domestic violence/sexual assault and disability organization (preferably but not necessarily with the aid of a facilitator) need to discuss the following issues in detail as these are initial steps necessary for building trust and understanding from which the work can begin. This is not an organization-wide cross-training.

- **Share philosophies and scope of work with one another.** Share information on what each agency understands as its ethical and legal obligations regarding service provision, confidentiality, mandatory reporting, and other issues. Organizational representatives should have the opportunity to question one another respectfully for clarification and understanding.⁶² Service providers should be able to identify common ground from which to begin their mutual work.

- **Build common definitions around issues and terms such as abuse, domestic violence, disability and accessibility.** Allocate sufficient time to achieve this, as agreement on terms often requires a significant amount of discussion.⁶³ In the present study, for example, disability service providers and domestic violence/sexual assault service providers in one community possessed different understandings of what constitutes abuse. In the past, when referrals were made, the receiving agency disagreed that abuse was occurring, delaying services for the victim. An agreed-upon definition of what constitutes abuse would place both types of service providers on the same page and hasten appropriate services for the victim/survivor no matter where she seeks aid.

- **Delineate expectations for the collaboration both for victims/survivors with disabilities and for the organizations themselves.** Each partnering organization should consider, define and communicate clearly what they need in order to remain at the table as well as any “deal breakers”.

- **Write everything down in the form of agreements, policies, and procedures for the multi-agency collaboration.** This formalizes the collaboration and eliminates disagreements over “who agreed to what” down the line, and it officially establishes all organizations’ commitment to the collaboration. Create a shared, multi-agency mission statement to define goals and work, dispute resolution protocols, and a memorandum of understanding or collaboration charter.

- **Discuss any past relationships/history between the collaborating agencies.** This includes both positive and negative perceptions and outcomes. If any anger or mistrust is present, it needs to be laid on the table early. Frustrations need to be aired honestly and with respect. Criticisms need to be listened to and received without a perceived need to defend what occurred in the past. If enthusiasm for the work exists, it too should be communicated.

Many issues are difficult to discuss, which is why a facilitator is so desirable to work the collaborators through misunderstandings, compromises, anger, and frustration. For example, when discussing prior relationships between organizations, an advocate at a disability service provider expressed frustration over never receiving follow up information on clients after referring them for domestic violence/sexual assault services. The advocate was not aware that domestic violence/sexual assault service providers cannot provide such information on clients who utilize their services due to safety and privacy concerns. This constitutes a misunderstanding about what types of services and ethical obligations each type of service provider maintains. In a situation such as this, the opportunity exists for a representative from the domestic violence/sexual assault service provider to react defensively, feeling blamed. A facilitator can mediate to ease possible tensions between the collaborators.

Similarly, when a domestic violence/sexual assault advocate discussed the challenges of making shelters and programs accessible for every type of disability, particularly in rural areas in which programs are underfunded and minimally staffed, a disability advocate firmly stated that accessibility was not optional for publicly funded service providers. Discussions became heated, but the facilitator questioned each participant and rephrased certain comments until the advocates came to a mutually acceptable understanding that strengthened the collaborators’ relationship and trust -- because they had remained at the table and worked out their differences satisfactorily.

The overall goal of these initial activities is for individuals and organizations to begin increasing confidence and trust in one other. At first, it might seem common sense that these groups -- which share a natural affinity

to equalize opportunities for historically marginalized individuals -- should easily form working relationships based on these shared goals. An often unrecognized dynamic to these multi-agency and multi-issue collaborations, however, is an historic, underlying competitiveness and defensiveness within their relationships. This uncomfortable issue must be confronted head on early in the process; otherwise, significant tensions may emerge unexpectedly later in the collaboration.

Domestic violence/sexual assault and disability organizations have had to struggle to gain recognition, legitimacy, and support for their causes with law and policy makers, medical professionals, law enforcement, the justice system, community organizations, the media, and even with other human rights and social justice organizations. Such debates often assume an understandably confrontational character. Advocates are conditioned to protect their clients and their causes and assume defensive postures against those who might challenge the import and legitimacy of their work. These organizations also compete for limited public funds and private donations.

As the Italian theorist and activist Antonio Gramsci observed, this long-standing environment of competition among social activists presents a significant barrier to meaningful collaborations among activists representing different constituencies. This occurs despite agreements about obvious societal inequities that the majority of people recognize as unfair and undesirable. Although it would seem common sense that advocates for disadvantaged populations -- such as domestic violence/sexual assault and disability advocates, women with disabilities and women who identify as victims/survivors of domestic violence -- would share their strengths to better combat the inequities, history does not bear this out. So-called "common sense" is limited by what Gramsci refers to as cultural hegemony, a pattern of unexplored ideals, beliefs and privileges that all people knowingly and unknowingly prop up with their choices and attitudes.⁶⁴

It is human nature to concentrate upon immediate concerns, such as stretching the budget to meet payroll so staff do not get laid off or to serve the immediate needs of women who are walking through the door rather than wondering who else you might attract to the program.⁶⁵ What often goes unexamined because of the preponderance of pressing needs, however, are the fundamental and systemic sources of the situations domestic violence/sexual assault and disability organizations attempt to address in the first place: the common roots of oppression in the devaluing of certain individuals in society because they do not meet the culturally hegemonic ideals of gender and/or ability.⁶⁶

This situation helps create an environment of competition and confrontation *among activists* for funds and support. It hinders the development of trust and working relationships across issues. It makes it harder for advocates to challenge their common sources of oppression. By not

collaborating effectively, advocates unwittingly reinforce this competitive environment amongst themselves, expending time, energy and resources they might otherwise use to create substantive systemic change. Executive Directors, staff, and even board members must recognize and confront this environment of competitiveness and master their fears in order to build trust and understanding in multi-agency work to offer more and better choices to women with disabilities who become victims/survivors of domestic violence. These are lessons organizations can extend to all their multi-disciplinary work with historically underserved populations.

Organization-wide Initiatives

Once the groundwork has been laid to increase the likelihood of successful long-term collaboration, broader efforts involving both organizations and women with disabilities in the community can be initiated. Focus groups and interviews allowed domestic violence/sexual assault service providers as well as women with disabilities who identified as victims/survivors of abuse to discuss the initiatives they would prefer and how they would like such initiatives implemented. The most significant initiatives for multi-agency collaborations are: multi-agency communication and cross-training on the intersections of gender, violence and disability, both between organizations and within communities; policies, procedures and budgets written to specifically include the issue of provision of services to women with disabilities who are victims/survivors of domestic violence/sexual assault; increased centralization of information; and creating welcoming environments for victims/survivors with disabilities.

Multi-agency communication and cross-training: Currently, there is little communication between domestic violence/sexual assault and disability service providers in the communities studied. Advocates do not yet cross-train one another. Furthermore, no community-wide education or discussions regarding the intersections of disability and domestic violence/sexual assault exist in the communities studied.⁶⁷

The consequences of insufficient knowledge, training, and discussions about the intersections between gender, violence and disability can have significant consequences on organizations' ability to form successful multi-agency collaborations and victims' ability and willingness to access appropriate services. Women with disabilities in every community mentioned this issue. Drawing upon past experiences with a variety of service providers, individuals with disabilities who sought services for domestic violence intuited that service providers were untrained in these areas. This created reluctance, according to the women, to seek services from either type of provider when they experienced abuse.

Both domestic violence/sexual assault and disability service providers within every community studied acknowledged their insufficient knowledge about these issues. A majority of staff members at domestic violence/sexual assault service providers, for example, reported that their training on disability issues was minimal. With hesitancy, many staff members recalled that information on disability-specific forms of abuse may have been part of their initial training but admitted they were unsure. Similarly, staff of disability service providers recalled that they may have received some training about issues of domestic violence and sexual assault when they first joined the organization. Most staff, however, recognized that their training has not prepared them to recognize abuse. Disability service providers in two of the communities studied rely upon Personal Care Attendants (PCAs) to report suspected abuse. Although laws in this particular state require all PCAs to be screened, earlier research has documented the prevalence of abuse by PCAs and other caregivers.⁶⁸ Yet no staff member discussed the possibility of abuse by the Personal Care Attendants themselves.

Furthermore, if a client does happen to disclose abuse, staff members at both types of service providers said that they are generally unprepared to serve the client's needs appropriately. As one advocate said, "We don't know what we don't know." Most of their knowledge of how best to serve such individuals comes from actual experience serving such clients which they gain over time. Many staff members described their usual *modus operandi* of "reading between the lines" or using "gut instinct" and "intuition." "[Y]ou just start drawing out more information," one disability staff member explained, "and then you realize the bells and whistles go off in your head that the person is abused." Conversely, domestic violence/sexual assault staff members reported that their awareness that a client has a disability and may need an accommodation comes from observing and using their "intuition" and "common sense." They might consult informally with other staff members, but each staff member usually defines what each thinks is best to meet the clients' needs. As one staff member commented: "We get creative." Sometimes it works. Sometimes it does not.

Service providers' acknowledgement of their need for information and training was coupled, however, with a willingness to fill these gaps through increased interagency communication and cross-training. The content and frequency of communication and cross-training, the manner in which communication and cross-training are presented, and the buy-in of Executive Directors and staff are all critical to the creation of successful multi-agency collaborations. When service providers were given the opportunity to state their preferences, they asked for the following:

Communication

- *Regular, scheduled communication:* Executive Directors and staff at every organization suggested increased coordination and regularly scheduled communication between local domestic violence/sexual assault advocates, disability advocates, and their organizations. This is in contrast to communication on an “as needed” basis, whenever a client seeks services. One possibility suggested was to schedule multi-agency agency meetings at which each agency has a representative. Following the meetings, the representatives take information back to share with the entire staff at the home agency. Advocates stressed the need for such communication to be both frequent and transparent.
- *Specific contacts:* Staff at each organization should be familiar with specific contact persons within other agencies, as well as the specific services each agency provides or to which they refer out. Staff preferred written, CD, and website formats to communicate such information in organized fashion.
- *Face to face contact:* Executive Directors and staff at the organizations studied emphasized that there is no substitute for face-to-face contact. Personal contact speeds and strengthens trust. Organizational representatives should visit one another’s facilities and meet one another rather than rely solely on contact lists, email, and phone conversations.
- *Exchange of board members:* Such an exchange would institutionalize the collaboration at the highest level of decision-making.
- *Avoid duplication of efforts:* Improved multi-agency communications should lessen duplication of services, which both types of agencies hoped would free up staff time and organizational resources for other efforts.

Cross-training

Women with disabilities and Executive Directors and staff of both service providers in each community prioritized larger multi-agency and community-wide efforts to cross-train themselves and educate others as the first step to addressing the needs of women with disabilities who are victims/survivors of domestic violence. Advocates from domestic violence/sexual assault service providers requested cross-training from disability service providers and individuals with disabilities in their area so they could acquire more knowledge, familiarity, and comfort about such disability-related topics as: understanding federal and state legal requirements for providing accessible services, especially the *Americans with Disabilities Act*; mental health-related disabilities; disability-specific abuse; ethics; assistive technologies available in their areas; and how to be more proactive and welcoming to serve women with disabilities who request services.⁶⁹

Disability advocates, in turn, requested more knowledge about: the dynamics of interpersonal violence; how to identify abuse; and what to do if a client discloses abuse.

- *Attitude is important:* The spirit in which cross-trainings would occur was important to all advocates. Both presenters and audiences at such trainings should adopt a “we need to learn from you” attitude rather than a “we come in and fix you” attitude.⁷⁰ They also agreed on the importance of:
- *Joint trainings:* Both types of advocates suggested joint trainings and conferences. Ideally, such trainings would provide staff members with Continuing Education Units (CEUs).
- *Multi-disciplinary teams:* Advocates envisioned the end result of these multi-agency cross-training efforts as the creation of multi-disciplinary teams composed of representatives from different agencies to aid them to “reintegrate [the client] into the community as a healthy, employed, successful woman.”⁷¹
- *Tools:* Each agency should assist one another to ensure that intake materials, screening tools, websites, documents, and other materials recognize the possibility of abuse of people with disabilities, are accessible, and create a welcoming environment for victims/survivors.

Two issues not discussed in detail by Executive Directors and staff in interviews and by focus group participants nonetheless should be included in cross-trainings:

- *New understandings about accessibility:* Organizations need a broader awareness of what constitutes full physical and programmatic accessibility for individuals with disabilities, as was discussed above.
- *Unacknowledged barriers to services:* Trainings should explore, with sensitivity, the multiple barriers among service providers which unintentionally limit access to services. The barriers to be confronted include, but are not limited to, attitudes and assumptions about domestic violence and/or disability that impact provision of services and historic competitiveness among service providers. Again, an impartial facilitator could be of great worth during such discussions.⁷²

Within Communities

In addition to inter-organizational cross-trainings, service providers and women with disabilities in the communities studied also suggested that community awareness of the intersections of gender, violence and disability and the services available to victims/survivors needed to be broadened.⁷³ A general unwillingness to admit publicly that either violence or disability exists is pervasive, according to one staff member. Community silence on such

issues contributes to limited knowledge about existing domestic violence/sexual assault programs and services or about violence against people with disabilities.

A staff member in a different community observed a similar situation and noted an additional consequence: that some men and women with disabilities do not recognize that what is happening to them is abuse. Women with disabilities confirmed during the focus groups that because such information is absent from their lives and communities as a whole, it took a long time for them to identify what was happening to them as abuse. No one in their communities, they said, was willing to talk about abuse of people with disabilities openly and honestly. Focus group participants repeatedly requested education on issues such as domestic violence/sexual assault and what healthy relationships look like. Such education of young men and women should begin, participants suggested, in secondary schools and churches. In fact, many women with disabilities identified churches as their first point of contact in seeking services for domestic violence or at least mentioned that if they needed such services, they would search at their church. Involving churches in domestic violence/sexual assault and disability work and the intersections between them occurs infrequently but might be expanded upon to increase access and choice in the future.⁷⁴

All public awareness campaigns, community dialogues, and outreach materials should send a message of a welcoming environment. Some participants mentioned positive, effective community programs, such as the "Healthy Hands are Not for Hitting" program that they had found welcoming and that should be expanded into the wider community. Other women with disabilities suggested public service campaigns and proposed a central community training center. In sum, women with disabilities who were victims/survivors of domestic abuse asked for a frank public discourse about disability and violence that prominently features the voices of women with disabilities in the dialogue, thus encouraging peers to connect with peers.

Such educational efforts, both between organizations and within communities, would garner several benefits, overcoming barriers identified within this study as well as by researchers in the literature discussed above. It would better educate more people within a community about what constitutes abuse, including disability-specific forms of abuse, so that individuals with disabilities can more readily identify what is happening to them as abuse.⁷⁵ Additionally, it would proactively prepare both domestic violence/sexual assault and disability advocates in ways to better meet the needs of women with disabilities who seek services for domestic violence. Lastly, by making both disability and domestic violence more visible, such efforts may help to normalize discussions surrounding these issues. Consequently, these efforts may mitigate some of the stigma and attitudinal barriers surrounding both disability and domestic violence which limit women with disabilities from

seeking and receiving services they want. Staff and Executive Directors discussed such training and education as a necessary first step toward better serving women with disabilities who are victimized but one that must be supplemented by a variety of other interactions and initiatives, including the following:

Policies, protocols, procedures, and budgets: Adopting written policies, protocols, and procedures that formally recognize the particular service needs of women with disabilities who are victims/survivors of domestic violence would demonstrate an organization's commitment across all levels of organizational hierarchy to serve women with disabilities. It also would address staff discomfort about serving women with service needs with which providers are unfamiliar. At present, service providers in each of the communities employ no such written policies, procedures, or protocols. Executive Directors and staff, however, requested assistance in creating and implementing such documents.

Each organization also should commit line items in their budgets to address this issue. Boards of Directors at domestic violence/sexual assault and disability organizations typically base budgetary allocations on who has walked through agency doors in the past year seeking particular types of services. Unfortunately, survivors with disabilities may not be seeking services because they do not consider the service providers to be accessible or as safe places to disclose abuse. A more proactive, rather than reactive, approach to budgeting is necessary to enhance program services so that they are more welcoming and accessible to survivors with disabilities.⁷⁶

The last two suggestions for multi-agency collaborations rely heavily on the suggestions of survivors with disabilities. It is not simply a case of "if you build it, they will come." As researchers and advocates have been encouraging, women with disabilities need to be included in the creation of service strategies to ensure that innovations meet their needs and are delivered in ways that will increase women's usage of them.⁷⁷

More centralization of information and resources: Women with disabilities who attended focus groups and interviews frequently requested "wrap around services" and "one stop" services. They asked for a centralized resource of information about services that makes it clear how the services interconnect. The following is a practical recommendation for organizing and delivering such information in a cost-effective manner.

As discussed above, domestic violence/sexual assault and disability service providers currently participate in parallel, multi-agency networks that might be made to overlap in the future. The next step involves connecting women with disabilities with this resource web. At present, according to women with disabilities in the communities studied, all that exist are various

lists containing contact information for some service provider organizations. It would be more useful, participants said, to have a coordinated roster -- indexed both by agency and by services offered -- of both disability and domestic violence/sexual assault service providers including: agency name, names of specific individuals at the agency prepared to speak to women with disabilities about violence issues, services offered, hours of operation, phone numbers, and addresses. This roster would be most useful, according to focus group participants, if available as a booklet or on community bulletin boards in venues frequented by individuals with disabilities. Such venues identified by focus group participants include: television and radio public service announcements, local TV station "tip lines," ads in local newspapers, flyers from local agencies (such as the welfare office, food stamps office, Medicaid, sheriff's office, police departments, behavioral health, unemployment office, hospital emergency rooms), Victim Advocate services, libraries, 2-1-1 Careline, disabilities service organizations, doctors' offices (including psychiatrists' offices), psycho-social rehabilitation (PSR) workers, attorneys, grocery stores, churches, posters in women's restrooms, including bar restrooms.⁷⁸

Creating welcoming environments for victims/survivors with disabilities:

Finally, once a woman knows about a service provider, what factors induce her to walk through the door, ask for services, and follow through? Women with disabilities consulted in this study recalled both positive and negative experiences with domestic violence/sexual assault and disability service providers. They drew upon such recollections as they explained that, in order to speak up and voice their need for accommodations and services, they must enter what they perceive to be a safe, welcoming environment in which they do not feel stigmatized or judged either for their disability or for being victimized by an abuser. Women identified several factors that contribute to creating such a welcoming environment:

- *Service providers who have been trained to recognize signs of abuse in women with disabilities and who understand their needs:* If this were not possible, women with disabilities asked that service staff willingly admit their inexperience with disability or with domestic violence. Such honesty would build bridges so service provider/client relationships could progress more productively. Ideally, women with disabilities would prefer peer-to-peer interactions at service providers.
- *Atmosphere:* Attractiveness and informality of facilities made a big impression on focus group participants, contributing to a "normalizing of atmosphere." When entering a service provider's facility for the first time, some women with disabilities found placement of desks in reception areas off-putting because of the resemblance to a doctor's office. They preferred a casual, "laid back" environment to an overly professional, clinical atmosphere.

- *Explanation:* Women wanted staff to explain the intake process and why certain questions, particularly those related to sexual experiences, need to be asked.
- *Trust:* Women with disabilities repeatedly asked that staff wait until trust develops between the individual and the service provider before asking questions about sensitive issues such as abuse or sex.
- *Respect/maintenance of confidentiality*
- *Perception of being safe while receiving services*
- *Attitude and appearance of staff:* Women with disabilities appreciated service providers whose compassion, sensitivity, and nonjudgmental attitudes helped them feel accepted and hopeful in an unfamiliar environment. They encouraged service providers to “be real.” Some women found staff language and dress that was too formal to be intimidating. They preferred staff to be wearing casual attire similar to what clients themselves might be wearing.
- *Consistency of experience:* Rather than being handed off to different staff members, women with disabilities said they would prefer to stay with one person.⁷⁹

As such insights reveal, multi-agency collaborations are important for creating opportunities for interdisciplinary services and referrals, but their existence does not necessarily ensure that women will go to the service provider. Asking women with disabilities who are victims/survivors of abuse about what types of information they want, where they want to access it, and how they want to receive services increases the likelihood that they will seek and follow through with services and referrals.

Conclusion

These initiatives -- from facilitation and first steps among collaborators to organization-wide efforts and suggestions from women with disabilities -- incorporate the state of research into abuse of women with disabilities and directly confront the obstacles to successful multi-agency collaborations between domestic violence/sexual assault and disability service providers identified earlier. They foster understanding and communication among service providers to focus serious attention on the issue of domestic violence committed against women with disabilities. They suggest strategies to build on the strengths service providers already possess.

The initiatives also recognize possible stumbling blocks to successful collaborations and offer realistic strategies and insights to increase agency buy-in and ensure that all partners at the table will follow through on their commitments. These approaches are intended to increase comfort and decrease frustrations of domestic violence/sexual assault and disability service providers in addressing the service needs of women with disabilities. They

also promote more successful dialogue and interaction among advocates, communities, and women with disabilities who are also victims/survivors to offer women more choices.

As one woman with a disability who had experienced domestic violence said:

“...[T]his isn’t just about services, this isn’t just about a house, this isn’t just about providing someone with some information. This is about ending domestic violence. This is about ending abuse. And when you’re out there and you’re able to give to us, then what you’re doing is giving hope. . . Every one of us lives that life. Every one of us knows it. When...there’s a place you can go that says, ‘Hey, we have this for you. This is a place for you to live. This is a place where you can have transportation, this is a place where you can get a group,’ what you’re doing is offering hope.”

To fulfill this hope, service providers and women with disabilities must all have a voice at the table. They must be engaged actively in the process of increasing access for women with disabilities who have been victimized, no matter where a woman seeks assistance. It is my hope that these strategies provide a base from which to begin doing so.

¹ There is no agreement on what constitutes “disability,” “domestic violence,” “abuse,” or “accessibility.” Legal and policy definitions are in flux, depending on court decisions and new laws. Section 902 of *The Americans with Disabilities Act Amendments Act of 2008* employs a statutory definition which defines “disability” as “a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; being regarded as having such an impairment.” Available from www.eeoc.gov/policy/docs/902cm.html.

² Bridget Penhale Parker, *Adult Protection* (New York: Routledge, 2004); Janine M. Zweig, Kathryn A. Schlichter, and Martha R. Burt, et al., “Assisting Women Victims of Violence Who Experience Multiple Barriers to Service,” *Violence Against Women* 8, no. 2 (2002): 174.

³ Zweig, Schlichter, and Burt et al., “Assisting Women Victims,” 174, 178. See also Richard Sobsey, *Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance?* (Baltimore: Paul H. Brookes Publishing Company, 1994) 347-; D.J. Elliot, A. Galloway, and K. Cellarius, *2002 Oregon Crime Victims’ Needs Assessment: Final Report* (Portland, OR: Portland State University Regional Research Institute for Human Service, 2003) 7; Linda G. Mills, “Benefiting From Violence: A Preliminary Analysis of the Presence of Abuse in the Lives of the New SSI Disability Recipients.” *Sexuality and Disability* 15 (1997): 99.

⁴ Even when all parties remain at the table, Sobsey found that verbal support was often unaccompanied by substantive action in the field. Sobsey, *Violence and Abuse*, 8.

⁵ These organizations formed the Idaho Equal Access Collaborative. This project was supported by Grant No. 2006-FW-AX-K011 awarded by the Office on Violence Against Women, U.S. Department of Justice. Much of the primary source information contained in this article was submitted to the U.S. Department of Justice, Office on Violence Against Women as part of a “Strengths and Needs Assessment Report from the State of Idaho” which is accessible under the Freedom of Information Act but which is otherwise unpublished. The opinions, findings, conclusions, and recommendations expressed in this article are those of this author, the primary author of the sections of that report interpreting the data collected.

They do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women or the Idaho Equal Access Collaborative.

⁶ Many studies emphasize the need for more qualitative research to include women with disabilities in the creation of domestic violence/sexual assault service strategies. See Mary Ann Curry, Dena Hassouneh-Phillips, and Anne Johnston-Silverberg, "Abuse of Women with Disabilities: An Ecological Model and Review," *Violence Against Women* 7, no. 1 (2001): 76; Margaret A. Nosek, Carol A. Howland, and Rosemary B. Hughes, "The Investigation of Abuse and Women with Disabilities-Going beyond Assumptions." *Violence against Women* 7 (2001): 493. Ann Boyer and Debbie Indyk, "Shaping Garments of Care: Tools for Maximizing Adherence Potential," *Social Work in Health Care* 42 (2006): 151-4; Elliot, Galloway and Cellarius, *Oregon Crime Victims*, 60.

⁷ M. LaPlante and D. Carlson, "Disability in the United States: Prevalence and causes," 1996. Available from <http://www.dsc.ucsf.edu/repl/index.html>. Study based on National Health Interview Survey of non-institutionalized individuals conducted in 1992 found 15.4% of US women identified as having a disability; The U.S. Census Bureau, using data from the 2006 American Community Survey, corroborates that approximately 15% of women nationwide identify as having a disability.

Available at http://factfinder.census.gov/servlet/DTable?_bm=y&-geo_id=01000US&-ds_name=ACS_2006_EST_G00_&-lang=en&-caller=geoselect&-state=dt&-format=&mt_name=ACS_2006_EST_G2000_C18001. The number of people who identify as having a disability and who receive benefits from Social Security as Supplemental Security Income (SSI benefits) has increased in last 25 years. The average recipient is below 50 years old and has a mental health rather than a physical disability. Among those studied, abuse—either in childhood or adulthood—was "a prevalent feature" in the lives of qualified SSI beneficiaries and 15% of those studies were battered women. See Mills, "Benefitting from Violence." 100-1, 104-5.

⁸ Berkeley Planning Associates, "Priorities for Future Research: Results of BPA's Delphi Survey of Disabled Women," (1996): 3.

Available at http://www.berkeleypolicyassociates.com/images/berkeleypolicyassociates.com/File/552_Priorities_for_future_research_09-1996.pdf; National Institute on Disability and Rehabilitation Research, "Focus group on women and disability: Report of Proceedings" (Washington DC: US Dept of Education, Office of Special Education Services, July 1994).

⁹ Nancy P. Swedlund and Margaret A. Nosek, "An Exploratory Study on the Work of Independent Living Centers to Address Abuse of Women with Disabilities." *Journal of Rehabilitation* 66 (2000): 57.

¹⁰ Elizabeth P. Cramer, Stephen F. Gilson, and Elizabeth DePoy, "Women with Disabilities and Experiences of Abuse." *Journal of Human Behavior in Social Environment* 7 (2003): 184-5; A.H. Flitcraft, "Violence, values and gender," *Journal of the American Medical Association* 267 (1992): 3194-5; "American Medical Association. Diagnostic and treatment guidelines on domestic violence" (Chicago: AMA, 1992); Lily Greenan. *Violence against women: A literature review* (Edinburgh: Scottish Executive, 2004); Susan Schechter. *Women and Male Violence: The Visions and Struggles of the Battered Women's Movement* (Cambridge, MA: South End Press, 1983); Deborah M. Goelman. "Shelter from the storm: Using jurisdictional statutes to protect victims of domestic violence after the Violence Against Women Act of 2000," *Columbia Journal of Gender & Law* 13, no. 1 (2004): 101; Hyunkag Cho and Dina J. Wilke, "How Has the Violence Against Women Act Affected the Response of the Criminal Justice System to Domestic Violence?" *Journal of Sociology & Social Welfare* 32, no. 4 (2005): 125-139; Jill J. Morris, "Pro/Con: Did Congress improve the Violence Against Women Act? *The CQ Researcher* 16, no. 1 (January 2006): 21-2; E. Stark, A. Flitcraft, and W. Frazier, "Medicine and Patriarchal Violence: The Social Construction of a 'Private' Event," *International Journal of Health Services* 9, no. 3 (1979): 461-493; J. McFarlane, K. Christoffel, L. Bateman et al., "Assessing for abuse: self-report versus nurse interview," *Public Health Nursing* (1991) 8: 245-50.

¹¹ See Nosek, Howland and Hughes, "Investigation of Abuse," 483; O.W. Barnett, C.L. Miller-Perrin and R.D. Perrin, *Family Violence across the Life Span* (Newbury Park: Sage, 1997); K.H. Rosen, "The ties that bind women to violent premarital relationships: Processes of seduction and entrapment." in *Family violence from a communication perspective*, eds. D.D. Cahn and S.A. Lloyd (Thousand Oaks, CA: Sage, 1996).

Most research on abuse and disability has investigated sexual abuse among children and adults with developmental disabilities and not necessarily included gender as a simultaneous analytical category. See Curry, Hassouneh-Phillips, and Johnston Silverberg, "Abuse of Women," 60, 68; Sobsey, *Violence and Abuse*, 87.

¹² For examples, see Rosemarie Garland-Thomson, "Feminist Disability Studies," Barbara Waxman Fiduccia Papers on Women and Girls with Disabilities (Washington D.C.: Center for Women Policy Studies, 2001). Available at <http://www.centerwomenpolicy.org/programs/waxmanfiduccia/documents/DIS2.pdf>; J.M. Mays, "Feminist Disability Theory: Domestic Violence against Women with a Disability," *Disability & Society* 21 (2006): 147-158; Maria Barile, "Individual-Systemic Violence: Disabled Women's Standpoint," *Journal of International Women's Studies* 4 (2002): 1-14; Lesley Chenoweth, "Violence Against Women with Disabilities: Silence and Paradox," in *Women's Encounters with Violence: Australian Experiences*, eds. Sandy Cook and Judith Bessant (London: Sage, 1997): chap. 2; Adrienne Asch and Michelle Fine, "Introduction: Beyond pedestals," in *Women with disabilities: Essays in psychology, culture and politics*, eds. Michelle Fine and Adrienne Asch (Philadelphia: Temple UP, 1988): 1-37; C. Thomas, *Female forms: Experiencing and understanding disability* (Philadelphia: Open University Press, 1999).

¹³ Sobsey, *Violence and Abuse*, chap. 10; Sandra L. Martin, Neepa Ray, and Daniela Sotres-Alvarez et al., "Physical and Sexual Assault of Women with Disabilities," *Violence Against Women* 12 (2006): 824-5; Nosek, Howland, and Hughes, "Investigation of Abuse," 478-9, 481, 496; Dena Hassouneh-Phillips and Mary Ann Curry, "Abuse of Women with Disabilities: State of the Science," *Rehabilitation Counseling Bulletin* 45 (2002): 99; Cramer, Gilson and DePoy, "Women with Disabilities," 193.

¹⁴ Martin, Ray, and Sotres-Alvarez et al., "Physical and Sexual Assault," 829, 831; Hassouneh-Phillips and Curry, "Abuse of Women," 96; Margaret A. Nosek, Carol A. Howland, Rosemary B. Hughes, and Catherine C. Foley, "Vulnerabilities for Abuse among Women with Disabilities." *Sexuality and Disability* 19 (2001): 177-189; Julia Wacker, Susan Parish, and Rebecca Macy, "Sexual Assault and Women with Cognitive Disabilities," *Journal of Disability Policy Studies* 19, no. 2 (2008): 86-94; Women with Disabilities Australia, *WWDA on violence against women with disabilities* (Rosny Park, Tas.: Women with Disabilities Australia, 2007); National Study of Women with Disabilities (Center for Research on Women with Disabilities [CROWD], 1988); M.E. Young, M.A. Nosek, C. Howland, and G. Chanpong, et al., "Prevalence of Abuse of Women with Physical Disabilities," *Archives of Physical Medicine and Rehabilitation* 78 (1997): 34-38; Sobsey, *Violence and Abuse*, 76-7; E.M. Furey, "Sexual abuse of adults with mental retardation: Who and where," *Mental Retardation* 32 (1994): 173-180; L. Muccigrosso, "Sexual abuse prevention strategies and programs for persons with developmental disabilities," *Sexuality and Disability* 9 (1991): 261-271; D. Sobsey and T. Doe, "Patterns of sexual abuse and assault," *Sexuality and Disability* 9 (1991): 243-259; M. Ticoll, *Violence and People with Disabilities: A Review of the Literature* (Ottawa: Roeher Institute/Canada National Clearinghouse of Family Violence, Health and Welfare, 1994).

¹⁵ Hassouneh-Phillips and Curry, "Abuse of Women," 96; Curry, Hassouneh-Phillips, and Johnston-Silverberg, "Abuse of Women," 67; Nosek, Howland, Hughes and Foley, "Vulnerabilities for Abuse,"; Young, Nosek, Howland, and Chanpong, et al., "Prevalence of Abuse,"; Sobsey, *Violence and Abuse*, 76-7.

¹⁶ Although there are commonalities among disability groups, such as isolation and economic dependence (See A.B. Andrews and L.J. Veronen, "Sexual assault and people with disabilities," *Journal of Social Work and Human Sexuality* 8 (1993): 137-159), there are important distinctions among individuals and groups. For example, Nosek, Hughes, Taylor, and Taylor concluded women with physical disabilities who are younger, more educated, less mobile, more socially isolated and who have higher levels of depression are more likely to have been abused within the last year. See Margaret A. Nosek, Rosemary B. Hughes, Heather B. Taylor, and Patrick Taylor, "Disability, Psychosocial, and Demographic Characteristics of Abused Women with Physical Disabilities," *Violence against Women* 12 (2006): 838-850. Also, Martin, Ray, and Sotres-Alvarez et al., "Physical and Sexual Assault," 834, identified young, unmarried women of color with disabilities as one of the groups at greatest risk. Among women with developmental disabilities in particular, emotional abuse was found to be almost universal, See Curry, Hassouneh-Phillips, and Johnston-Silverberg, "Abuse of Women," 65, as well as Nosek, Howland, Hughes, and Foley, "Vulnerabilities for Abuse," 186; For intersections with substance abuse, see Michael Wolf-Branigin, "Disability and Abuse in

Relation to Substance Abuse: A Descriptive Analysis," *Journal of Social Work in Disability & Rehabilitation* 6, no. 3 (2007): 65-74.

¹⁷ M. Lundy and S.F. Grossman, "Elder Abuse: Spouse/Intimate Partner Abuse and Family Violence among Elders," *Journal of Elder Abuse and Neglect* 16, no. 1 (2004): 96. Lundy and Grossman also ask researchers to consider intersections between elder abuse and abuse of persons with disabilities. The elder population is one of fastest growing segments of the US population. Elders are also very vulnerable to abuse by family members and other caregivers, and many experience some form of disability. Justifications for abuse, such as "caregiver stress," come up for both individuals with disabilities as well as individuals who are elderly (86).

¹⁸ Many forms of abuse among women with disabilities are not seen as abuse because of a fully-abled definition of what constitutes abuse. See Curry, Hassouneh-Phillips, and Johnston-Silverberg, "Abuse of Women," 61.

¹⁹ Ticoll, *Violence and People*, 7-14.

²⁰ Nosek, Howland, and Hughes, "Investigation of Abuse," 496.

²¹ Zweig, Schlichter, and Burt et al., "Assisting Women Victims," 168; Nosek, Howland, and Hughes, "Investigation of Abuse," 484; Nosek, Howland, Hughes, and Foley, "Vulnerabilities for Abuse," 182-4; Cramer, Gilson and DePoy, "Women with Disabilities," 183; Hassouneh-Phillips and Curry, "Abuse of Women," 96-104; Chenoweth, "Violence Against Women," 31-37; Barile, "Individual-Systemic Violence," 5; Young, Nosek, Howland, and Chanpong et al., "Prevalence of Abuse," 34-8.

²² Nosek, Howland, Hughes, and Foley, "Vulnerabilities for Abuse," 184-5; Cramer, Gilson, and DePoy, "Women with Disabilities," 183; Nosek, Howland, and Hughes, "Investigation of Abuse," 484. See also Chrystal Barranti and Francis Yuen, "Intimate Partner Violence and Women with Disabilities: Toward Bringing Visibility to an Unrecognized Population," *Journal of Social Work in Disability & Rehabilitation*, 7, no. 2 (2008): 115-130; Women with developmental disabilities have more difficulty than fully-abled women in getting out of abusive relationships and accessing services. See Bonnie Carlson, "Physical and emotional abuse in adults with mental retardation: Reports from victims and key informants" (Unpublished manuscript, University at Albany, SUNY, 1996).

²³ C. G. Tyiska, *Working with Victims of Crimes with Disabilities* (Washington DC: U.S. Dept. of Justice, 1998).

²⁴ Nosek, Howland, Hughes, and Foley, "Vulnerabilities for Abuse," 178, 186. See also Curry, Hassouneh-Phillips, and Johnston-Silverberg, "Abuse of Women," 70.

²⁵ Andrews and Veronen, "Sexual assault," 148; Barbara Waxman Fiduccia and Leslie R. Wolfe, *Violence against Disabled Women: Research & Data in Brief* (Washington, DC: Center for Women Policy Studies, 1999); Bonnie E. Carlson, "Mental Retardation and Domestic Violence: An Ecological Approach to Intervention," *Social Work* 42 (1997): 79-89; Cramer, Gilson, and DePoy, "Women with Disabilities," 186-7, 193.

²⁶ Andrews and Veronen referenced and discussed in Curry, Hassouneh-Phillips, and Johnston-Silverberg, "Abuse of Women," 72.

²⁷ Elliot, Galloway, and Cellarius, *Oregon Crime Victims*, 59.

²⁸ Young, Nosek, Howland, and Chanpong et al., "Prevalence of Abuse," 34-38; Swedlund and Nosek, "An Exploratory Study," 57; Hassouneh-Phillips and Curry, "Abuse of Women," 97; Nosek, Howland, Hughes, and Foley, "Vulnerabilities for Abuse," 179; Elliot, Galloway, and Cellarius, *Oregon Crime Victims*, 29.

²⁹ Chenoweth, "Violence against Women," 33-5.

³⁰ Barile, "Individual-Systemic Violence," 1-14.

³¹ Swedlund and Nosek, "An Exploratory Study," 57-8; Cramer, Gilson, and DePoy, "Women with Disabilities," 184; Nosek, Howland, and Hughes, "Investigation of Abuse," 478; Hassouneh-Phillips and Curry, "Abuse of Women," 103; Fiduccia and Wolfe, *Violence against Disabled Women*, 1.

³² Sally A. Lloyd and Beth C. Emery, "The Context and Dynamics of Intimate Aggression against Women," *Journal of Social and Personal Relationships* 17 (2000): 503-521.

³³ Lloyd and Emery, "Context and Dynamics," 510-13.

³⁴ Nosek, Howland, Hughes, and Foley, "Vulnerabilities for Abuse," 180, 186; Zweig, Schlichter, and Burt et al., "Assisting Women Victims," 162, 178.

³⁵ Elliot, Galloway, and Cellarius, *Oregon Crime Victims*, 47, 49.

³⁶ Zweig, Schlichter, and Burt et al., "Assisting Women Victims," 162-3, 169, 177. Zweig, Schlichter and Burt as well as Elliot, Galloway, and Cellarius concluded that this was particularly true for individuals with mental health disabilities. See *Oregon Crime Victims*, 49.

³⁷ Hassouneh-Phillips and Curry, "Abuse of Women," 101; See also J.C. Chang, S.L. Martin, and K.E. Moracco et al., "Helping Women With Disabilities and Domestic Violence: Strategies, Limitations, and Challenges of Domestic Violence Programs and Services" *Journal of Women's Health* 12 (2003): 699-708; Cramer, Gilson, and DePoy, "Women with Disabilities," 191-2; Nosek, Howland, and Hughes, "Investigation of Abuse," 478, 496; Lundy and Grossman, "Elder Abuse," 95.

³⁸ For example, fewer than 20% shelters in California were deemed accessible in accordance with basic standards of accessibility as defined by the ADA in a study reported by the California Women's Law Center discussed by Fiduccia and Wolfe, *Violence against Disabled Women*, 2.

³⁹ Cramer, Gilson, and DePoy, "Women with Disabilities," 187.

⁴⁰ Beverly L. Frantz, Allison C. Carey, and Diane Nelson Bryen, "Accessibility of Pennsylvania's Victim Assistance Programs," *Journal of Disability Policy Studies* 16 (2006): 209-219. "Most communities have extremely limited or non-existent options for victims of abuse who have a disability. Shelters are seldom physically accessible, are not set up to accommodate a caregiver, may not have physical space to accommodate adaptive equipment, and, even if physically accessible, may not be adaptational accessible," according to the National Coalition Against Domestic Violence, *Open Minds, Open Doors: Technical assistance manual assisting domestic violence service providers to become physically and attitudinally accessible to women with disabilities* (Denver, CO: 1996) quoted in Curry, Hassouneh-Phillips, and Johnston-Silverberg, "Abuse of Women," 72;

⁴¹ J. McFarlane, R.B. Hughes, and M.A. Nosek et al., "Abuse assessment screen-disability (AAS-D): Measuring frequency, type, and perpetrator of abuse towards women with physical disabilities." *Journal of Women's Health and Gender-Based Medicine* 10, no. 9 (2001): 861-866. The most commonly used screening instrument for abuse among general population is the Abuse Assessment Screen, which questions about physical and sexual abuse but not emotional or disability-specific abuse. See Nosek, Howland, and Hughes, "Investigation of Abuse," 486. Researchers emphasize the need for the development of more disability-specific screening tools and interventions particular to a woman's capabilities that teach women with disabilities how to recognize abuse, be safe, and leave abusive situations. See Nosek, Howland, Hughes, and Foley, "Vulnerabilities for Abuse," 177; Cramer, Gilson, and DePoy, "Women with Disabilities," 197.

⁴² As Frantz, Carey, and Bryen reported in their study of Pennsylvania service providers, the majority of domestic violence/sexual assault service providers train their staff on disability awareness. Staff ask clients about any needed accommodations on intake and provide TTY/relay systems for Deaf and hard of hearing clients. What were needed were materials in alternative formats, websites that were fully accessible, training on disability-specific issues for board members, and written policies and procedures for serving women with disabilities who become victims/survivors. Frantz, Carey, and Bryen, "Accessibility," 209-219. See also Cramer, Gilson, and DePoy, "Women with Disabilities," 187, who identify the following limitations on accessibility among their study population: materials not in alternative formats, no one available who knew ASL, no transportation support to get women with disabilities to the shelter, and no counseling appropriate for women with cognitive disabilities.

⁴³ Cramer, Gilson, and DePoy, "Women with Disabilities," 186; Zweig, Schlichter and Burt et al., "Assisting Women Victims," 165.

⁴⁴ Young, Nosek, Howland, and Chanpong et al., "Prevalence of Abuse," 34-38. Even if disability service providers say they wish to screen for such abuse, most have received no training to do so.

⁴⁵ "Strengths and Needs Assessment," 27-36.

⁴⁶ Barile, "Individual-Systemic Violence," 6-7; S.J. Schleen, P.A. Germ, and L.H. McAvoy, "Inclusive community leisure services: Recommended professional practices and barriers encountered," *Therapeutic Recreation Journal* 30, no. 4 (1996): 260 - 273.

⁴⁷ Elliot, Galloway, and Cellarius, *Oregon Crime Victims*, 7.

⁴⁸ L. Coleman, "Stigma: An enigma demystified," in *The Disability Studies Reader*, ed. L. Davis (New York: Routledge, 1997) 216-232; Nosek, Howland, Hughes, and Foley, "Vulnerabilities

for Abuse," 178; Sobsey, *Violence and Abuse*, 141, chap. 11; Elliot, Galloway, and Cellarius, *Oregon Crime Victims*, 46; "Strengths and Needs Assessment," 31-33.

⁴⁹ Hilary Brown and Council of Europe: Working Group on Violence Against, and Ill Treatment, as Well as Abuse of People with Disabilities, *Safeguarding Adults and Children with Disabilities* (France: Council of Europe, 2002); See also Cramer, Gilson, and DePoy, "Women with Disabilities," 193-5.

⁵⁰ Cramer, Gilson, and DePoy, "Women with Disabilities," 196. See also Hassouneh-Phillips and Curry, "Abuse of Women," 97, on shelters not admitting women with disabilities. Lesley Chenoweth has documented staff using stalling tactics when women with disabilities request services from domestic violence/sexual assault providers. "Violence Against Women," 32-3.

⁵¹ "Strengths and Needs Assessment," 33-34.

⁵² Such an approach is mirrored in Hassouneh-Phillips and Curry, "Abuse of Women," 102, and the discussion of the need for "universal screening for abuse during every client contact in rehabilitation, health-care and other professional settings" and "improvement of services for victims of abuse." Curry, Hassouneh-Phillips, and Johnston-Silverberg, "Abuse of Women," 76, also discuss the need for more qualitative research to include to include women with disabilities in the creation of service strategies and the need to coordinate services and disseminate information in ways women with disabilities can access. This research begins to fill these gaps.

⁵³ Much of the methodology conforms to research design recommendations made by Nosek, Howland, and Hughes, "Investigation of Abuse," 487. For a more complete description of methodology, participant recruitment, etc., see "Strengths and Needs Assessment," 10-16.

⁵⁴ As Martin, Ray, and Sotres-Alvarez et al. observed, not much research exists on the intersections of violence and disability in rural areas and among the poor. See Martin, Ray, and Sotres-Alvarez et al., "Physical and Sexual Assault," 835. Elliot, Galloway, and Cellarius, in their study of Oregon, suggested that in less populated areas, a consortium of service providers cooperate to meet needs, rather than having one institutional entity responsible, because over half of service provider respondents to their survey identified victims in rural areas as underserved. See *Oregon Crime Victims*, 7.

⁵⁵ "Strengths and Needs Assessment," 10-11.

⁵⁶ In two out of the three communities studied, domestic violence/sexual assault advocates specifically mentioned that they did not enjoy connections to the disability service providers with which they would be partnered on the IEAC initiative. "Strengths and Needs Assessment," 44.

⁵⁷ Although the extent of knowledge about local services varied from community to community and from woman to woman, every focus group participant with a disability knew of some local disability and domestic violence/sexual assault services. One participant had knowledge about a specific local service which the remaining women did not possess. During the focus groups, women with disabilities often exchanged information about available services within their communities, thus educating one another. "Strengths and Needs Assessment," 19.

⁵⁸ This reflects the "Nothing about us, without us" philosophy which is common within many sectors of the disability rights movement, as well as other movements for social justice for historically marginalized groups. It articulates that no policy or program should be developed and implemented without the participation and consent of the group(s) impacted by that initiative.

⁵⁹ This proved true among among the three organizations collaborating as the Idaho Equal Access Collaborative as well as the among the disability and domestic violence/sexual assault service providers in each of the three communities studied.

⁶⁰ Zweig, Schlichter, and Burt et al., "Assisting Women Victims," 174, discuss the importance of "*facilitating* [my emphasis] the sharing of information, referrals and resources among domestic violence/sexual assault and disability service providers" but without a discussion of the facilitation process. Facilitation does not occur on its own, and I contend that the manner in which facilitation occurs impacts the likelihood of collaboration success.

⁶¹ Zweig, Schlichter and Burt, et al., "Assisting Women Victims," 176.

⁶² For example, in the current study, misunderstandings about the services each type of service provider offered were common, resulting in a variety of inter-agency misperceptions that hindered multi-agency cooperation. One disability advocate, for example, regretted that shelters were not more proactive, not understanding that this is not a shelter's role. Another

staff member worried that if she referred a client to a shelter that the shelter staff would simply put the client in a nursing home because they lack the funds needed to provide accommodations that a woman with a disability might require. Finally, it was unclear if disability advocates understood that domestic violence/sexual assault staff are limited in what they can ask clients relating to disability. A client with a disability must disclose and/or request accommodations before a shelter or other service provider begin to meet a woman with a disability's needs. "Strengths and Needs Assessment," 25.

⁶³ As no universally accepted definitions of terms such as domestic violence, abuse and disability exist, useful discussions of terminology on these issues can be found in Curry, Hassouneh-Phillips, and Johnston-Silverberg, "Abuse of Women," 62, 66, and Nosek, Howland, and Hughes, "Investigation of Abuse," 484.

⁶⁴ Similar to second-wave and multi-racial feminist analyses, Feminist Disability Studies interprets disability as a cultural rather than an individual or medical issue and insists on examining power relations rather than assigning deviance when analyzing cultural representations of oppressed groups. See Garland-Thomson, "Feminist Disability Studies," as well as Judith Lorber, "The Social Construction of Gender," in *Reconstructing Gender: A Multicultural Anthology*, 3rd ed., ed. Estelle Disch (Boston: McGraw Hill, 2003) 96-102, and Maxine Baca Zinn and Bonnie Thornton Dill, "Theorizing Difference from Multiracial Feminism," in Disch, *Reconstructing Gender*, 81-90.

⁶⁵ Antonio Gramsci, *Prison notebooks*, ed. Joseph A. Buttigieg (New York: Columbia University Press, 1992), 233-238. See also Cherríe Moraga, "La Güera," in Disch, *Reconstructing Gender*, 593-600.

⁶⁶ For example, according to Garland-Thomson, "Feminist Disability Studies," 8, the cadre of adjectives such as "helpless," "dependent," "ungovernable," and "weak" currently stigmatizing individuals with disabilities sound strikingly similar to the descriptive terms used to justify the denial of rights to women.

⁶⁷ "Strength and Needs Assessment," 16, 21-27.

⁶⁸ See fn 22. Many states and countries have no system in place for registering and monitoring caregivers. See Curry, Hassouneh-Phillips, and Johnston-Silverberg, "Abuse of Women," 71; Sobsey, *Violence and Abuse*, 249-50.

⁶⁹ "Strengths and Needs Assessment," 23-27; Swedlund and Nosek, "An Exploratory Study," 57, and Zweig, Schlichter, and Burt et al., "Assisting Women Victims," 162, 168, emphasized the need for training on disability-specific issues for staff who intervene in abuse situations or provide related services.

⁷⁰ Advocates should tread lightly when working with service providers from other disciplines to minimize possible alienation. Zweig, Schlichter and Burt et al., "Assisting Women Victims," 177.

⁷¹ "Strengths and Needs Assessment," 60.

⁷² Zweig, Schlichter and Burt et al., "Assisting Women Victims," 172.

⁷³ The need for such broad community education programs on such issues was corroborated by Zweig, Schlichter and Burt et al., "Assisting Women Victims," 171.

⁷⁴ Many churches, such as the LDS (Mormon) Church in one community studied, are strong influences and often provide social support services and resources that are unavailable elsewhere in their areas. Religious and secular social service organizations often work in isolation from one another but might explore multi-agency collaborations with greater frequency.

⁷⁵ Such a need is corroborated in Sobsey's recommendations to educate individuals with disabilities about inappropriate behaviors, sex education, and personal safety. Sobsey, *Violence and Abuse*, chap. 7.

⁷⁶ "Strengths and Needs Assessment," 36-40.

⁷⁷ Curry, Hassouneh-Phillips, and Johnston-Silverberg, "Abuse of Women," 76. Providers should empower individuals with disabilities to make their own choices and take appropriate risks. Discrimination and stigma contribute to increased risk of abuse. See Brown and Council of Europe, *Safeguarding Adults*.

⁷⁸ "Strengths and Needs Assessment," 20-1. Interestingly, focus group participants discouraged service providers from viewing the Internet as a major resource for this type of information by individuals with disabilities, since many people with disabilities lack regular access to computers. Zweig, Schlichter and Burt et al., "Assisting Women Victims," 171, also identified the need for a better synchronized information and referral system and suggested

flyers, posters, PSAs, TV, and newspaper announcements but did not recommend locations where individuals with disabilities were likely to encounter such information, as this research did.

⁷⁹ "Strengths and Needs Assessment," 34-6.