

Two Paths - One Journey



Ending oppression. . . one accessible step at a time.

"If you have come to help me, please go home. But if you have come because your liberation is somehow bound with mine, then we may work together."

– Australian Aboriginal Woman

Kansas Association of Centers for Independent Living



Kansas Coalition Against Sexual and Domestic Violence



UNITED AGAINST VIOLENCE

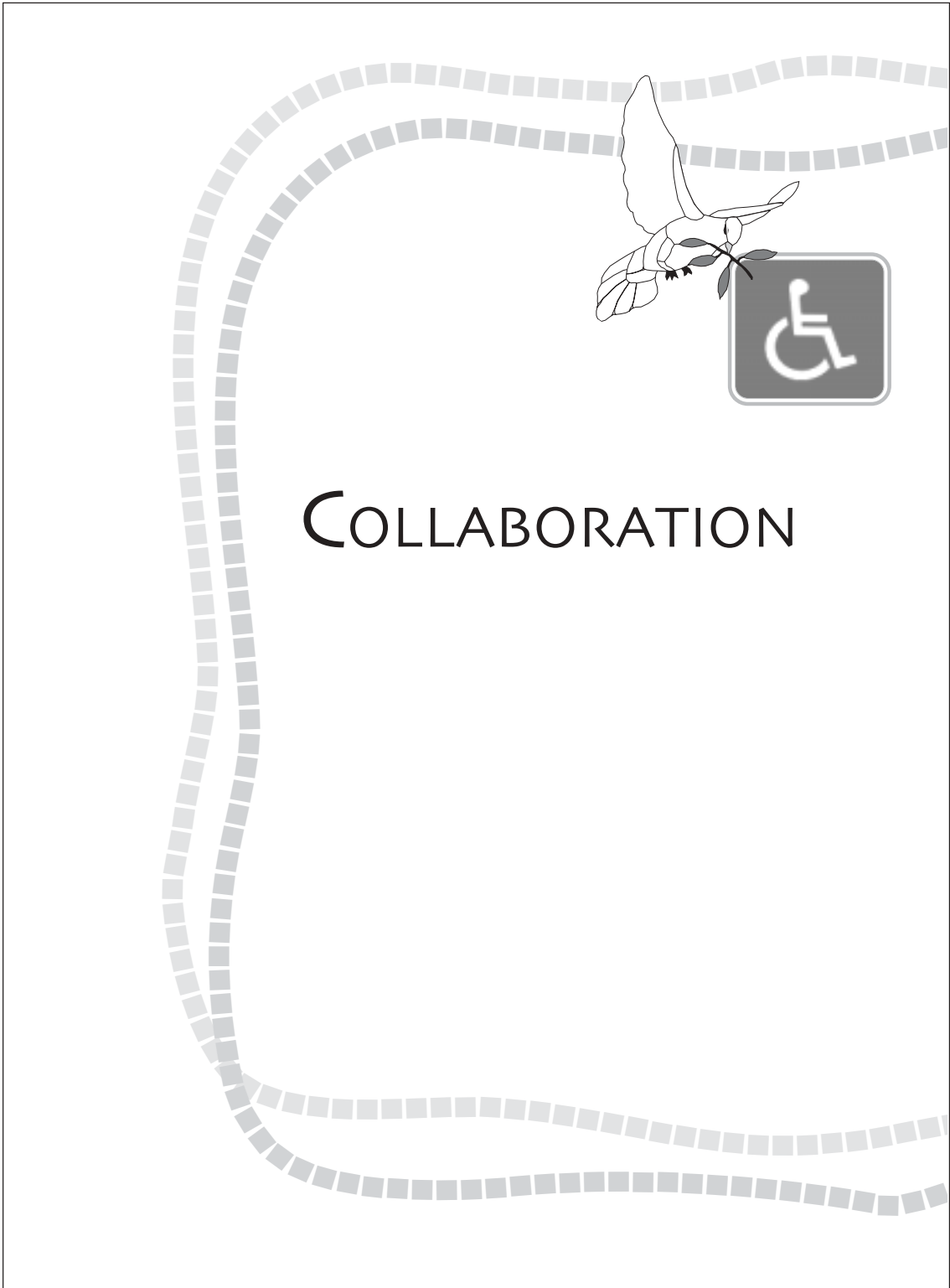
TABLE OF CONTENTS

COLLABORATION	4
KACIL & KCSDV	5
Collaboration Plan	5
Putting it on Paper - Collaboration Agreement	7
SEXUAL VIOLENCE	9
Facts About Sexual Violence	10
The Offender	10
Sexual Violence has Serious Consequences	10
DOMESTIC VIOLENCE	12
Facts about Domestic Violence	13
Power and Control	13
Power and Control Wheel	14
DISABILITIES	17
Disability Labels	18
Syndromes Associated With Victimization	19
Communication	22
ABUSE OF PEOPLE WITH DISABILITIES	24
Statistics	25
Barriers Faced by People with Disabilities	26
Disabilities Power and Control Wheel	27
Barriers to Escaping or Reporting Abuse	29
SAFETY PLANNING	30
Points to Remember for the Disability Advocate	31
Survivor Safety Plan Form	32
Points to Remember for the Domestic Violence Advocate	33
REFERENCES	34
HIGHLIGHTS OF CIL AND DV/SA MOVEMENTS	37
HISTORY OF INDEPENDENT LIVING	40
ADVOCACY ON BEHALF OF BATTERED WOMEN	48
RESOURCES	64
Disability and Domestic and Sexual Violence Resources	65
Attachment A - Kansas Centers for Independent Living	68
Attachment B - Kansas Domestic Violence and Sexual Assault Services	70
Attachment C - SRS Contact Information	72

INTRODUCTION

In 1999, the Kansas Department of Health and Environment (KDHE) surveyed persons with disabilities and parents of children with disabilities to determine the major health risks affecting their lives. The survey identified violence in the lives of people with disabilities as a significant issue in Kansas. As a result, KDHE formed the Violence Against Women with Disabilities Steering Committee. The committee's task is to encourage collaboration among statewide organizations to improve services to people with disabilities who are experiencing domestic or sexual violence. The Kansas Coalition Against Sexual and Domestic Violence (KCSDV), KDHE, Kansas Association of Centers for Independent Living (KACIL), and Washburn University's Joint Center of Violence and Victim Studies (JCVVS) received the Violence Against Women's Office 2002 Education and Training Grant to End Violence Against Women with Disabilities. Together, the grant partners provide training, technical assistance and on-going support to six communities.

This project is supported by Grant No. 2002-FW-BX-0013 awarded by the Violence Against Women Office, Office of Justice Programs, and U.S. Department of Justice. Points of view in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.



COLLABORATION

The Kansas Association of Centers for Independent Living, KACIL, and the Kansas Coalition Against Sexual and Domestic Violence, KCSDV, and their member programs share a common philosophical belief that each individual is entitled to dignity, worth, and the right to a self-directed life. Independent living advocates believe that people with disabilities should have the same civil rights, options, and control over choices in their lives as do people without disabilities. Domestic violence and sexual assault advocates believe in the right of battered women to make decisions for themselves and in the right of all persons to live without fear, sexual, emotional, or physical abuse, or oppression. KCSDV and KACIL, and their member programs, promote advocacy, education /awareness, support services, and system change.

While domestic and sexual assault advocates and disability rights advocates share a lot of common philosophical ground, there are areas where both groups will need to negotiate and work for better understanding of each others roles in service provision. The following are questions and barriers to collaboration advocates should explore at the start of a collaborative process:

Define goals and objectives:

- What tools do we have and what do we need?
- What population will the project serve?
- Who are the providers of the population?
- What are the geographic areas?
- What are the expected outcomes from the project?

Define a plan of action:

- What is the issue?
- What is the population and geographic area?
- What would it look like if it were resolved?
- What are the barriers?
- How will it be documented?
- What needs to happen and who will do it?
- What achievements will be immediate? Long-term?
- How will you know it has been accomplished?

Identify and work through possible barriers to collaboration:

- Confidentiality
Concern for secrecy of shelter regarding personal assistants.
- Guardianship
Confusion about the function and limits of a guardianship.
Fear that disclosure of domestic violence will trigger guardianship actions.
- Mandatory reporting
Who is mandated to report and what are the possible consequences of reporting?
Will the consumer be informed that a referral could mean a report?



- Access to medications
In shelter, how can medications be accessible to resident and safely locked away from children?
- Personal attendants at shelter
Concerns about confidentiality and emergency availability.
- Money for accessibility changes
Shelters are often housed in old, inaccessible buildings with significant expense involved to make them accessible.
- Fear of failing to meet standards
Concern about litigation if unable to find resources to meet ADA standards.
- Reluctance to screen for abuse
Violence not seen as a primary focus of disability work.
Fear of mandatory reporting that could result in unwarranted guardianship.
- Blaming the victim attitude
This reflects our general societal attitude.
- Discomfort working with people with disabilities
Because of the historical isolation of people with disabilities, there is a lack of education and exposure.
- Scarcity of resources: time and money
Agencies are short-staffed and operate on shoestring funding.
- Crisis mentality
Staff and financial resources are already strained to meet crisis needs, leaving few resources available to plan for future possible needs.
- Transportation
Creative solutions needed to defray cost or lack of availability of accessible transportation.



Putting it on Paper

After advocates work through questions and barriers to collaboration, a written interagency agreement can help clarify and formalize the mutual expectations. The following is an example:

Collaboration Agreement

Our agencies hold the following in common:

- Commitment to honoring the dignity and worth of the individual.
- Belief in the consumer/survivor right to self-determination.
- Belief in the right of people to live safely in their chosen environment.
- Belief that confidentiality is critical to the services and advocacy we provide and is a fundamental underpinning both of consumer/survivor safety and the integrity/efficacy of our services.

The goal of our collaboration is to maximize our resources to:

- Enhance safety
- Enhance quality of services/support rendered
- Educate the public and train the professionals
- Reach out to consumer/survivors in our community

Interagency Communication

No consumer/survivor situation will be discussed without the permission (release of information) of the consumer/survivor. The released information will not be shared with other staff members except on a “need to know” basis. The release of information will contain the names of all persons with whom this information will be shared.

Confidentiality

Confidential communications are accorded to any survivor /consumer who seeks our assistance. It is our agency’s policy to hold confidential all communications, observations and information made by, between, or about survivors/consumers.

Self-Determination

We will make every effort to refer consumers/survivors to all out-of -agency providers of services requested for full and informed choice. We recognize the right of consumers to choose from where they receive community services.

Clarity of Service Possibilities

A comprehensive list of services offered by my agency will be made available to my collaborative partner. Updates will be made as needed.

Personal Assistant Abuse

Abuse by a personal assistant who is not related or in an intimate relationship with the consumer/survivor will/will not (circle one) be considered domestic violence for the purpose of entitlement to domestic violence or sexual assault program services.



Awareness Materials

My agency will display the outreach materials of my collaborative partner where they can be seen by consumers/survivors. My agency staff will be prepared to discuss the services offered by my collaborative partner.

Mandated Reporters

Staff referring from the collaborative agency will be informed if they are talking to a person mandated to report abuse to Adult Protective Services.

Consumer/Survivor Safety

All collaborations will be done with the primacy of survivor/consumer safety in mind.

Data Collection

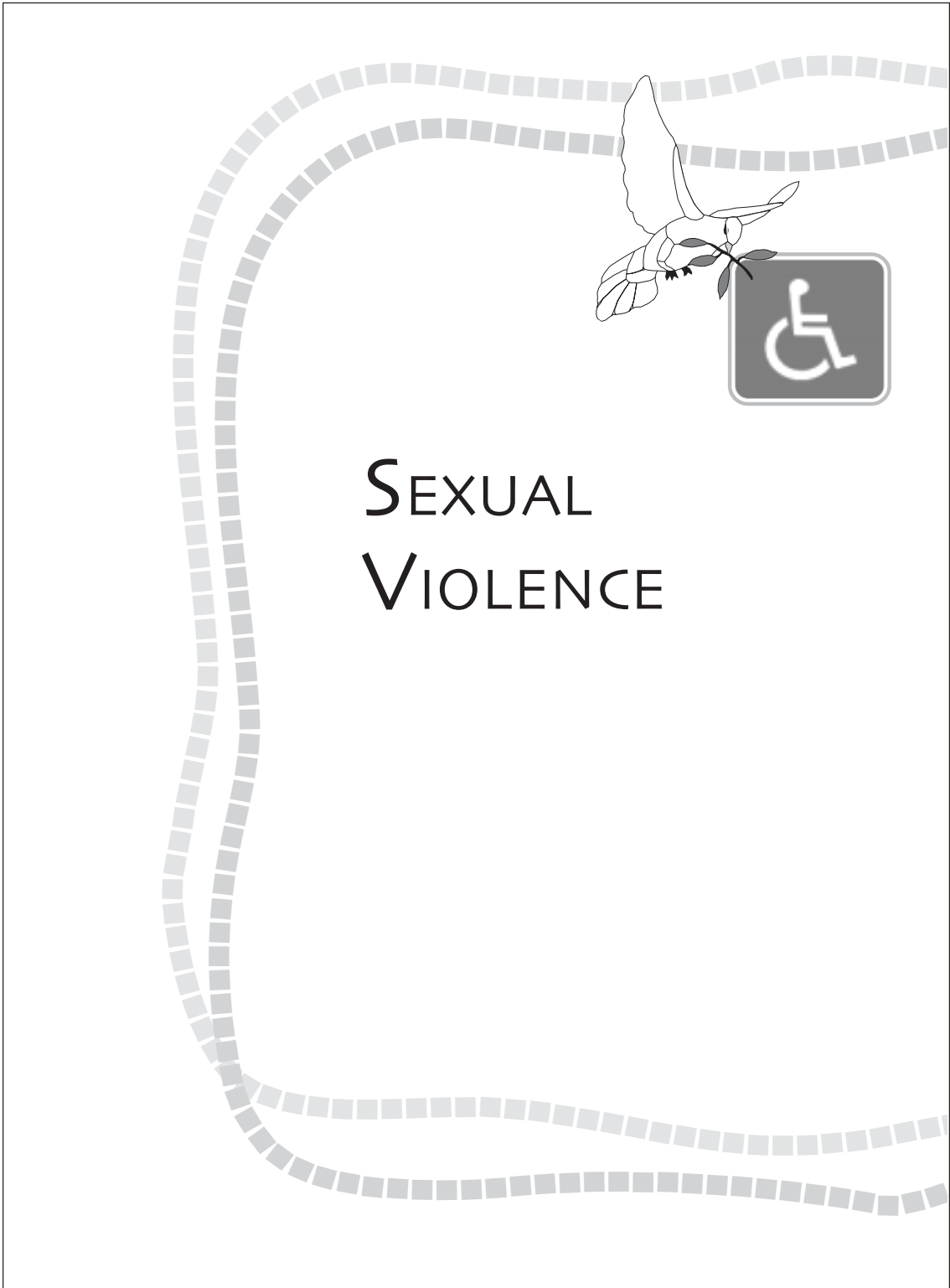
Statistics will be collected when possible to show the need to fund services for people with disabilities who are survivors.

Joint meetings

Staff from my agency will commit to meet (fill in the blank with the number of agreed upon meetings) _____ with my collaborative partner.

Cross training

My agency will offer, and in turn be willing to receive, training to and from the staff of my collaborative partner agency once every (fill in the blank with the number of agreed upon trainings) _____.



SEXUAL VIOLENCE

Sexual Assault is any type of sexual activity to which a person has not freely consented. It ranges from inappropriate touching to penetration or intercourse. It also can be verbal, visual, audio, or any other form which forces a person to participate in unwanted sexual contact or attention. Sexual assault includes rape and attempted rape, child molestation, voyeurism, exhibitionism, incest, and sexual harassment. It can happen in different situations, such as date rape, personal assistant or domestic or intimate partner violence, or by a stranger.

Facts about sexual violence

- Sexual assault is the violent crime least often reported to law enforcement.
- Rape is a crime and an act of violence where sex is the weapon of choice.
- Rapists are motivated by the desire to dominate and control another person.
- Offenders are usually people known to the survivor: too often the offenders are fathers, brothers, male relatives, boyfriends, husbands, and caretakers.
- Most acquaintance rapes occur within the survivor's home.
- Rape occurs within domestic violence relationships as a form of power and control.

The offender

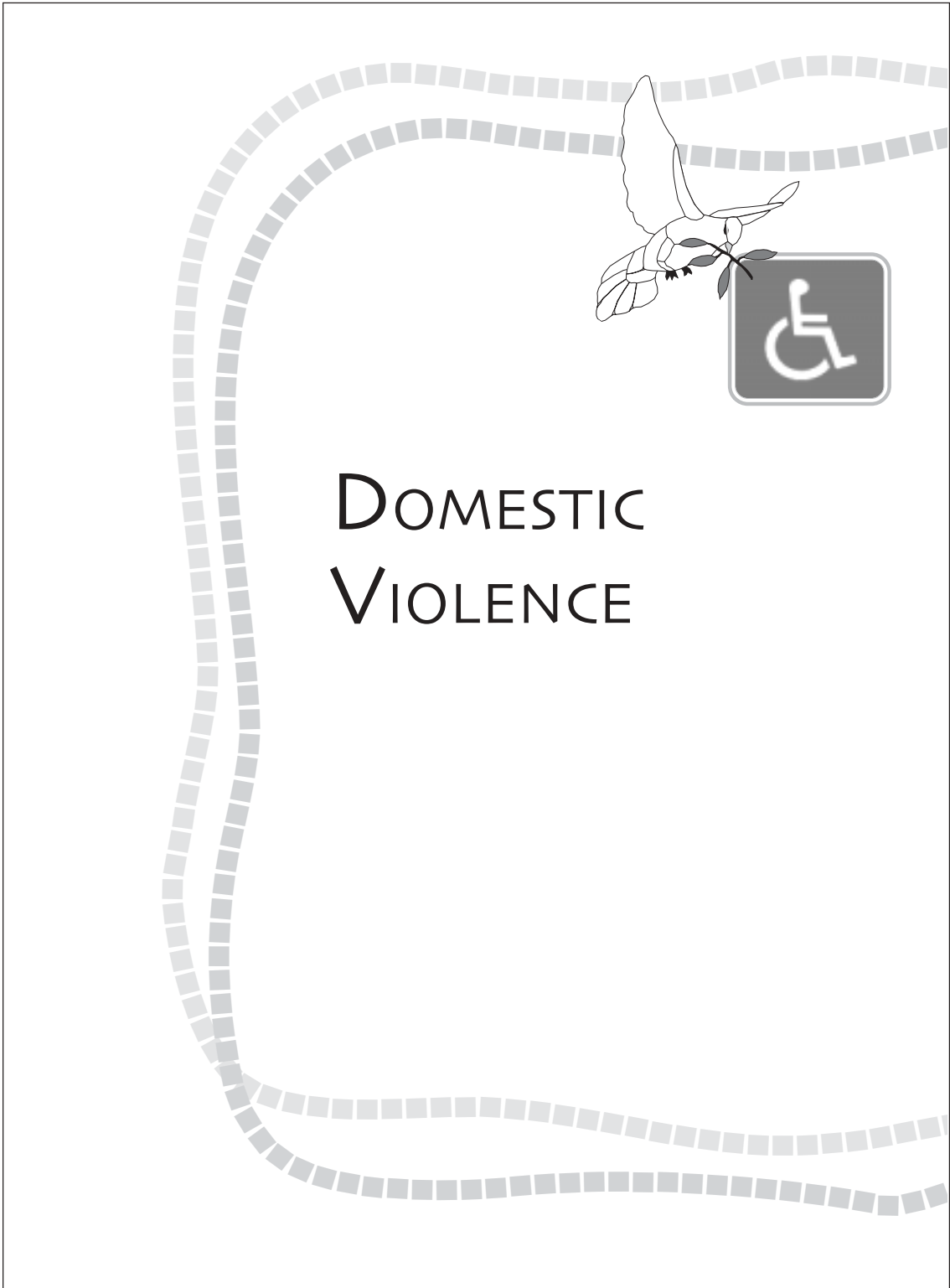
- Sex offenders are overwhelmingly male.
- Sex offenders usually have access to consensual sex.
- Sex offenders are not typically mentally ill.
- Most sex offenders start as juveniles.
- Most sex offenders were not sexually or physically abused as children.

Sexual violence has serious consequences

- Physical Injury / Disability
Many long-lasting physical symptoms and illnesses have been associated with sexual victimization including chronic pelvic pain; premenstrual syndrome; gastrointestinal disorders; and a variety of chronic pain disorders, including headache, back pain, and facial pain.
- Sexually Transmitted Disease
Between 4% and 30% of rape victims contract sexually transmitted diseases.¹
- Pregnancy
A longitudinal study in the United States estimated that over 32,000 pregnancies result each year from rape in victims aged 12 to 45 years old.²
- General Health Risks & Psychological Impact
Nearly one-third of all rape survivors develop rape-related post-traumatic stress disorder at some time during their lifetimes: sleeping and eating disorder, nervousness, fatigue, withdrawal from society and distrust of others. Rape victims are 4.1 times more likely than non-crime victims to contemplate suicide.³



- **Sexual Dysfunction**
Sexually abused women have more sexual dysfunction than those who have not experienced sexual abuse.⁴
- **Community Safety**
Community safety is impacted by a lack of institutional support from the police and judicial systems, general tolerance of sexual assault within the community, and weak community sanctions against perpetrators of sexual violence.
- **Monetary Costs**
The National Institute of Justice estimates that rape and other sexual assaults of adults cause an annual minimum loss of \$127 billion, or about \$508 per U.S. resident.⁵
- **Overall Societal Impact**
A culture of societal norms that support sexual violence, male superiority, and sexual entitlement as well as weak laws and policies related to gender equity and high levels of crime and other forms of violence.





DOMESTIC VIOLENCE

Domestic Violence is a pattern of abusive and coercive behavior used to gain power and control over an intimate partner, former partner, or family member.

Domestic violence robs victims of their fundamental right to maintain control over their own lives. Individuals who are abused live in fear and isolation in the one place they should always feel safe, their home. With tremendous courage and strength, they struggle each day to keep themselves and their children safe.

Facts about Domestic Violence

- The abuser does not “lose control”. Abusers can stop the abuse when there is a knock on the door or when the phone rings. Abusers often direct punches and kicks to parts of the body where bruises will not show, thereby indicating control over his behavior.
- Abusive and controlling tactics used by abusers are not about poor anger management. Anger and intimidation are tools abusers use to get what they want.
- Alcohol and drugs do not cause domestic violence. Domestic violence is a choice. Many abusers will make sure they have alcohol or drugs on hand, in order to use them as an excuse for their actions.

Power & Control

Physical and sexual assaults, or threats to commit them, are the most apparent forms of domestic violence and are usually the actions that allow others to become aware of the problem. However, regular use of other abusive behaviors by the batterer, when reinforced by one or more acts of physical violence, makes up a larger system of abuse. Although physical assaults may occur only once or occasionally, they instill a threat of future violent attacks and allow the abuser to take control of the woman’s life and circumstances.

POWER AND CONTROL WHEEL



Figure 1

Wheel developed by Domestic Violence Intervention Project, Duluth, MN

Provided by KCSDV, 220 SW 33rd Street, Topeka, KS. 66603
785-232-9784, Fax 785-266-1874, www.kcsdv.org

For accessibility purposes a text version of the power and control wheel will follow each figure.

Figure 1

POWER AND CONTROL

The Power and Control model is a helpful tool in understanding the overall pattern of abusive and violent behaviors, which are used by a batterer to establish and maintain control over his partner. Very often, one or more violent incidents are accompanied by an array of these other types of abuse. They are less easily identified, yet firmly establish a pattern of intimidation and control in the relationship.

At the top and bottom arch of the wheel the words; physical violence sexual, are displayed in a wide darkened circle.

The wheel is cut into eight spokes. The words power and control are at the center of the wheel. Each spoke represents a type of abuse that is used. The following is the description of each spoke beginning at the top moving right of the center:

USING INTIMIDATION:

- making her afraid by using looks, actions, gestures
- smashing things
- destroying her property
- abusing pets
- displaying weapons

USING EMOTIONAL ABUSE:

- putting her down
- calling her names
- making her think she's crazy
- playing mind games
- humiliating her
- making her feel bad about herself
- making her feel guilty

USING ISOLATION:

- controlling what she does, who she sees and talks to, what she reads, where she goes
- limiting her outside involvement
- using jealousy to justify actions

MINIMIZING, DENYING, AND BLAMING:

- making light of the abuse and not taking her concerns about it seriously
- saying the abuse didn't happen
- shifting responsibility for abusive behavior
- saying she caused it



USING CHILDREN:

- making her feel guilty about the children
- using the children to relay messages
- using visitation to harass her
- threatening to take the children away

USING MALE PRIVILEGE:

- treating her like a servant
- making all the big decisions
- acting like the "master of the castle"
- being the one to define men's and women's roles

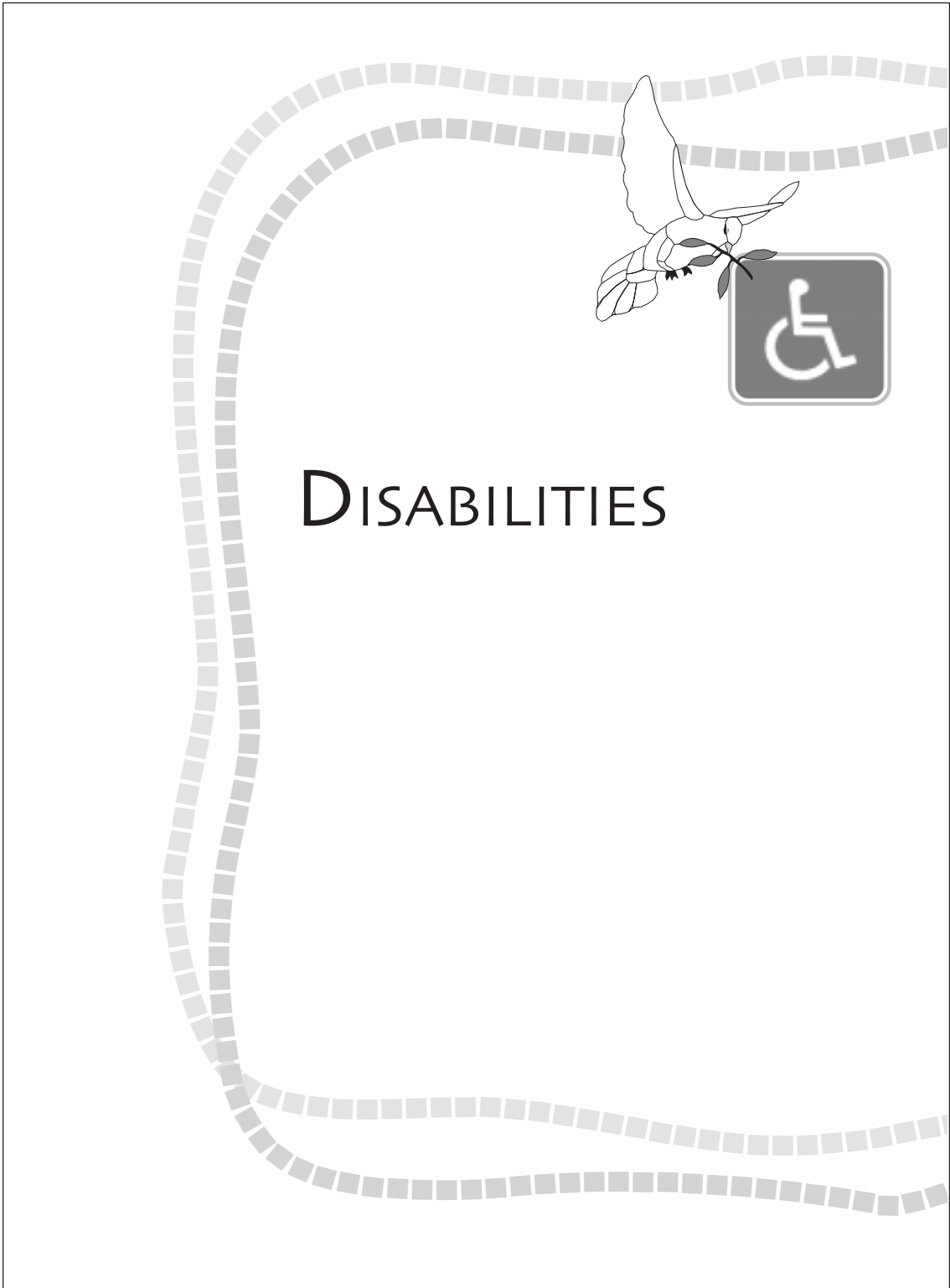
USING ECONOMIC ABUSE:

- preventing her from getting or keeping a job
- making her ask for money
- giving her an allowance
- taking her money
- not letting her know about or have access to family income

USING COERCION AND THREATS:

- making and/or carrying out threats to do something to hurt her
- threatening to leave her, to commit suicide, to report her to welfare
- making her drop charges
- making her do illegal things

Wheel developed by Domestic Violence Intervention Project, Duluth, MN.
Provided by KCSDV, 220 SW 33rd Street, Topeka, KS. 66603.
785-232-9784, Fax 785-266-1874, www.kcsdv.org





DISABILITIES

People with disability labels constitute our nation's largest minority group. This group is simultaneously inclusive and diverse: all ages, all religions, all socioeconomic levels, every ethnicity, and any sexual orientation and both genders are represented. Yet people who have been labeled disabled are all different from one another. The only thing these individuals truly have in common with one another is dealing with societal misunderstanding, prejudice, and discrimination. Additionally, this largest minority group is the only one that any person can join, at any time. Some join at birth. Others join in the split second of an accident, through illness, or by the aging process.

Disability Labels

To be considered disabled under the ADA a person must have a physical or mental impairment that substantially limits a major life activity, has a record of such an impairment or is regarded as having such an impairment.

Disability category labels can be useful to communicate with other professionals and to determine service eligibility for persons with a disability. Categories of disabilities include visual, physical, hearing/auditory, specific learning, speech, mobility and dexterity. Other disabilities include but are limited to mental, psychological or personality disorders, cardiovascular and circulatory conditions, blood serum disorders, respiratory disorders, attention deficit hyperactivity disorder as well as other chronic health conditions.

Every person, with or without a disability, who is seeking advocacy services, has a unique set of strengths, challenges, attitudes, life experiences and access to resources. The only way to know how to offer the best assistance possible is to ask the person what is needed.



SYNDROMES ASSOCIATED WITH VICTIMIZATION

An abused individual is at increased risk for brain injury, depression and acute stress reactions/ post-traumatic stress disorder. Advocates with some knowledge about the signs and symptoms of these painful conditions can use that information when deciding whether to offer mental or physical health referrals.

BRAIN INJURY

"Mild" brain injury occurs when the head impacts an object or undergoes the acceleration/deceleration movement (i.e., whiplash) without direct external trauma to the head. Persons may lose consciousness for less than twenty minutes or not at all.

Mild brain injury can result in a constellation of symptoms that has been referred to as post-concussion syndrome and post-traumatic syndrome. These symptoms include: feeling dazed, disoriented and confused, nausea, vomiting, dizziness, headache, blurred vision, sleep disturbance, fatigue, sensitivity to light/sound; difficulty with attention and concentration, memory, judgment and problem-solving, speech/language; irritability, low frustration tolerance, anger, mood swings, and depression.

A traumatic brain injury occurs when the skull slams against a stationary object, such as a windshield or the ground. Damage results from the rapid acceleration/deceleration of the brain when it is slammed back and forth against the structures inside the skull. When this happens, the neural connections that transmit and receive messages between the brain and other parts of the body are twisted, sheared, and pulled apart. An acquired brain injury can also result from lack of oxygen to the brain (anoxia), as in near drowning or suffocating, cardiac arrest, stroke, or strangulation.

Brain injury can be difficult to detect; x-rays, MRI (magnetic resonance imaging) and CT (CAT scan) may appear unremarkable or normal. Brain injuries may remain undiagnosed, or may be misdiagnosed as other conditions such as psychiatric disorders.

Some Possible Consequences of Brain Injury

Through inner strength, rehabilitation, and support from family members and the community, people with brain injuries continue to lead fulfilling and productive lives. Brain injury, even "mild" brain injury, can result in alterations in all aspects of a person's functioning: physical, emotional, psychological, spiritual, financial, interpersonal and vocational.

Among the more prominent consequences:

Physical: difficulties with speech, vision, hearing, eating, swallowing, mobility and gait (walking); headaches, seizures, sensitivity to light and noise; taste changes; paralysis.

Cognitive: disorientation to time and place; difficulties with memory, concentration, judgment, problem-solving, perception; problems with reading, writing, planning, shifting from one task to another, knowing the order of the steps to complete a task (i.e. sequencing).

Psychosocial: Depression; anxiety; frustration; anger; egocentricity seen through insensitivity to others; low self-esteem; acts out socially; inappropriate limitations, and engaging in self-destructive behaviors such as stealing, promiscuity, gambling, spending sprees. ⁶

DEPRESSION

Depression is a "whole-body" illness, involving your body, mood, and thoughts. It affects the way you eat and sleep, the way you feel about yourself, and the way you think about things. A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years. Symptoms of depression may vary from person to person, and also depend on the severity of the depression. Depression causes changes in thinking, feeling, behavior, and physical well-being.

Changes in Thinking: Problems with concentration and decision-making. Some people report difficulty with short-term memory, forgetting things all the time. Negative thoughts and thinking are characteristic of depression. Pessimism, poor self-esteem, excessive guilt, and self-criticism are all common. Some people have self-destructive thoughts during a more serious depression.

Changes in Feelings: Feelings of sadness for no reason at all. Some people report that they no longer enjoy activities that they once found pleasurable. They might lack motivation and become more apathetic. Feeling "slowed down" and tired all the time. Sometimes irritability is a problem, and some people have more difficulty controlling their temper. In the extreme, depression is characterized by feelings of helplessness and hopelessness.

Changes in Behavior: Changes in behavior during depression are reflective of the negative emotions being experienced. Some people act more apathetic, because that's how they feel. Some people do not feel comfortable with others, so social withdrawal is common. People may experience a dramatic change in appetite, either eating more or less. Because of the chronic sadness, excessive crying is common. Some people complain about everything and act out their anger with temper outbursts. Sexual desire may disappear, resulting in lack of sexual activity. In the extreme, people may neglect their personal appearance, even neglecting basic hygiene. Needless to say, someone who is this depressed does not do very much, so work productivity and household responsibilities suffer. Some people even have trouble getting out of bed.

Changes in Physical Well-being: Chronic fatigue, despite spending more time sleeping, is common. Some people can't sleep or don't sleep soundly. These individuals lay awake for hours, or awaken many times during the night and stare at the ceiling. Others sleep many hours, even most of the day, although they still feel tired. Many people lose their appetite, feel slowed down by depression, and complain of many aches and pains. Others are restless and can't sit still. ⁷

ACUTE STRESS DISORDER (ASD)
POST-TRAUMATIC STRESS DISORDER (PTSD)

ASD is a transient disorder of significant severity that develops in an individual in response to exceptional physical and/or mental stress. It usually subsides within hours or days. Acute Stress Reaction occurs in the first month following a traumatic event. If it persists beyond a month, the person may be experiencing PTSD.

Signs of PTSD may include the following:

Intrusion: Re-living the event through recurring nightmares or other intrusive images that occur at any time. People who suffer from PTSD also have extreme emotional or physical reactions such as chills, heart palpitations or panic when faced with reminders of the event.

"Flashbacks" may be so strong that individuals almost feel like they are actually experiencing the trauma again or seeing it unfold before their eyes and in nightmares.

Avoidance: Avoiding reminders of the event, including places, people, thoughts or other activities associated with the trauma. PTSD sufferers may feel emotionally detached, withdraw from friends and family, and lose interest in everyday activities. Avoidance symptoms affect relationships with others: the person often avoids close emotional ties with family, colleagues, and friends. At first, the person feels numb, has diminished emotions, and can complete only routine, mechanical activities.

Hyperarousal: Being on guard or being hyper-aroused at all times, including feeling irritability or sudden anger, having difficulty sleeping or concentrating, or being overly alert or easily startled. PTSD can cause those who have it to act as if they are constantly threatened by the trauma that caused their illness. They can become suddenly irritable or explosive, even when they are not provoked. They may have trouble concentrating or remembering current information, and, because of their terrifying nightmares, they may develop insomnia. This constant feeling that danger is near causes exaggerated startle reactions.

Clusters: Many people with PTSD attempt to blunt their pain and temporarily forget the trauma by abusing alcohol or other drugs as a "self-medication". As a result, a person with PTSD may show poor control over his or her impulses and may be at risk for suicide.

Consider referring survivors to a mental health provider for an assessment for PTSD if the person you are working with has experienced a traumatic event and reports experiencing a number of the following:

- Has recurring thoughts or nightmares
- Has trouble sleeping or changes in appetite
- Experiences anxiety and fear
- Is on edge, easily startled or overly alert
- Feels depressed, sad, low energy
- Has memory problems

- Feels "scattered" and unable to focus on work or daily activities
- Has difficulty making decisions
- Feels irritable, angry and resentful
- Feels emotionally numb, disconnected, or different from others
- Spontaneously experiences crying, sense of despair and hopelessness
- Feels extremely protective of, or fearful for, the safety of loved ones
- Avoids activities, places, or even people related to trauma ⁸

COMMUNICATION

Language shapes our perception of reality. Language can be used to hurt, to console, to degrade, to heal. When we communicate we have a responsibility to use language that respects the dignity of all individuals. You should use words that put the person first, rather than the disability. If you're not sure how to refer to a person with a disability, ask them.

People First Language

Using people first language will become a habit if you practice people first thinking. Think, "People first." Say "a woman who is blind" rather than "a blind woman."

Examples of Language to avoid	Examples of People First Language
Disabled person	Person with a disability
Defective child	Child with a disability
Disabled victim	Woman who has a disability and has experienced domestic violence or sexual assault
Chronic mental illness	Woman with symptoms of mental illness
Confined to a wheelchair	Person who uses a wheelchair
Cripple	Person with a limp
Client	Woman, survivor, or her given name

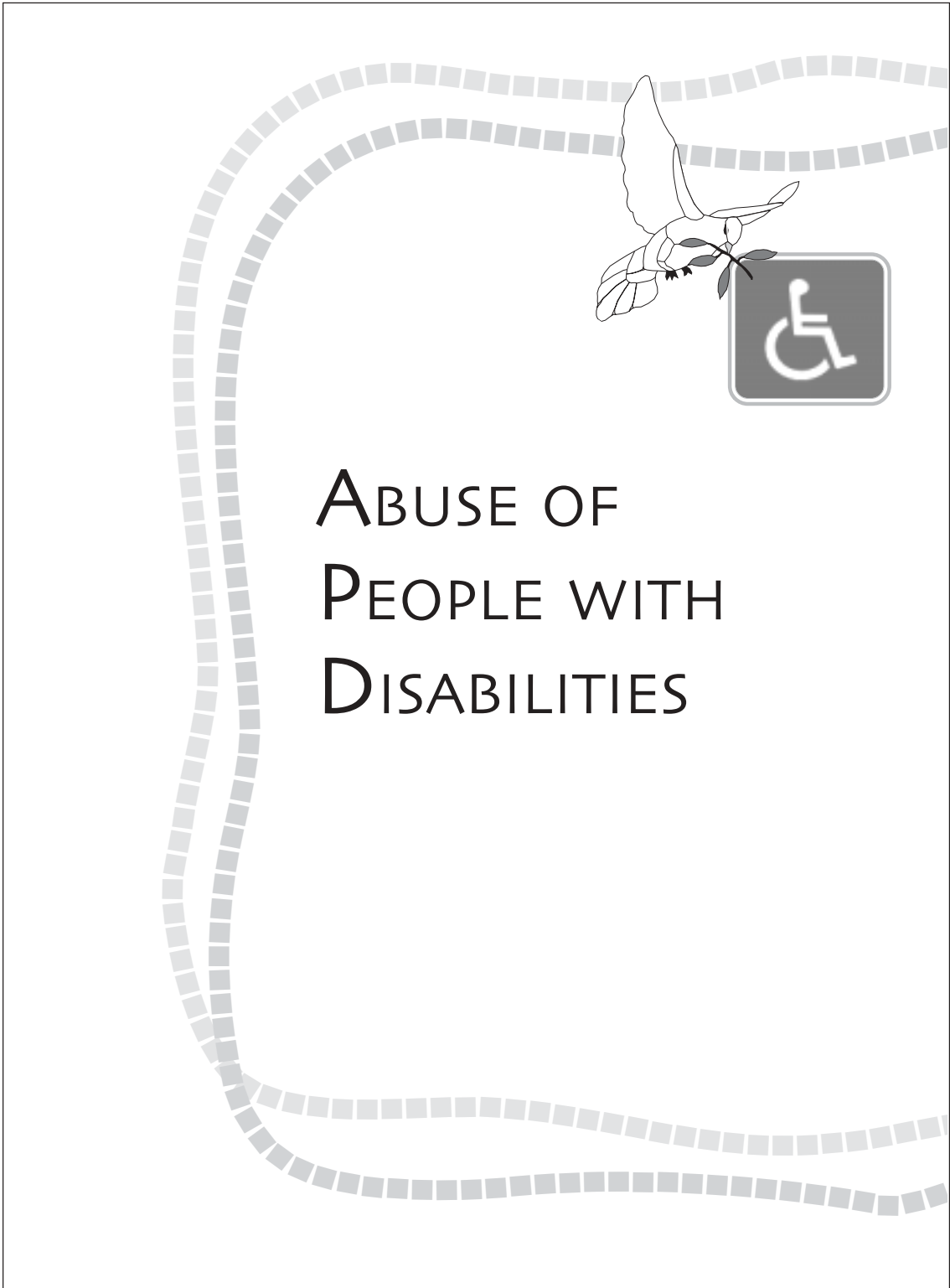
Communication Tips

Communication may be enhanced by using the tips below.

- Organize information sequentially.
- Use concrete examples.
- Minimize distractions.
- Review key concepts to ensure that they are understood.
- Use reflection or rephrasing to be sure you understood.
- Allow sufficient time to hear and understand the person's story.
- Pay close attention to verbal and non-verbal language.



-
- Slow down: do not insert your words.
 - Remember speech impairment is not related to intelligence.
 - Do not mistake a woman's communication disability (e.g., if she has a speech disability) for drunkenness.
 - Have all program information available in accessible formats: audiotape, large print (14-16 pt) type and Braille.
 - Have pictorial information available.
 - All staff and crisis volunteers have access to and knowledge of TTY and email use.
 - Hire ASL interpreters for public presentations unless registration inquiring about accessibility needs indicates no signer is needed.
 - Include portrayals of women with disabilities in agency literature and publications.



ABUSE OF PEOPLE WITH DISABILITIES



THE ABUSE OF PEOPLE WITH DISABILITIES

The biological/physical fact of disability does not in and of itself create greater risk. Rather, the communities perception of vulnerability or the actual lack of accessible services creates risk for persons with disabilities. Some examples of risks faced by women with disabilities are highlighted below:

Abusers may perceive women with mobility, sensory, or other disabilities to be easier "targets".

- A woman with a developmental disability may find it difficult to distinguish between appropriate/non-appropriate touch due to lack of education about sex, sexuality, and abuse.
- A woman with communication/speech disabilities may not be able to verbalize the abuse if she lacks the appropriate assistive devices. Further, her communication board may not have the terms for the anatomy and other related terms for her to communicate her experience.

Limited information exists regarding the criminal victimization of people with disabilities, but the information that is available is horrifying in nature and scope. Clearly people with disabilities are exposed to many situations that increase vulnerability to violence at the hands of spouses, partners, family members, caregivers, and strangers.

Statistics

- About 9 million individuals with disabilities use some form of personal assistance.⁹
- Many women, men and children with disabilities face additional risk of abuse by people who give them assistance. 97% to 99% of abusers are known and trusted by the victim who has developmental disabilities.¹⁰
- 80% of people with disabilities are sexually assaulted more than one time. 50% of people with disabilities are sexually assaulted more than 10 times.¹¹
- Children with mental retardation suffered a rate of neglect 3.7 times higher than children without disabilities; physical abuse 3.8 times higher; emotional abuse 3.8 times higher; and sexual abuse 4 times higher.¹²
- In one study more than half (53.4%) of all deaf children were sexually abused.¹³
- Women with physical disabilities: 62% report having experienced some form of abuse in her lifetime. This is consistent with the national norm for all women. However, the intensity and duration of abuse was higher for women with disabilities.¹⁴
- More than 90% of people with developmental disabilities will experience sexual abuse at some point in their lives. Forty-nine percent will experience 10 or more abusive incidents.¹⁵
- Other studies suggest that 39% to 68% of girls and 16% to 30% of boys will be sexually abused before their eighteenth birthday. The likelihood of rape is staggering: 15,000 to 19,000 of people with developmental disabilities are raped each year in the United States.¹⁶
- Each year, nearly ten thousand women and children become permanently hearing impaired due to being repeatedly struck on or near the ear.¹⁷



Barriers Faced by People with Disabilities

Society's attitudes and beliefs about persons with disabilities are perhaps the most difficult barriers to overcome. However, over-coming these barriers is critical to gaining full access to civil rights for persons with disabilities. The following are examples of attitudinal barriers:

- The belief in the superiority and the right of non-disabled people to exercise power and control over people with disabilities.
- The belief among abusers that people with disabilities in general, and women with disabilities in particular, are "easy targets". This belief is widespread and reinforced by television and movies.
- The belief/myth held by abusers that women with disabilities are not harmed by abuse (e.g., the myth that women with paralysis do not feel the abuse; or that women with development disabilities aren't aware of the abuse).
- Poverty presents another barrier. Lack of employment results in a lack of funds to pay for quality care or can force reliance on unpaid caregivers. This dependency in turn reduces the options for women with disabilities to leave abusive environments.
- Increasing the barriers posed by racism, heterosexism and sexism - immigrant women with disabilities, native women with disabilities, disabled women of color in general, and lesbians with disabilities have additional barriers to surmount in a society which privileges its white and straight members. For example, they are at greater risk than white, straight women of losing their children, being poor, being institutionalized in psychiatric hospitals, being disbelieved, etc.

DISABILITIES POWER AND CONTROL WHEEL



Figure 2

Wheel developed by Domestic Violence Intervention Project, Duluth, MN.

Provided by KCSDV, 220 SW 33rd Street, Topeka, KS. 66611
 785-232-9784, Fax 785-266-1874, www.kcsdv.org



The wheel showing power and control against people with disabilities can be a helpful tool in understanding the overall pattern of abusive and violent behaviors against people with disabilities. The graphic is a wheel with Power and Control and a wheelchair symbol in the middle circle. The external circle has the words, PHYSICAL SEXUAL VIOLENCE.

The spokes of the wheel say:

INTIMIDATION:

Making her afraid by using looks, actions, gestures • Smashing things • Destroying her property • Using her disability against her • Displaying weapons

EMOTIONAL ABUSE:

Using her disability as a put-down • Telling her no one will believe her • Making her feel guilty for needing help • Manipulating her • Humiliating her

ISOLATION:

Taking away adaptive aids • Controlling daily activities • Not allowing her to have friends • Leaving her without attendant care • Not allowing access to available resources, i.e. interpreter services, transportation • Canceling her doctor appointments • Telling her there is no help for her

MINIMIZING, DENYING, AND BLAMING:

Not taking her seriously • Blaming her for having a disability • Blaming her for the abuse • Minimizing her physical needs

USING CHILDREN:

Telling children she can not take care of them • Taking children away • Telling others that she uses children as attendants • Threatening to sue for custody of the children

MALE PRIVILEGE:

Treating her like a burden • Making all decisions regarding her life • Treating her like a child • Telling her nobody else could love her • Being the one who defines what's "normal" and "abnormal"

ECONOMIC ABUSE:

Telling her she's useless if she can't work • Not allowing her to work • Not letting her apply for public benefits or taking the money away from her • Telling her she is not capable of handling finances • Abusing payee status

COERCION AND THREATS:

Making and/or carrying out threats to do something to hurt her • Threatening to leave her, to commit suicide, to report her to welfare • Making her drop charges • Making her do illegal things



Barriers to Escaping or Reporting Abuse

Lack of knowledge of abuse resources due to:

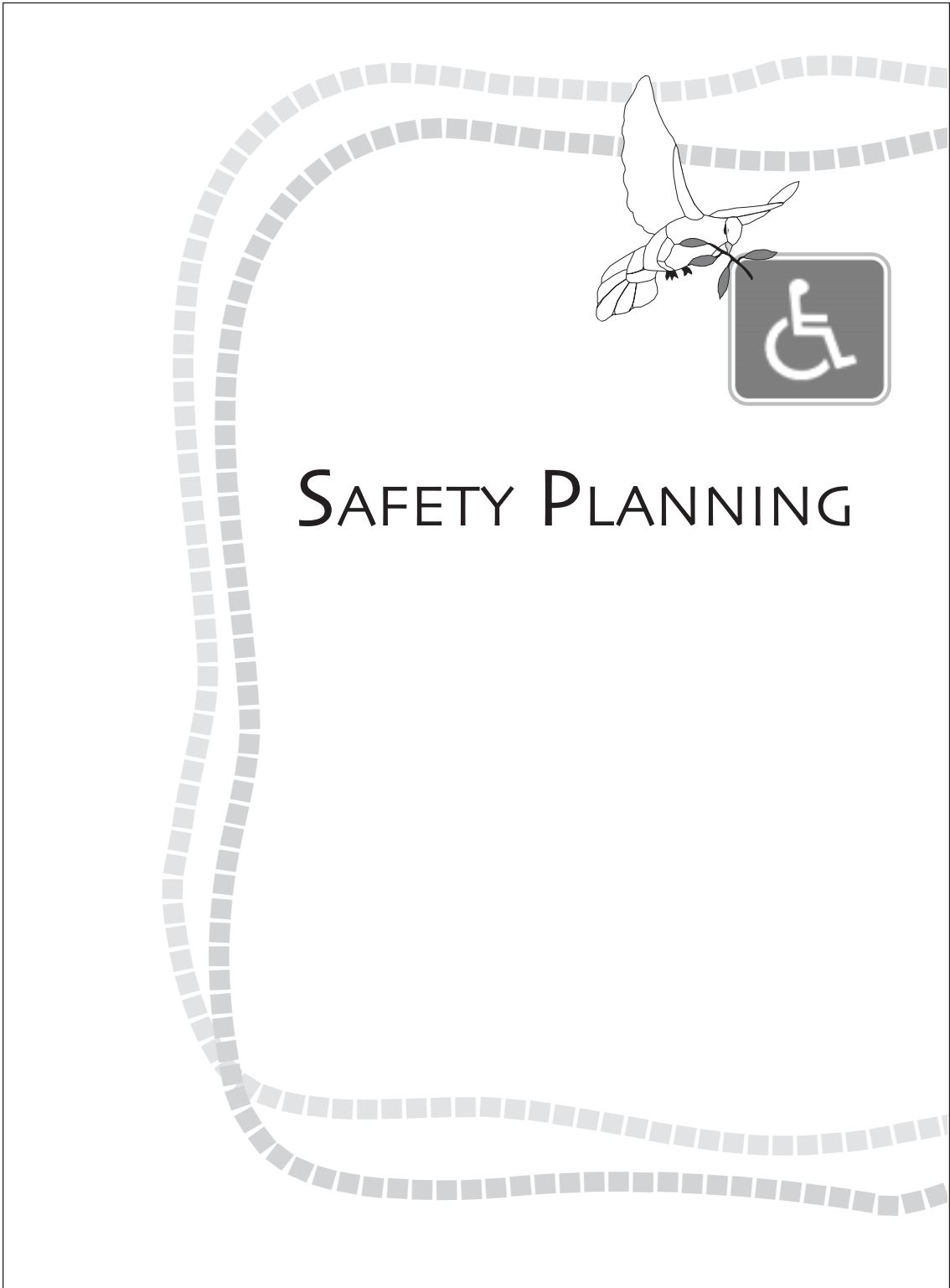
- Inaccessible public education materials about community/crisis services, courts, police and legal clinics
- Too few agencies that provide outreach to the disability community

Common fears of survivors:

- Being institutionalized
- Losing child custody due to disability
- Retaliation
- Losing essential services
- Losing their primary relationship, their home, and services such as physical assistance, interpretation, and readers of print material
- Losing partner's financial support and/or health insurance
- Being ostracized from their community
- Not being believed

Lack of accessible 24-hour emergency services such as:

- Accessible transportation
- Sign language or multi-lingual interpretation
- Multi-lingual attendant care services
- Deaf-blind services
- Accessible shelters, sexual assault centers, transition houses
- Personal care assistance





SAFETY PLANNING

It is preferable that a disability advocate and a domestic violence advocate work together to create a comprehensive safety plan for a battered woman who has a disability. However, that is not always possible in emergency situations. Disability advocates and domestic violence advocates should consider the following information when developing safety plans for battered women with disabilities.

Points to Remember for the Disability Advocate

- Options are more complex than simply staying or leaving.
- Remaining in the relationship does not mean acceptance of the violence.
- Leaving does not necessarily mean that the violence ends or other risks are reduced.
- Some women will stay in the abusive relationship.
- Most women leave and return several times before permanently leaving.
- Not all women will benefit from abuser's arrest, restraining order, the court and other systemic responses.
- Arrest might stop violence but results in the victim losing her privacy, in some cases, may result in her arrest.
- Leaving might reduce the violence, but results in homelessness and loneliness for the woman.
- Any option may result in an escalation of violence.
- If the abuser is threatening to kill her or himself, or if the abuser has access to weapons, there is an increased chance for lethality.

In an emergency situation the disability advocate can use the following form as a guide to help the victim assess risk and plan for a crisis situation. Although this form is helpful in an emergency, it does not constitute a complete safety plan. A comprehensive safety plan can be done with the help of a domestic violence advocate who is trained to assist with lethality assessment and option exploration.

Safety Plan

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I do not have control over my partner's violence, I do have a choice about how to respond to her and how to best get my children and myself to safety.

If I decide to leave, I will _____. (Practice how to get out safely. What doors, windows, elevators, stairwells, or fire escapes would you use?)

I can keep my purse and car keys ready and put them (place) _____ in order to leave quickly.

I can tell _____ about the violence and request they call the police if they hear suspicious noises coming from my house.

I can teach my children how to use the telephone to contact the police and the fire department.

I will use _____ as my code word with my children or my friends so they can call for help.

If I have to leave my home, I will go _____. (Decide this even if you don't think there will be a next time.)

I can also teach some of these strategies to some/all of my children.

When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as _____. (Try to avoid arguments in the bathroom, garage, kitchens, near weapons or in rooms without access to an outside door.)

My disability could impact my safety plan because _____.

These are my ideas for dealing with these barriers _____.

The following equipment could help me to stay safe _____.



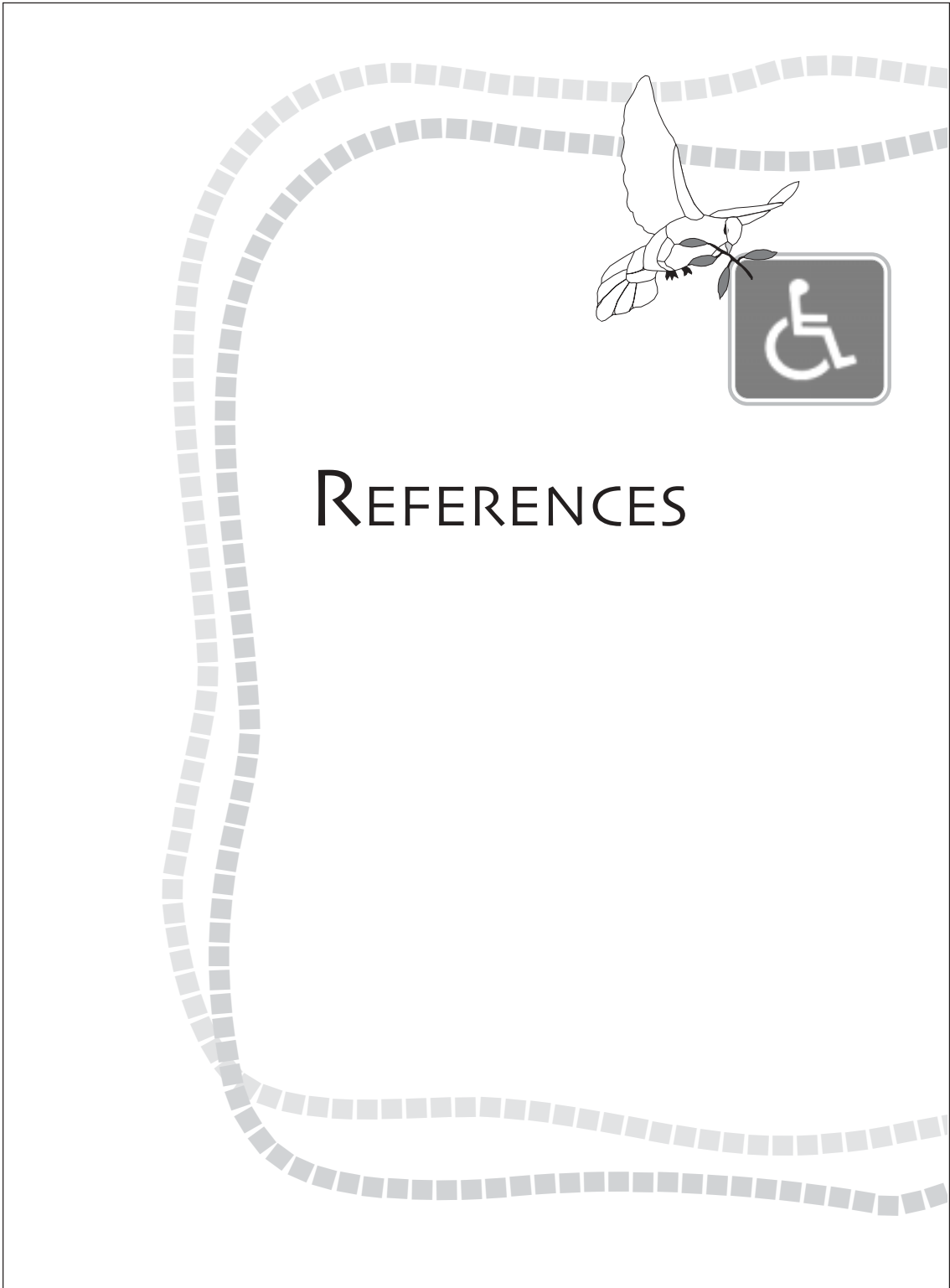
Points to Remember for the Domestic Violence Advocate

Dependent upon the nature of the disability consider the following:

- Possible safety solutions in reading TTY device
- Accessible travel routes
- Method of communication preferred by survivor
- How past trauma impacts the safety plan
- How some behaviors have been coping mechanisms
- Survivor's range of physical abilities
- Distance, weather and physical obstacles
- A prearranged code word to call for help
- Alert buttons
- Access to a phone or communication device
- An eye-level spy hole
- Attendant screening
- Funds available for personal attendant services
- Availability of emergency caretakers
- Reading and writing assistance needed for filling out forms and applications

Skill set of battered woman to consider when safetyplanning:

- Ability to say no
- Ability to deceive, keep secrets
- Ability to move to avoid a strike
- Mobility with/without a wheelchair
- Ability to leave the house
- Ability to use public transportation
- Ability to see alternative solutions to barriers
- Ability to use safety devices
- Strength and stamina of limbs
- Distance able to travel
- Short- and long-term memory
- Concentration, organization, and focusing skills
- Ability to recognize an emergency
- Communication skills, phone, 911
- Able to communicate quickly/fast response to questions
- Able to relate personal history to authority using short- and long- term memory
- Able to explain events consistently and in time sequence
- Ability to trust and use resources in the community



REFERENCES

REFERENCES

1. Koss MP, Heslet L. (1992). Somatic consequences of violence against women. *Archives of Family Medicine*, 1, 53-9.
2. Holmes, M.M., Resnick, H.S. Kilpatrick, D.G. and Best C.L. (1996). "Rape-related pregnancy: Estimates and descriptive characteristics from a national sample of women." *American Journal of Obstetrics and Gynecology*. 175(2), 320-324.
3. National Center for Victims of Crime and Crime Victims Research and Treatment Center. (1992). *Rape in America: A Report to the Nation*. Arlington, VA.
4. Meston CM, Heiman JR. (2000). Sexual abuse and sexual function: an examination of sexually relevant cognitive processes. *Journal Consulting Clinical Psychology*. Jun; 68 (3), 399-406.
5. US Department of Justice, *Victim Costs and Consequences: A New Look*, (1996), Summary by Virginians Aligned Against Sexual Assault.
6. The Brain Injury Association of Kansas and Greater Kansas City (online) available <http://www.braininjuryresource.org/>
7. Franklin, D.J. (2001). Depression – information and treatment. *Psychology Information Online* (online). Available: <http://www.psychologyinfo.com/depression>
8. Long, P.W. (2003) *Internet Mental Health*. (online) Available <http://www.mentalhealth.com/dis/p20-an06.html>
9. Litvak, S., Zukas, H., & Heumann, J. E. (1987). *Attending to America: Personal assistance for independent living. A survey of attendant service programs in the United States for people of all ages with disabilities*. Berkeley, CA: World Institute on Disability.
10. Baladerian, N. (1991). Sexual abuse of people with developmental disabilities. *Sexuality and Disability*, 9(4), 323-335.
11. Sobsey, D., & Doe, T. (1991). Patterns of sexual abuse and assault. *Journal of Sexuality and Disability*, 9(3), 243-259.
12. Sullivan, P. & Knutson, J. (2000). Maltreatment and disabilities: A population based epidemiological study. *Child Abuse & Neglect*, 24 (10), 1257-1273.
13. Sullivan, P.M., Vernon, M., & Scanlan, J., 1987. "Sexual abuse of deaf youth." *American Annals of the Deaf*, 132, 256-62.

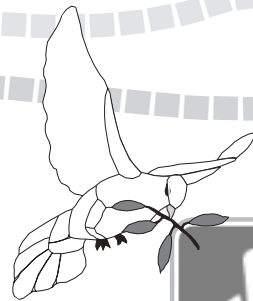


14. Nosek MA, Howland CA, Hughes RB. The investigation of abuse and women with disabilities: going beyond assumptions. *Violence Against Women* 2001; 7: 477–99.

15. Valenti-Hein, D. & Schwartz, L. (1995). *The sexual abuse interview for those with developmental disabilities*. James Stanfield Company. Santa Barbara: California.

16. Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities: The end of silent acceptance?* Baltimore: Paul H. Brookes Publishing Co.


17. National Institute on Deafness and Other Communication Disorders; National Institutes of Health, *National Strategic Research Plan (1989)*. Bethesda, Maryland.

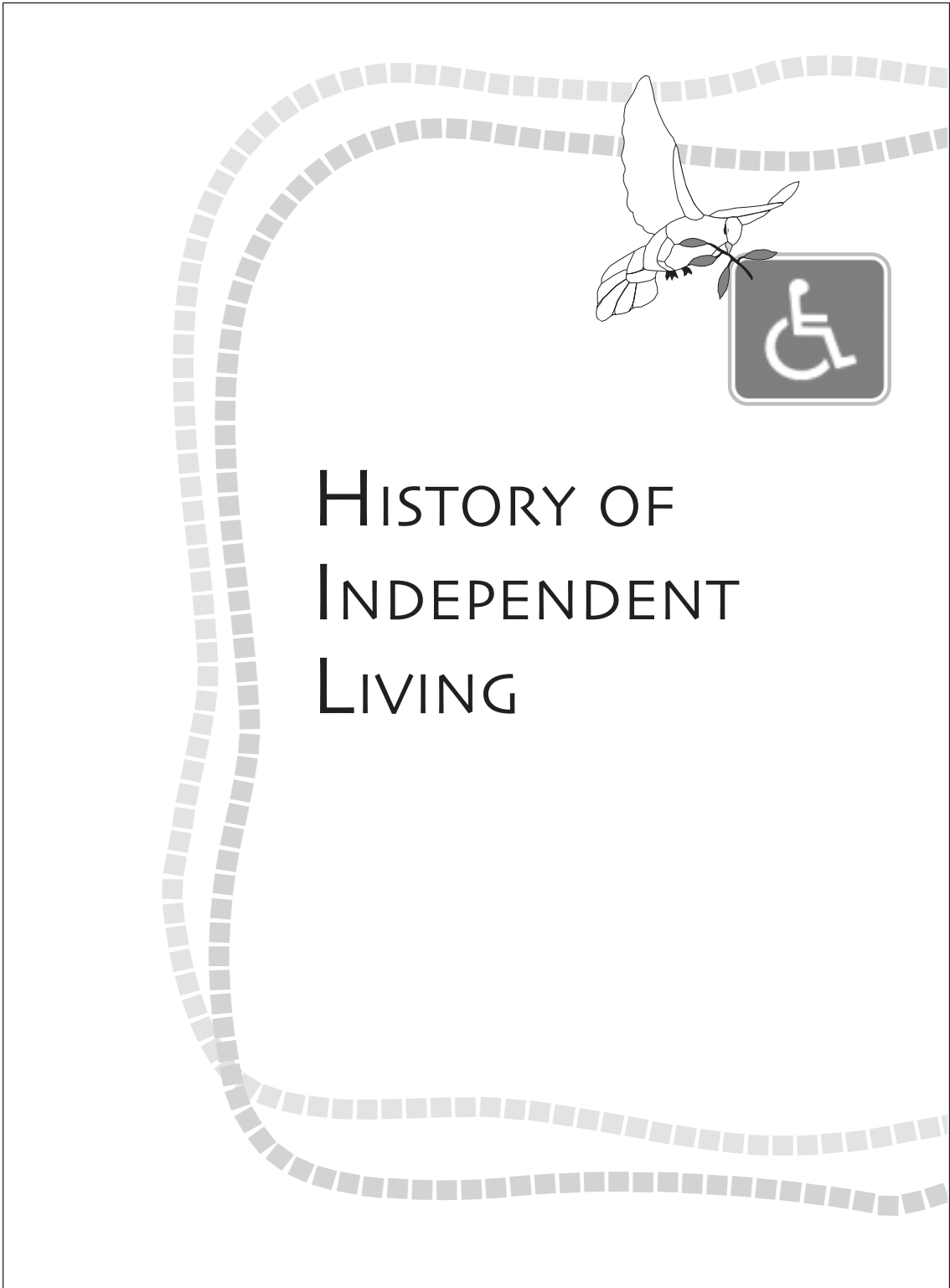


HIGHLIGHTS OF CIL AND DV/SA MOVEMENTS

HIGHLIGHTS OF CIL AND DV/SA MOVEMENTS

- 1964 Civil Rights Act
- 1968 Architectural Barrier Act
- 1970 Ed Roberts and his peers at Cowell (UC Berkeley Health Center) formed a group called the Rolling Quads. Rolling Quads form the Disabled Students' Program on the UC- Berkeley campus.
- Urban Mass Transit Act
- 1971 Domestic Violence movement first gains momentum in England, as Chiswick Women's Aid, the first identified shelter opens.
- 1972 Women's advocates in St. Paul, Minnesota starts the first hotline for battered women. Women's Advocates and Haven House in Pasadena, California, establish the first shelters for battered women.
- First Kansas sexual assault program founded in Lawrence.
- 1973 Rehabilitation Act
- 1975 Developmental Disabilities Bill of Rights Act
Education of All Handicapped Children Act
Kansas Sexual Assault Coalition is formed.
- 1976 Pennsylvania establishes the first state coalition against Domestic violence.
First Kansas sexual assault and domestic violence program founded in Emporia.
- 1977 April: A group of protesters with disabilities takes over the San Francisco offices of Health, Education & Welfare Dept. to protest the lack of meaningful regulations for Section 504.
May: The Section 504 regulations were issued.
Oregon becomes the first state to enact legislation mandating arrest in domestic violence cases.
- 1978 Amendments to the Rehabilitation Act providing for consumer-controlled Centers for Independent Living.
American Disabled for Accessible Public Transit (ADAPT) was founded and eventually became the nation's first grassroots disability rights activist organization.
Kansas Sexual Assault Coalition is formed.
- 1979 Centers for Independent Living (CIL's) began to form in Kansas.
Kansas Association of Domestic Violence Programs formed.

-
- 
- 1984 Passage of the Family Violence Prevention and Services Act, through grassroots lobbying efforts; earmarks federal funding for programs serving victims of domestic violence.
 - 1985 Tracy Thurman, who remains scarred and partially paralyzed from stab wounds inflicted by her husband, wins a \$2 million judgment against the city. The suit leads to Connecticut's passage of its mandatory arrest law.
U.S. Surgeon General issues report identifying domestic violence as a major health problem.
 - 1987 NCADV establishes the first national toll-free domestic violence hotline.
 - 1988 First Kansas Disability Caucus, Salina, KS
Civil Right Restoration Act
 - 1990 Americans With Disabilities Act
 - 1999 Olmstead vs. L.C. – The U.S. Supreme Court held that the unnecessary segregation of individuals with disabilities in institutions might constitute discrimination based on disability.
 - 2002 Kansas Coalition against Sexual and Domestic Violence, Kansas Association of Centers for Independent Living team up along with Kansas Department of Education and Washburn University's Joint Center for Victim Studies and community advocacy agencies to provide technical assistance, training, education and awareness to Kansas advocacy programs on violence against women with disabilities.
 - 2003 Free Our People" March from Philadelphia to Washington, D.C. to protest the inaction of Congress that ignores the over 2 million Americans hidden behind institutional walls.
 - 2004 Tennessee v. Lane - The Supreme Court held that the ADA gives private citizens the right to seek money in court if a state fails to live up to the law's requirements.



HISTORY OF INDEPENDENT LIVING



HISTORY OF INDEPENDENT LIVING

by
Mike Oxford and Gina McDonald

This account of the history of independent living stems from a philosophy which states that people with disabilities should have the same civil rights, options, and control over choices in their own lives as do people without disabilities.

The history of independent living is closely tied to the civil rights struggles of the 1950s and 1960s among African Americans. Basic issues - disgraceful treatment based on bigotry and erroneous stereotypes in housing, education, transportation, and employment - and the strategies and tactics are very similar. This history and its driving philosophy also have much in common with other political and social movements of the country in the late 1960s and early 1970s. There were at least five movements that influenced the disability rights movement.

SOCIAL MOVEMENTS

The first was deinstitutionalization, an attempt to move people, primarily those with developmental disabilities, out of institutions and back into their home communities. This movement was led by providers and parents of people with developmental disabilities and was based on the principle of "normalization" developed by Wolf Wolfensberger, a sociologist from Canada. His theory said that people with developmental disabilities should live in the most "normal" setting possible if they were expected to be have "normally." Other changes occurred in nursing homes where young people with many types of disabilities were warehoused for lack of "better" alternatives (Wolfensberger, 1972).

The next movement to influence disability rights was the civil rights movement. Although people with disabilities were not included as a protected class under the Civil Rights Act, it was a reality that people could achieve rights, at least in law, as a class. Watching the courage of Rosa Parks as she defiantly rode in the front of a public bus, people with disabilities realized the more immediate challenge of even getting on the bus.

The "self-help" movement, which really began in the 1950s with the founding of Alcoholics Anonymous, came into its own in the 1970s. Many self-help books were published and support groups flourished. Self-help and peer support are recognized as key points in independent living philosophy. According to this tenet, people with similar disabilities are believed to be more likely to assist and to understand each other than individuals who do not share experience with similar disabilities.

Demedicalization was a movement that began to look at more holistic approaches to health care. There was a move toward "demystification" of the medical community. Thus, another cornerstone of independent living philosophy became the shift away from the authoritarian medical model to a paradigm of individual empowerment and responsibility for defining the meeting one's own needs.

Consumerism, the last movement to be described here, was one in which consumers began to question product reliability and price. Ralph Nader was the most outspoken advocate for this movement, and his staff and followers came to be known as "Nader's Raiders." Perhaps most fundamental to independent living philosophy today is the idea of control by consumers of goods and services over the choices and options available to them.

The independent living paradigm, developed by Gerben DeJong in the late 1970s (DeJong, 1979), proposed a shift from the medical model to the independent living model. As with the movements described above, this theory located problems or "deficiencies" in the society, not the individual. People with disabilities no longer saw themselves as broken or sick, certainly not in need of repair. Issues such as social and attitudinal barriers were the real problems facing people with disabilities. The answers were to be found in changing and "fixing" society, not people with disabilities. Most important, decisions must be made by the medical or rehabilitation professional.

Using these principles, people began to view themselves as powerful and self-directed, as opposed to passive victims, objects of charity, cripples, or not-whole. Disability began to be seen as a natural, not uncommon experience in life; not a tragedy.

INDEPENDENT LIVING

Ed Roberts is considered to be the "father of independent living". Ed became disabled at the age of fourteen as a result of polio. After a period of denial in which he almost starved himself to death, Ed returned to school and received his high school diploma. He then wanted to go to college. The California Department of Rehabilitation initially rejected Ed's application for financial assistance because it was decided that he was "too disabled to work." He went public with his fight and within one week of doing so, was approved for financial aid by the state. Fifteen years after Ed's initial rejection by the State of California as an individual who was "too" disabled, he became head of the Department of Rehabilitation - the agency that had once written him off.

After Ed earned his associates degree at the College of San Mateo, he applied for admission to the University of California at Berkeley. After initial resistance on the part of the university, Ed was accepted. The university let him use the campus hospital as his dormitory because there was no accessible student housing (none of the residential buildings could support the weight of Ed's 800 lb. iron lung). He received attendant services through a state program called "Aid to the Totally Disabled." This is a very important note because his was consumer-controlled personal assistance services. The attendants were hired, trained, and fired by Ed.

In 1970, Ed and other students with disabilities founded a disabled students' program on the Berkeley campus. His group was called the "Rolling Quads." Upon graduation, the "Quads" set their sights on the need for access beyond the university's walls.

Ed contacted Judy Heumann, another disability activist, in New York. He encouraged her to come to California and along with other advocates, they started the first center for independent living in Berkeley. Although it started out as a "modest"

apartment, it became the model for every such center in the country today. This new program rejected the medical model and focused on consumerism, peer support, advocacy for change, and independent living skills training.

In 1983, Ed, Judy, and Joan Leon, co-founded the World Institute on Disability (WID), and advocacy and research center promoting the rights of people with disabilities around the world. Ed Roberts died unexpectedly on March 14, 1995.

The early 1970s was a time of awakening for the disability rights movement in a related, but different way. As Ed Roberts and others were fighting for the rights of people with disabilities presumed to be forever "homebound" and were working to assure that participation in society, in school, in work, and at play was realistic, proper, and achievable goal, others were coming to see how destructive and wrong the systematic institutionalization of people with disabilities could be. Inhuman and degrading treatment of people in state hospitals, schools, and other residential institutions such as nursing facilities were coming to light and the financial and social costs were beginning to be considered unacceptable. This awakening within the independent living movement was exemplified by another leading disability rights activist, Wade Blank.

ADAPT

Wade began his lifelong struggle in civil rights activism traveling with Dr. Martin Luther King, Jr. to Selma, Alabama. It was during this period that he learned about the stark oppression which occurred against people considered outside the "mainstream" of our "civilized" society. By 1971, Wade was working in a nursing facility, Heritage House, trying to improve the quality of life of some of the younger residents. These efforts, including taking some of the residents to a Grateful Dead concert, ultimately failed. Institutional services and living arrangements were at odds with the pursuit of personal liberties and life with dignity.

In 1974, Wade founded the Atlantis Community, a model for community-based, consumer-controlled, independent living. The Atlantis Community provided personal assistance services primarily under the control of the consumer within a community setting. The first consumers of the Atlantis Community were some of the young residents "freed" from Heritage House by Wade (after he had been fired). Initially, Wade provided personal assistance services to nine people by himself for no pay so that these individuals could integrate into society and live lives of liberty and dignity.

In 1978, Wade and Atlantis realized that access to public transportation was a necessity if people with disabilities were to live independently in the community. This was the year that American Disabled for Accessible Public Transit (ADAPT) was founded. On July 5-6, 1978, Wade and nineteen disabled activists held a public transit bus "hostage" on the corner of Broadway and Colfax in Denver, Colorado. ADAPT eventually mushroomed into the nation's first grassroots, disability rights, and activist organization.

In the spring of 1990, the Secretary of Transportation, Sam Skinner, finally issued the regulations mandating lifts on buses. These regulations implemented a law passed in 1970 - the Urban Mass Transit Act - which required lifts on new buses. The transit

industry had successfully blocked implementation of this part of the law for twenty years, until ADAPT changed their minds and the minds of the nation.

In 1990, after passage of the Americans With Disabilities Act (ADA), ADAPT shifted its vision toward a national system of community-based personal assistance services and the end of the apartheid-type system of segregating people with disabilities by imprisoning them into institutions against their will. The acronym, ADAPT, became "American Disabled for Attendant Programs Today." The fight for a national policy of attendant services and the end of institutionalization continues to this day.

Wade Blank died on February 15, 1993, while unsuccessfully attempting to rescue his son from drowning in the ocean. Wade and Ed Roberts live on in many hearts and in the continuing struggle for the rights of people with disabilities.

The lives of these two leaders in the disability rights movement, Ed Roberts and Wade Blank, provide poignant examples of the modern history, philosophy, and evolution of independent living in the United States. To complete this rough sketch of the history of independent living, a look must be taken at the various pieces of legislation concerning the rights of people with disabilities, with a particular emphasis on the original "bible" of civil rights for people with disabilities, the Rehabilitation Act of 1973.

CIVIL RIGHTS LAWS

Before turning to the Rehabilitation Act, a chronological listing and brief description of important federal civil rights laws affecting people with disabilities is in order.

1964 - Civil Rights Act: prohibits discrimination on the basis of race, religion, ethnicity, national origin, and creed; later, gender was added as a protected class.

1968 - Architectural Barriers Act: prohibits architectural barriers in all federally owned or leased buildings.

1970 - Urban Mass Transit Act: requires that all new mass transit vehicles be equipped with wheelchair lifts. As mentioned earlier, it was twenty years, primarily because of machinations of the American Public Transit Association (APTA), before the part of the law requiring wheelchair lifts was implemented.

1973 - Rehabilitation Act: particularly Title V, Sections 501, 503, and 504, prohibits discrimination in federal programs and services and all other programs or services receiving federal funding.

1975 - Developmental Disabilities Bill of Rights Act: among other things, establishes Protection and Advocacy services (P & A).

1975 - Education of All Handicapped Children Act (PL 94-142): requires free, appropriate public education in the least restrictive environment possible for children with disabilities. This law is now called the Individuals with Disabilities Education Act (IDEA).

1978 - Amendments to the Rehabilitation Act: provided for consumer-controlled centers for independent living.

1983 - Amendments to the Rehabilitation Act: provides for the Client Assistance Program (CAP), an advocacy program for consumers of rehabilitation and independent living services.

1985 - Mental Illness Bill of Rights Act: requires protection and advocacy services (P & A) for people with mental illness.

1988 - Civil Rights Restoration Act: counteracts bad case law by clarifying Congress' original intention that under the Rehabilitation Act, discrimination in ANY program or service that is part of an entity receiving federal funding - not just the part which actually and directly receives the funding - is illegal.

1988 - Air Carrier Access Act: prohibits discrimination on the basis of disability in air travel and provides for equal access to air transportation services.

1988 - Fair Housing Amendments Act: prohibits discrimination in housing against people with disabilities and families with children. Also provides for architectural accessibility of certain new housing units, renovation of existing units, and accessibility modifications at the renter's expense.

1990 - Americans with Disabilities Act: provides comprehensive civil rights protection for people with disabilities; closely modeled after the Civil Rights Act and the Section 504 of Title V of the Rehabilitation Act and its regulations.

The modern history of civil rights for people with disabilities is three decades old. A key piece of this decades-long process is the story of how the Rehabilitation Act of 1973 was finally passed and then implemented. It is the story of the first organized disability rights protest.

THE REHABILITATION ACT OF 1973

In 1972, Congress passed a rehabilitation bill that independent living activists cheered. President Richard Nixon's veto prevented this bill from becoming law. During the era of political activity at the end of the Vietnam War, Nixon's veto wasn't taken lying down by disability activists who launched fierce protests across the country. In New York City, an early leader for disability rights, Judy Heumann, staged a sit-in on Madison Avenue with eighty other activists. Traffic was stopped. After floods of angry letters and protests, in September 1973, Congress overrode Nixon's veto and the Rehabilitation Act of 1973 finally became law. Passage of this pivotal law was the beginning of the ongoing fight for implementation and revision of the law according to the vision of independent living advocates and disability rights activists.

Key language of the Rehabilitation Act, found in Section 504 of Title V, states that: No otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Advocates realized that this new law would need regulations in order to be implemented and enforced. By 1977, Presidents Nixon and Ford had come and gone. Jimmy Carter had become president and had appointed Joseph Califano his Secretary of Health, Education and Welfare (HEW). Califano refused to issue regulations and was given an ultimatum and deadline of April 4, 1977. April 4 went by with no regulations and no word from Califano.

On April 5, demonstrations by people with disabilities took place in ten cities across the country. By the end of the day, demonstrations in nine cities were over. In one city - San Francisco - protesters refused to disband.

Demonstrators, more than 150 people with disabilities, had taken over the federal office building and refused to leave. They stayed until May 1. Califano had issued regulations by April 28, but the protesters stayed until they had reviewed the regulations and approved of them.

The lesson is a fairly simple one. As Martin Luther King said, "It is a historical fact that the privileged groups seldom give up their privileges voluntarily. Individuals may see the moral light & voluntarily give up their unjust posture, but, as we are reminded, groups tend to be more immoral than individuals. We know, through painful experience that freedom is never voluntarily given by the oppressor, it must be demanded by the oppressed."

Leaders In The Independent Living Movement

The history of the independent living movement is not complete without mention of some of the other leaders who continue to make substantial contributions to the movement and to the rights and empowerment of people with disabilities.

- Max Starkloff, Charlie Carr, and Marca Bristo founded the National Council on Independent Living (NCIL) in 1983. NCIL is one of the only national organizations that is consumer-controlled and promotes the rights and empowerment of people with disabilities.

- Justin Dart played a prominent role in the fight for passage of the Americans with Disabilities Act, and is seen by many as the spiritual leader of the movement today.

- Lex Frieden is co-founder of ILRU Program. As director of the National Council on Disability, he directed preparation of the original ADA legislation and its introduction in Congress.

- Liz Savage and Pat Wright are considered to be the "mothers of the ADA". They led the consumer fight for the passage of the ADA.

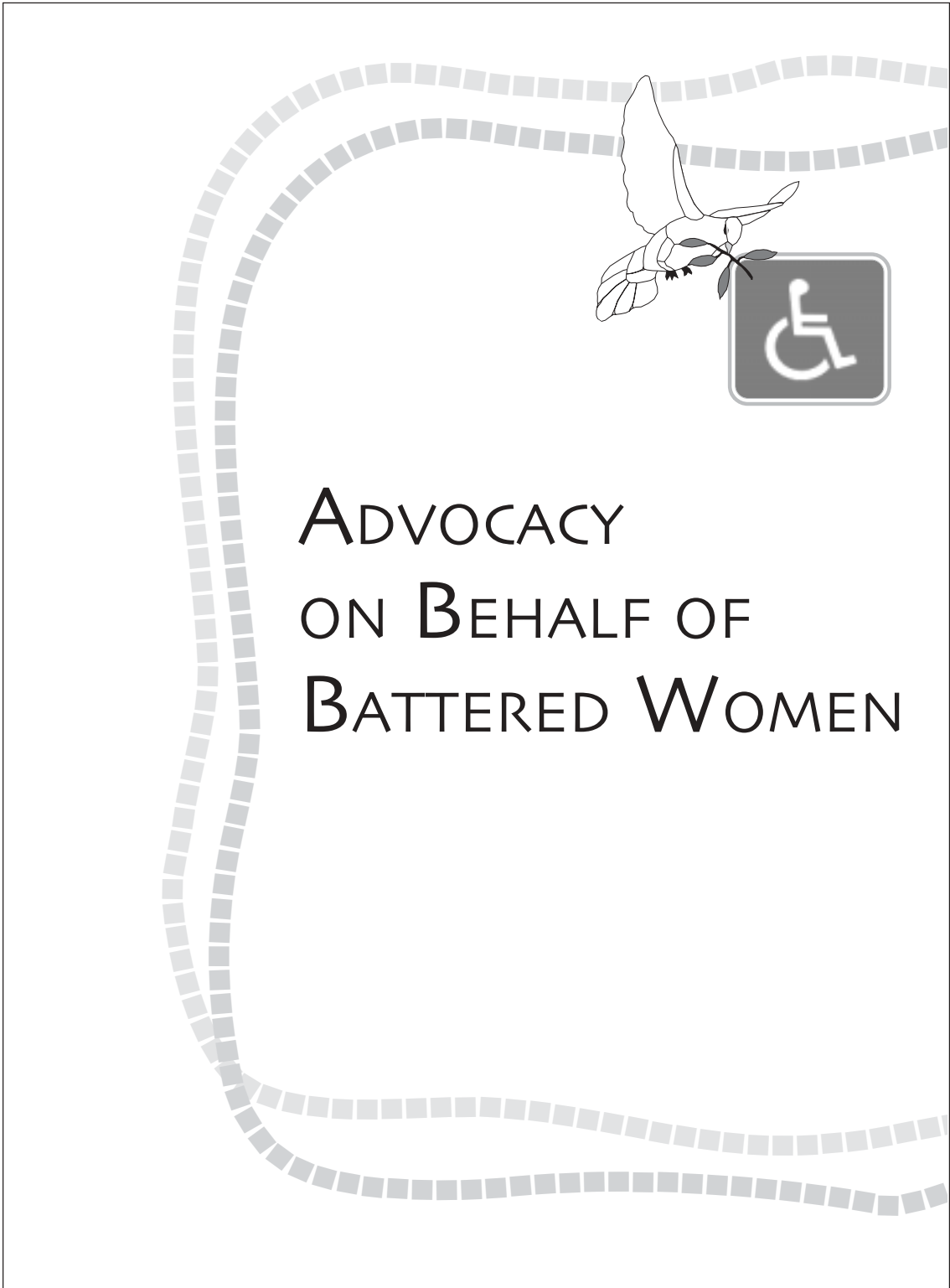
There are countless other people who have and continue to make substantial contributions to the independent living movement.



REFERENCES

DeJong, Gerben. "Independent Living: From Social Movement to Analytic Paradigm," Archives of Physical Medicine and Rehabilitation 60, October 1979.

Wolfensberger, Wolf. The Principle of Normalization in Human Services. Toronto: National Institute on Mental Retardation, 1972.



ADVOCACY
ON BEHALF OF
BATTERED WOMEN



ADVOCACY ON BEHALF OF BATTERED WOMEN

by
Ellen Pence

Over the past 25 years, reform efforts for battered women have produced two distinct yet interwoven forms of advocacy. The first, individual case advocacy, is characterized by an advocate who tries to help one woman get what she wants and needs—either from a local agency or an entire institution, representing a complex system of community agencies that help the state regulate the lives and conflicts of ordinary citizens. This advocate takes up the woman's situation as one case to be managed and resolved by the state. In the second form of advocacy, often called systems or institutional advocacy, an advocate takes up many cases as one representative unit and tries to alter the practices that produce unfair outcomes for battered women as a group. My mother, who has been engaged in both forms of advocacy since the mid-1970s, defines the difference this way:

"When I advocate for an individual woman, I am trying to help her overcome the many obstacles on her path to effectively using the courts and police to protect her. When I do systems advocacy, I am trying to build a new path. I come to understand what I need to do in systems advocacy by my work with individual women."

In this chapter, I will offer some observations about the current state of institutional advocacy in the U.S. battered women's movement. Specifically, I want to discuss advocacy efforts to create civil and criminal court responses that effectively protect women who are being battered and to examine our efforts to correct the criminal court system's historic hands-off approach to men who beat their wives and partners.

Almost three decades after the first battered women's shelters opened in the United States, we face a critical juncture in our work as advocates. As our programs and agendas for social change become mainstreamed into the legal system, we risk losing our most powerful tool—our position of solidarity with women who are beaten. Today, advocates witness alarming numbers of battered women being arrested for assaults that, given a slightly different set of circumstances, would be hailed as acts of heroism. The legal system has reluctantly granted us interventions that gain control over offenders.

However, in many communities, advocates are not positioned to argue that applying those strategies to women who are battered and fight back neither protects public safety nor meets any reasonable standard of justice. Women are being charged with child neglect for failing to stop their batterers from using force against them. New laws require shelter advocates to report women for child neglect when they fail to stop their batterers' use of violence and are unable to leave them. At the same time, judges grant unsupervised visitation to men who have brutally assaulted their children's mothers, but judges themselves are not charged with failure to protect children. More and more women are being aggressively prosecuted for crimes com-

mitted on behalf of drug dealers who regularly beat them. Immigration policies are changing—for example, the 1985 marriage fraud act and HI work permit rules—and making foreign-born women more vulnerable to their partners' violence (Dasgupta, 1998). Finally, shelters once open to all battered women are increasingly screening out “inappropriate” women from their life-saving resources. These are not problems that cannot be overcome or transformed, but doing so requires a critical examination of our present course, a more sophisticated understanding of how institutions—such as the legal system—continuously reproduce relationships of domination between men and women, and a commitment to finding new ways to stand in solidarity with women.

I was asked to write this chapter because I have been around since the earliest days of our collective work. I have been a part of the Duluth Domestic Abuse Intervention Project, the most often cited example of an effective, locally organized, criminal justice reform effort. I have also had the opportunity to visit similar projects in the United States and abroad to learn about their successes and frustrations in using the legal system to protect women from continued abuse. These experiences give me an insight into our history that can be important for those who are working to move our collective efforts forward. Still, I am limited in my experience, both personally and politically. A chapter such as this should be written by a group of advocates from different states, representing different communities. As I describe the history of advocacy, I will use terms such as *we*, *us*, and *our* if there were a universal “we,” but there never was. I use these terms to represent the social movement of the 1970s and 1980s, in which women worked toward common goals, even while holding different views on how to reach those goals.

The Early Years of Institutional Advocacy—The 1970s

The women who organized the first shelters for battered women described themselves as advocates. The term *advocate* means mouthpiece; it connotes one who speaks for or takes up the cause of another. The *others* in this context were women who were being beaten by their husbands, lovers, or partners. The notion of speaking out was a core theme of the women's movement, the same movement in which local women's groups opened shelters and articulated a message to a community that was alternately half-hostile and half-listening. However, we did not use the term *advocate* to distinguish between those who were beaten and those who fought for new institutional responses to battered women, particularly because many advocates themselves had experienced violence in their lives. As advocates, we intended to stand in solidarity with shelter residents. Working at a shelter did not so much require a college degree as a willingness to speak out in often hostile institutional environments. We hoped that battered women differentiated the role of advocates from the role of social workers or other professionals who managed their situations as cases. By the 1970s, social workers had long left their radical roots and were fully entrenched in the institutional processes of regulating and managing the lives of poor people and, in particular, the lives of poor women. As advocates, we claimed the role of articulating the needs of women to the system, not the reverse.

Social movements are characterized by the changes they demand in their formative years. The women's movement in the United States was preceded by over a decade of progressive organizing by black civil rights activists to strike down the Jim Crow laws, organizing by migrant farm workers to get decent wages and health protection, organizing by welfare recipients to get rid of patronizing vendor payments and secure a guaranteed annual income, organizing by Native American activists to assert tribal rights as sovereign nations, and organizing by antiwar protesters to end the draft and the Vietnam war. Many early women's advocates had worked in or were heavily influenced by these struggles.

As women filled shelters to the rafters, they told their stories. Women were devastated by the personal betrayal of their abusers but perhaps equally harmed by the seemingly endless ways that police officers, clergy, welfare workers, judges, family members, landlords, attorneys, and therapists found to blame them for their partners' violence. Advocates heard the same stories in every state. Of course, every story had its parochial twist, but the overarching theme of community collusion with batterers was starkly visible. Like activists in all of the progressive social movements of the 1960s, we sought a paradigm shift. We wanted practitioners in agencies that battered women needed for protection to refrain from finding fault with the victims and instead to understand and eliminate the social facilitators of this violence. We wanted to train the eye of scrutiny away from a woman's so-called "healthy" response to being beaten, on to both the abuser and the institutional practices that failed to help women.


Our demands as a social movement emerged from what women needed: They needed to be safe. Women needed exceptions to the legal aid rule that determined eligibility through the family's income level. Women needed new welfare intake rules that recognized their need to hide from the father of their children. Women needed police to keep records of repeated calls to their homes. To control the use of violence against them and their children, women needed a revision of most of the social service system's rules. In a sense, we were breaking new ground. We were using legal strategies inspired by Thurgood Marshall and other civil rights activists, but at the same time, we were trying to alter the case management practices of the court and human service systems. This dual role of outside agitator and inside reformer characterized our early years of advocacy.

When we listened to a woman's experience of being beaten and then turned with her to the legal system for help that was not forthcoming, her anger became ours. Although this empathy with women was seen as unprofessional, in those days being called unprofessional was not an insult; we had no desire to be professionals. In fact, many of us were glad someone noticed the difference. We were also labeled man-haters, a name that struck a more divisive cord among us. For some, it was not much of an insult, although it seemed unfair that our indignation over men beating women was interpreted as *our* problem with men rather than men's problem with women. Nevertheless, some women felt that the accusation questioned their loyalty to their sons, fathers, and husbands. Our critics often coupled these accusations with claims that we were all lesbians, unable to get a man, biased because we had been in bad

marriages, or alarmists because we had not yet healed from our personal traumas. The list of what made us biased—and, by default, made the practitioners objective—seemed endless, and it was a powerful tool of resistance to our efforts. The accusations eventually fueled divisions in advocacy organizations and added to the complex set of circumstances in which many activists stepped back and stopped critiquing institutional collusion with batterers. Still, although the seeds of division were already being sewn, so, too, were the fundamental principles of good advocacy. The notion of basing our critique on the experiences of real women was fully entrenched by the late 1970s. Our strength at the state legislatures, with the media, and in efforts to counter bogus research lay in our connection to what was happening to women and our willingness to speak out.


Some workers in the movement identified themselves as feminists, but feminists hardly constituted the majority of volunteer and paid staff. It was a personal commitment rather than a political ideology that inspired large numbers of women to start and maintain local shelters. Many workers in the movement had themselves escaped violent partners or were still living in or attempting to leave violent relationships. Others were daughters, sisters, or mothers of women who had been or were being beaten. Middle-class, working-class, and poor women all joined the working committees and carried out the work of the newly organized shelters. The presence of so many women who had used these systems enriched our movement. Whereas many white middle- and working-class feminists offered a political analysis important to our work, those same women tended to be somewhat naïve about how the state regulated the private lives of women. The term *feminist* was used mostly by white women who offered an important gender analysis to our work. Progressive African, Native, Asian, and Latin American women in the movement were less likely to use the term *feminist*. Nevertheless, women of color brought a deeply historical and far less naïve understanding of relationships of domination and exploitation—and, correspondingly, of the pitfalls we would face in using institutions of social control to benefit women.

Progressives in the movement offered a crucial analysis of the violence we all abhorred, but because they did not make up the majority of workers, they did not control the movement's politics. This broad spectrum of movement workers was not unanimous on how to talk about families, marriage, and women's roles within those institutions. We did, however, agree that—contrary to what was portrayed in Hollywood and women's magazines, in romance novels and from the pulpit—women were not safe within the family setting. We agreed that community agencies responsible for controlling criminal and antisocial behavior made the widespread abuse of women possible, and even worse when they engaged in practices that either ignored violence or treated it as a symptom of defective relationships. Practices that assumed that violence was the result of a relationship gone sour were particularly problematic because of the resulting intervention activities that focused on changing women. These practices were not simply misguided or ineffective; they were often dangerous. We perceived safety as every woman's right, as the goal of our work, and most important, as the responsibility of the community to ensure. Safety was to this social movement what liberation was to the larger women's movement.




In response to the specific needs of women entering shelters, we developed legal avenues of protection in both civil and criminal courts. A number of activists argued that pursuing civil remedies to this violence undermined our long-term goal of getting the police and court systems to view domestic violence as a serious crime against women. However, some civil solutions, such as court restraining orders, held great promise for women who needed immediate state intervention with “teeth” that achieved the same level of relief afforded by a divorce without the long, drawn-out process. On the criminal side, we pushed for greater enforcement of criminal statutes, which had, for almost a century, been ignored when the offender was the husband or lover of the victim.

Seeking a Civil Remedy




In 1976, the Pennsylvania Coalition against Domestic Violence became the first advocacy organization to approach its state legislature for a civil relief tailored specifically to the needs of battered women. Within 5 years of the coalition’s success, more than 30 other states had passed legislation allowing courts to grant immediate restraining orders; among other protections, these orders could exclude an abusive party from the petitioner’s home. Few people working in courthouses and advocacy programs today are aware of the historical significance of this accomplishment. For more than 10 centuries, women in Western society futilely sought and went without state protection from the violence of brutal husbands. By the late 1970s, we had garnered the political strength and the social consciousness to undermine the husband’s “king of the castle” privilege. Women could now tell their story in a courtroom and if a judge were convinced, by a preponderance of the evidence, that she was being physically or sexually abused, the judge could order the man to leave his home and have no contact with her until the court lifted the order. This achievement is on par with the victories of the first wave of feminists, who struggled for almost a century for the right to divorce, sue for custody of our children, use birth control, and vote.



The protection order replaced the old peace bond and divorce restraining order. It was more powerful—most states made the violation of a protection order a misdemeanor—and gave police the authority to arrest violators without requiring women to return to court. In average-size cities such as Minneapolis, Minnesota, literally thousands of women filed for this protection every year, and hundreds of men were arrested for not obeying the orders.

Criminal Intervention Strategies



Activists in the battered women’s movement were deeply conflicted over an agenda for criminal system reforms. Yet we did find common ground in the problems women faced as cumbersome and adversarial criminal court system slowly processed their abusers’ cases. We knew it was not in the best interests of women to have laws that effectively required them to arrest their abusers, so we advocated for—and achieved—police authority to arrest in misdemeanor cases without witnessing the assault. We knew that taking part in hostile court actions against their abusers was dangerous for women, so we successfully argued for several evidentiary rule changes,

as well as police documentation practices that gave prosecutors the ability to bring the victim's story into the courtroom without relying exclusively on her testimony.

Women wanted and needed many things from the justice system, including police protection, orders for their abusers to leave them alone or even leave the house, limits placed on their abusers' contact with them, financial help from him or the state, freedom to stay in their own homes safely, and a way to make abusers' contact with children safe for both the women and the children. Moreover, some women wanted the most hotly contested and controversial of wishes: someone to help him change.

Few women said they wanted their abusers punished, jailed, or put in prison. Most battered women saw imprisonment as a last resort, whereas advocates were more likely to pursue jail as an intervention goal. However, even many advocates recognized jails or prisons as hostile to women and felt that little was to be gained by sending men already fully engaged in anti-woman behaviors into an environment that would only reinforce their hatred of women. Many activists were reluctant to adopt a strategy that used imprisonment against men who were already overly criminalized in our society. Not surprisingly, Native American and African American women offered particularly strong arguments for alternative strategies.

As advocates, we had all seen or heard police officers, prosecutors, probation officers, social workers, or judges shake their heads sympathetically and say, "she's just not ready to testify," "she's reluctant," "she's still stuck in the honey-moon phase," or "she's too dependent on him." While we relentlessly educated professionals in training sessions and courthouse hallways about the personal struggles of battered women, we also tried to maintain the premise that the problem lies not in a woman's response to being beaten but in the community's response to the beating. Adhering to the notion that women's experiences should form the foundation of our agenda, we asked a fundamental question.

Why would a woman who is being punched by her husband take an adversarial action against him that (a) will take up to a year to resolve; (b) will likely result in her being cross-examined by a lawyer who will try to make 12 perfect strangers think that she is an evil, wicked, lying, wretched woman; (c) will focus exclusively on the violence in this one incident and rule as irrelevant the countless blows, insults, threats, and disloyalties she has endured over the years; (d) may result in him being sent to jail—but probably will not; (e) may result in him being sent to a batterers' group that he will hate and probably not finish; (f) may result in him being fined by the court—a fine he could coerce her into paying; and (g) will very likely not penalize him if he fails to follow through on any of the court orders that presumably protect her?

We pursued an agenda of criminalization, not because women in shelters were saying, "I want my partner prosecuted," but because many activists believed that men would not stop battering women until the community thought of and treated doing so as a crime. We knew that no group of people who systematically dominated others quit doing so because of a spiritual or ethical revelation.

Historically, excessive power—the freedom of dominators to act without consequence—has only been curbed by the oppressed who organize to take it away. Our strategy was inspired by the assumption that to make wife beating a crime would profoundly alter the premise of male dominance in marriage. Prosecuting an individual batterer does not necessarily protect the woman he is beating. In fact, sometimes, she becomes subjected to even more intimidation and abuse. Pursuing a criminal agenda meant using individual cases to make a social point. We tried to create some safeguards so that this agenda would not be used against women, but even from the beginning, we faced an uphill battle. When we criticized the almost universal problem of low conviction rates, some prosecutors— instead of improving investigations and police evidence gathering—responded by criminally charging women who refused to testify or who changed their testimony when subpoenaed to testify against their wishes. Today, many advocates have lost sight of this history, and they join other practitioners in viewing the primary barrier to holding offenders accountable as the failure of women to cooperate with prosecution efforts. Criminal consequences for individual men who batter—prosecution and convictions—have become goals of advocates, and many of us see battered women who do not share our enthusiasm for this presumed deterrence strategy as problematic. We label them as reluctant, in denial, recalcitrant, recanters. Note that using the legal system to right a historic wrong is rarely free of risk to those whom the reformed laws are intended to protect.

Eventually, efforts to enhance the state’s control over offenders translated into laws that expanded police powers of arrest, strengthened a prosecutor’s ability to present evidence, and allowed jailers to hold suspects longer. This type of reform is typically supported by the political right, not people of color, progressives, and/or feminists. We pursued every reform effort only cautiously; as I mentioned earlier, each gain has itself been used against some battered women in ways we tried, but were unable, to avoid.

Training and Conversion Efforts

In the late 1970s and early 1980s, on the heels of new legislation, we had the notion that if we trained practitioners to understand the new laws, things would change. We put together training packages—for police officers, social workers, therapists, doctors, judges, and anybody who would let us into their training rooms. I still remember every detail of the first training I did at a police station.

In 1977, we had successfully lobbied the Minnesota legislature to pass a law saying that if, during their investigation, police officers reasonably established that one adult household member had assaulted another, the officers could arrest and charge the suspect without the victim initiating the legal action. However, 6 months after its passage, advocates from every shelter in the state were reporting that the new law was rarely used. Police were still asking women at the scene of the assault if they wanted to arrest and prosecute their abusers. Women, of course, continued to say, “No, just get him out of the house.”

It was common in those days for us to train in a group. Usually, one woman went as the expert and gave a speech full of statistics and the feminist analysis of battering.

Then, three or four other women—the “victim’s panel”—talked about their personal experiences of being abused. The expert speaker got dressed up and carried a briefcase. If she had been battered, she would not necessarily talk about it. The other women dressed innocently—no low-cut blouses or tight pants. We all tried to look very heterosexual, because police and others in the system had branded us as man-hating lesbian radical feminists who had been turned off men by some bad experience with a guy. We even stooped to coaxing pregnant shelter workers into accompanying us on these training sessions to improve our image.

On this occasion, in August 1978, I got dressed up as the expert. Three former residents of the Duluth shelter, all of whom had called the police within the past year, dressed innocently. We went off to the police department for 2-hour training, having spent the early part of the day drinking coffee in the shelter lounge and talking with four or five of the current residents, discussing exactly what the police needed to hear. We planned for me to talk for about 20 minutes on the new arrest law and the “dynamics” of battering. Specifically, I was to say that women who lived with men who battered were not sick, crazy, masochistic, or products of bad families but were being controlled by violence and constrained by the inadequate backing of police and the courts. Then, each woman was to talk for about 15 minutes about the kinds of violence her husband used against her and the impact that the police response had on her and her husband. Then, we would open it up for questions.

The speech would open their minds, the panel their hearts. On leaving, we would know that, through our efforts, the police had seen the light and the state—instead of women—would start to take responsibility for arresting men who battered. We were all nervous but determined to do our task well. When we arrived at the police station, the desk sergeant directed us to a basement training room and said—“Good luck” as we turned to the staircase. I remember thinking, “How nice.” Downstairs, the training officer introduced us as “the girls from the shelter” to 25 or so uniformed officers, and we began.

I started by answering the question police always ask: Why do women stay? About 5 minutes into this little speech, an officer named Tommy Cich—a name etched into my memory—raised his hand and said, “I’ll tell you why *these* women get hit—they let their alligator mouths outrun their hummingbird brains.” I was a bit shocked, but I said, “Thank you, Officer Cich, for that analysis. Mine was slightly different,” and I went back to my planned remarks. Then, another officer raised his hand; I ignored him, but he spoke anyway. “You know, there is something about a battered woman that just makes you want to hit her.” For the second time in as many minutes, the room filled with laughter, and I found myself at a complete loss for words. I finally blurted out in a high pitched tone, “Well, let’s take a short break here, and you boys can all go get yourselves a cup of coffee!” I motioned to the victim panel, which looked as stunned as I felt, and we slipped off to the women’s toilet. The Duluth Police Department in 1977 did not boast a large women’s restroom with several stalls. Instead, the women’s restroom was a converted closet with a stool in the middle and a tiny sink off to the side. Nevertheless, we hovered around the toilet and said, “Now what?” I remember

one woman asking, “Why do they hate us so much?” None of us attempted an answer. None of us knew what to do, nor did we want to try anything. So, we walked out the back door, drove back to the shelter, called the desk sergeant, who no longer seemed so nice, and told him we had left.

Advocates from shelters across the state spent the next few years subjecting themselves to these types of training experiences. We quickly learned how to make witty comebacks to officers who acted like they had been recruited from caves. We occasionally converted an officer or two to be sympathetic to the plight of beaten women. Almost every shelter found a couple of allies in its local police department: someone they could go to with complaints. In some cities, police chiefs agreed to ongoing training programs for officers. Several departments ordered their dispatchers to make calls from the shelter a top priority for sending a squad car. In city after city, police became active participants in the increasing number of task forces and commissions addressing the problem. Nevertheless, none of these accomplishments seemed to substantially alter the way that police responded to calls. In fact, many of us felt that our newly formed cooperative relationships were drawing us into the police way of thinking more than we were persuading them to ours.

Eventually, we recognized the futility of these educational efforts. We began to understand that patriarchy is not simply a mind-set or just a function of attitudes—patriarchy is a practice. We needed to change it at the level of practice. This realization led to the development of criminal justice reform projects in cities across the United States and Canada. These projects were marked by the attention their organizers paid to drafting and lobbying for the enactment of procedures and policies that defined what practitioners could and could not do when responding to cases involving women abuse.

Intervention and Coordinated Community Response Projects—The 1980s

Every community has its own advocacy story. No single strategy was employed by everyone, but innovators created common visions for those of us who attended the growing number of regional and national gatherings. Seattle and San Francisco developed early prosecution programs. The state of Oregon took the lead in requiring police to make an arrest when violence reached a certain level. Pennsylvania shaped the dual track agenda of civil and criminal interventions. Courageous lawsuits against police inaction in New York, California, and, later, Connecticut, gave countless advocacy programs access to police training rooms for the first time.

Advocates in Duluth, who organized the first community-wide intervention project, capitalized on the work of dozens of other programs when defining their multi-agency approach to intervention, and they introduced some of their own innovations. They organized a local effort to implement legal strategies conceived at state, regional, and national gatherings. Most state domestic violence coalitions had already obtained new arrest laws, civil protection legislation, and welfare regulations. Duluth’s contribution was organizing a project with advocates at the center of a planning and implementation strategy for law enforcement, courts, and human service agencies, responding to

the mounting criticism of inadequate protection for battered women. We met with policy makers from key intervening agencies and somehow convinced them to let us help write a comprehensive policy for their agencies on responding to domestic violence cases. Toward that end, we called a series of small interagency meetings to work out the overlap in policy language, and ultimately, we became the central group encouraging interagency relationships for cases involving domestic violence. We immersed ourselves in the intricacies of case processing and, by so doing, learned to stop pointing at practitioners with poor attitudes and a lack of understanding about battered women and focus instead on the institutional work routines, policies, and procedures that produced an inattention to women's safety.

From the 911 dispatcher to the probation officer, scores of system workers—representing agencies from federal, state, county, or city government—will act on one woman's case before it is closed. Each action taken, beginning with that call to the police, is an opportunity to centralize or marginalize women's safety. When Duluth advocates started raising questions gleaned from the reality of our own and other women's lives, we were brought deep into the daily workings of the justice system. We began to take note of literally hundreds of institutional steps used to process a case while listening to women's stories, observing courtroom procedures, riding along with police, and attending meetings between women and prosecutors. We found opportunities to enhance women's safety in dispatch and patrol response procedures, booking procedures, and bail hearings; when decision were being made to prosecute, defer, or drop a case; during pretrial maneuvers, trial tactics, sentencing hearings, and revocations of probation. We proposed changes at every stage of a case's journey through the system. We proposed new legislation, new notions of practitioners' job duties, new department policies, new interagency protocols, and new administrative forms. Although never instrumental in achieving landmark legal decisions, we were pioneers in fighting for their enforcement, and we succeeded in rearranging how the system processes each aspect of a case. In doing so, we carved out a role for ourselves that few grassroots groups before us had done.

This intervention model eventually became known as a Coordinated Community Response (Shepard & Pence, 1999). In 1987, the Hilton Foundation awarded close to a million dollars to a national judicial organization to coordinate an intensive summit of interdisciplinary teams from all 50 states. After the 5-day conference, teams returned home with the message that effective coordination should be spearheaded by community councils and that the judiciary should play a key role in organizing those councils. Advocates should be present at the table, but not in the central, agenda-setting role that Duluth and other grassroots groups had envisioned. Coordinating councils proliferated, and advocates became increasingly marginalized in identifying problematic practices in a community. Even more significantly, the agenda of change focused more on increased efficiency, arrests, and convictions than on critiquing the impact of institutional responses on the safety, autonomy, and integrity of battered women.

While "systems-driven" reform efforts were taking shape, shelter and nonresidential advocacy programs were maturing in several unfortunate ways. Urban programs

started placing their workers into limited and specialized roles. Some advocates were restricted to accompanying women to civil protection court—day after day, month after month—or to working the criminal court, or to finding housing. Such a development has many implications for our effectiveness. First, advocates began to talk about women in noticeably different ways. Opportunities for advocates to problem-solve larger issues disappeared as administrators in the increasingly stratified workforce took on the roles of agency spokespersons. Without full responsibility, advocates lost the ability to respond fully. Second, a growing attraction to being professional left fewer opportunities for shelter residents to have meaningful ways of joining the struggle. Finally, funding relationships started to shape advocacy programs in several problematic ways. Foundations and local government funding sources began to link dollars to units of services provided. Women coming into shelters became clients, advocates became counselors, and the distinction between the shelter programs and the institutions that regulate women's lives became far less pronounced. The federal government finally supported institutional advocacy on a large scale in 1994 with the passage of the Crime Bill's Violence Against Women Act. However, grant guidelines funneled a substantial amount of Violence Against Women Act funds through police and prosecutors, whom they required to collaborate with local advocacy programs. In some communities, local advocacy programs received subcontracts from the police or prosecutors' offices, but in other communities, the police department or prosecutor's office built its own advocate staff positions into the budget. In cities and towns across the country, advocates started being managed by or working directly for the very agencies we had originally organized to change.

The crux of advocacy is identifying the site of problems and the standpoint from which to articulate and pose solutions to those problems. An advocate, therefore, places herself at the position of interaction between the battered woman and the system and makes her agenda the problematic ways in which the woman experiences that interaction. This standpoint of advocacy is unattainable when


the advocate has only partial loyalty to the woman. Advocates must offer absolute confidentiality, a clear commitment to the safety needs of a woman, and the ability to speak out on behalf of women without risking reprisal—conditions that do not exist when we merge with the institutions that we are committed to changing.

Advocacy in the New Millennium: Reclaiming Our Roots

I want to propose five concrete actions that can return advocacy programs to our more radical roots while still capitalizing on our growth of the past three decades. I offer each of these proposals as a point of departure—an action plan that should quickly transform our waning attachment to the viewpoint of women and, in doing so, map out a new course of advocacy for the next decade.¹

Build critical reflection into the structure of advocates' work.

At the core of my proposal is increasing an advocate's ability to develop critical perspectives about her work. This program will be successful if advocates can nest their



efforts in the larger political understanding of violence against women and move away from atomized tasks. Advocates from all around the country complain about how little time they get to think. Their activities on behalf of battered women seem to take them from crisis to crisis. As a result, advocates rarely get the chance to pursue theoretical questions that arise from their work, scrutinize the fundamental philosophies of their programs, debate policy issues, or link domestic violence work with other oppressions in society. Nor do they get the space or time to acquire information that is vital to connecting theory with practice. This lack of opportunity to think critically makes advocates fall into traditional and fragmented work patterns, lose their connection to women's realities, and prioritize their tasks according to bureaucratic expediency. We can take several simple steps to recapture our perspective. First, schedule regular discussions—at least every 2 months—for advocates and battered women to think through issues they are facing. Second, assemble a video and article library to expose workers to new ideas for ending oppression from a broad range of progressive efforts. Finally, set aside at least a half hour of every staff meeting for one advocate to summarize an article or documentary and lead a short discussion on its local implications.

Build community-organizing activities into advocates' job duties.

Ultimately, we must guarantee a battered woman's safety *within* her community, not away from it. The community is a battered woman's life source; removing her from it may be a temporary solution to her problems but never a permanent one. The success of the battered women's movement, therefore, hinges on changing minds and society. Organizing communities must become central to our advocacy work. However, in the melee of our frenetic activities to ensure the safety of individual battered women, we have increasingly ignored this basic understanding. Even when we recognize community organizing as an important part of our program, most of us do not quite comprehend what it entails, nor the skills it requires. We must acknowledge community organizing as the complex activity that it is and prepare ourselves. The work of transforming our communities is the work of all women, including battered women. It is our community and, therefore, our historic task to change the conditions that make women unsafe in their homes. Again, simple steps will make this a reality. Every advocate should attend at least one community-organizing training a year. We should restructure women's groups to introduce ways for battered women to organize around their common problems, which means that group facilitators should plan to spend more than 2 hours a week in each group. Every group should lead into subsequent sessions to act on an issue, and women attending the groups should be provided with the basic resources of community organizing, such as paper, stamps, and transportation funds.²

Give battered women and advocates decision-making control over the work methods used by advocacy programs.

The battered women's movement was founded on the reclamation of decision-making power by the women whose lives were affected by program policies. Over time, most programs abandoned their efforts to include battered women's opinions and

voices in the decisions being made on their behalf. The same thing eventually happened to advocates, as programs moved from cooperative management structures to increasingly hierarchical ones. It is time to reverse this condition. I propose that each program develop a decision-making committee in which battered women occupy prominent positions, holding veto power over every proposed policy. The decision making tree might even allow advocates who work closely with battered women to have a central role in developing program policies. Ultimately, the reference point of all policies would be the interests of battered women.³

Strengthen the collective advocacy efforts of progressives in the community by linking the anti-violence work of marginalized groups.

A significant problem of the contemporary battered women's movement is that it has drifted away from other types of violence against women, as well as the oppressions under which other marginalized groups struggle. Unless we understand the relationships between various social oppressions, our movement runs the risk of working in isolation and perhaps even in opposition to other social change campaigns. We can overcome this by developing an accountability committee made up of community members and activists from other progressive groups working against oppression. This committee would not only help the domestic violence program make decisions but also act as the watchdog of official institutions such as the courts and police. Thus, if a judge makes a decision that endangers a woman or her children, the committee—rather than a “special interest program”—would assume the responsibility for public confrontation. Today, advocacy programs have been reduced to the status of special interest groups, separated from the concerns of the larger community. An accountability committee could create connections among progressive organizations to enhance our collective work toward a society free of relationships of domination and deepen our commitment to the whole experience of women.

Rebuild our programs to minimize our dependence on institutions that subjugate women.

It is impossible for us to be truly free of the influence of institutions that produce and maintain patriarchal privilege. We can, however, be far more conscious of how our relationships to our funding sources and other institutions that manage women's cases might subvert our ability to stand in solidarity with battered women. The first step to reclaiming our grass roots is to ensure that every community's advocacy program for battered women is independent from local law enforcement and criminal and civil court systems. That does not mean we cannot work cooperatively with court-employed victim assistants, nor that we compete with staff in other institutions for the role of victim advocate. It simply means that we must be clear about the differences between people who help manage victims' participation in legal proceedings, such as prosecutors, and people who are mouth-pieces for the goals and needs of battered women. The second step is to set standards for fund raising that give our relationship with battered women priority over our financial stability. The politics of money plays out differently in each state and philanthropic setting. However, we collectively face similar challenges in our approaches to federal funding. We must not

have unspoken agreements, if we get money from funding sources, to not speak out about their failures to protect battered women. State and federal sources—the largest being the U.S. Department of Justice—now provide some of the most influential advocacy programs in the country with significant financial support. Yet we are almost silent on the Justice Department’s role in increasing the vulnerability of immigrant and undocumented women to abusive partners through their immigration policies, practices, and laws.

We have mounted no unified voice against the failure of the Justice Department to offer guidelines to prosecutors on working with women living under the control of drug dealers—women who are easy game for major convictions in federal court. We have no national plan to confront the dismal charging and conviction rates of prosecutors charged with upholding the law on reservations and federal lands. I only mention these as examples of how subtle collusion can be and how easily the system co-opts our voices. The decision to apply for and accept funding must always be accompanied by an analysis of how a funding source contributes to women’s vulnerability to male violence. Although we are not obliged to be penniless by taking a position of only accepting clean money, we must not be silent about funders’ institutional practices that are harmful to battered women.

Conclusion

Today, we are miles away from where we started. Although we are weaker in some ways, we are stronger in others. We have established a foundation of important legislation, we enjoy more resources and a more diverse leadership, we have more experience, we have a more sophisticated understanding of how institutions affect our lives, and we have greater access to inner chambers of power. Nevertheless, we must actively pursue an agenda of reclamation if we are to continue to be a force of liberation for women who are battered. The suggestions I have made for immediate actions toward reclamation are only starting points. As we discuss the possibilities in our state coalitions and local programs, a more contextually appropriate course of action will emerge.

Thirty years ago, we faced incredibly hostile reactions to our insistence on the most basic protections for women: sending a squad when she calls or arresting men who brutally beat their partners. Because of our work and the important and courageous work of allies in the system, these institutional responses are now normal. However, these institutions are still the guardians of men’s power over women. Our role is never to help the legal system manage cases or women’s lives—it is to continue to make women’s real experiences visible and to make women’s safety a goal of legal intervention and the responsibility of the community. We must resist the forces that swallow up social movements and their transforming agendas.



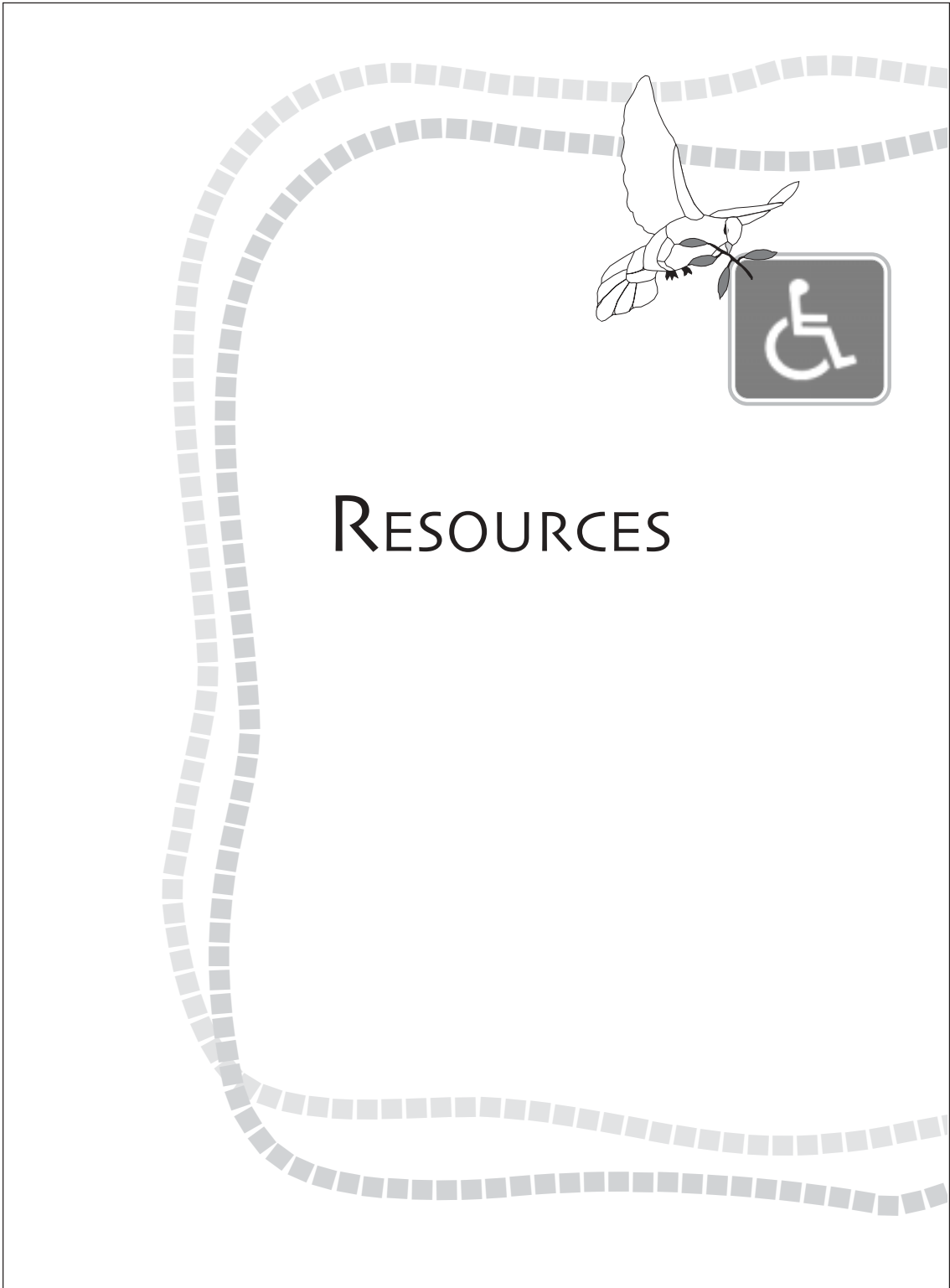
Notes

1. A special thanks to Shamita Das Dasgupta who helped me think through these five points and eliminate others that would have cost so much money as to further compromise our autonomy.
2. A wonderful resource for thinking like organizers in a women's group is *Training for Transformation: A Handbook for Community Workers* by Anne Hope and Sally Timmel. This manual can be ordered from the Grailville Art & Bookstore, 932 O'Bannonville Rd., Loveland, OH 45140, 1-888-683-2302.
3. In 1990, when the Domestic Abuse Intervention Project faced the problems discussed here, we adopted such a decision-making tree. To obtain a copy, write to DAIP, 202 East Superior Street, Duluth, MN 55802.

References

- Dasgupta, S. D. (1998). Women's realities: Defining violence against women by immigration, race, and class. In R. Bergen (Ed.), *Issues in intimate violence* (pp. 209-219). Thousand Oaks, CA: Sage.
- Shepard, M. F., & Pence, E. L. (1999). *Coordinated community responses to domestic violence: Lessons from Duluth and beyond*. Thousand Oaks, CA: Sage.
- Chapter 17 of "Sourcebook on Violence Against Women", pp. 329-343, copyright © 2001

Reprinted by Permission of Sage Publications, Inc., www.Sagepub.com



Referral points to national, statewide, and community resources on the Internet.

Americans with Disabilities Act (ADA)

<http://www.usdoj.gov/crt/adaadahom1.htm>

This site provides information about the implementation of the Americans with Disabilities Act. This act gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. This site provides information about equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications.

Bobby Approved

<http://bobby.watchfire.com/bobby/html/en/index.jsp>

The Bobby Approved site can check on the accessibility of your program's web site. You are allowed to check two sites per day at no charge. There is also available software for purchase.

CENTERS FOR INDEPENDENT LIVING (See Attachment A, page 68)

Kansas Association Centers for Independent Living (KACIL)

<http://www.kacil.org>

The KACIL site has links to the 13 centers through out the state. The individual center sites will have local resources available. Information for local resources can be found at the following individual community sites in Appendix D.

Children

<http://www.familiestogetherinc.com>

Offers resources for families supporting children with disabilities as well as parents with disabilities.

Criminal Record Check

<http://www.publicrecords-search.com>

Fee-based service

(There is no charge to search for a criminal record by checking your local county court house web site or entering a persons name on google.com)



Disability Rights Center of Kansas (DRC)

Formerly Kansas Advocacy & Protective Services (KAPS)

<http://drckansas.org/>

The Disability Rights Center of Kansas is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities.

DOMESTIC VIOLENCE AND SEXUAL ASSAULT SERVICES

(See Attachment B, page 70)

Kansas Coalition Against Sexual and Domestic Violence

<http://www.kcsdv.org/>

Shelters/Safe homes, support services and counseling for domestic violence and sexual assault through out the state can be found on this web site.

See Attachment E

Giant Disability Resource Page

<http://www.independenceinc.org/ability.html>

Links to a wide variety of web sites from advocacy to religion.

Kansas Commission on Disability Concerns

<http://www.hr.state.ks.us/dc/>

The Kansas Commission on Disability Concerns (KCDC) branch of the Kansas Department of Commerce is an information and referral office, providing technical assistance on civil rights and legislative issues.

Kansas Department of Social and Rehabilitation Services

(See Attachment C, page 72)

<http://www.srskansas.org/>

Numerous disability resources. See attachment for contact numbers

National Coalition Against Domestic Violence

<http://www.ncadv.org/>

<http://www.ncadv.org/resources/state.htm>

Domestic violence information and links to state coalitions that can be used to locate shelters throughout the United States.

National Council on Independent Living

<http://www.ncil.org>

NCIL is a membership organization that advances the independent living philosophy and advocates for the human rights of, and services for, people with disabilities to further their full integration and participation in society.



National Domestic Violence Hotline

<http://www.ndvh.org/>

Get help in your state

Psychotropic Medications 2004 list

<http://www.mattc.org/index.asp>

Contains information on medication uses and side effects.

Rape, Abuse, and Incest National Network

<http://www.rainn.org/>

Sexual assault hotline

Statewide Independent Living Council of Kansas (SILCK)

<http://www.silck.org/>

SILCK offers information of legislative issues arising in the state of Kansas.

TTY Services

<http://www.teltextinc.com/>

TELTEX FOR REFURBISHED TTY MACHINES.

Text-to-Speech

<http://www.microsoft.com/reader/developers/downloads/tts.asp>

Readers

<http://www.microsoft.com/reader/downloads/pc.asp>

Reader supports for persons with impaired vision or speech is software to use on your computer. Some can act as communication devices with others who have the software instead of a TTY or relay system.

Victims Assistance and Crime Compensation

http://www.ksag.org/victims_assistance.htm

Resources and services available to victims of crime.

KANSAS CENTERS FOR INDEPENDENT LIVING

***Center for Independent Living of Southwest Kansas, Garden City**

<http://www.cilswks.org/>
1-800-736-9443

***Coalition for Independence, Kansas City**

<http://www.cfi-kc.org/>
TTY: (913) 321-5216 or (913) 321-5140

***Independence Connection, Salina**

<http://www.occk.com/icsection.htm>
TTY (785) 827-7051 or 1-800-526-9731

***Independence Inc., Lawrence**

<http://www.independenceinc.org/>
TDD: (785) 841-1046 or (888) 824-7277

***Independent Living Center of North East Kansas, Atchison**

<http://www.ilcnek.org/>
TDD: (913) 367-1830 or 888-845-2879

***Resource Center for Independent Living, Osage City**

<http://www.rcilinc.org/>
TDD: 1-785-528-3106 or 1-800-580-7245

***Three Rivers, Inc., Wamego**

<http://www.threeriversinc.org/>
Toll Free: (800) 555-3994

Topeka Independent Living Resource Center, Topeka

<http://www.tilrc.org/>
(785) 233-4572 V/TDD

***The Whole Person, Kansas City, Kansas and Missouri**

<http://www.thewholeperson.org/>
(913) 369-9005

***Independent Living Resource Center, Wichita**

<http://www.ilrcks.org>
316-942-6300 v/TDD or 1-800-479-6861

***LINK, Inc., Hays**

<http://www.linkinc.org>
(785) 625-5196



***Prairie Independent Living Resource Center, Hutchinson**

<http://www.pilr.org>
TDD:(620) 663-9920 or 1-(888) 715-6818

***Southeast Kansas Independent Living, Inc., Parsons**

<http://www.skionline.com>
620-421-5502

* Member of KACIL

DOMESTIC VIOLENCE AND SEXUAL ASSAULT SERVICES

Kansas Crisis Hotline I-888-END ABUSE (1-888-363-2287)

CITY	MEMBER PROGRAMS	HOTLINES
Atchison	DoVES (also serves Hiawatha)	800-367-7075 or 913-367-0363
Coffeyville	Crisis Resource Center of Southeast Kansas, Inc.	888-320-7218
Dodge City	Crisis Center of Dodge City	620-225-6510
Emporia	SOS, Inc.	800-825-1295 or 620-342-1870
Garden City	Family Crisis Services	620-275-5911
Great Bend	Family Crisis Center	620-792-1885
Hays	Northwest Kansas Family Shelter (also serves Goodland)	800-794-4624 or 785-625-3055
Hutchinson	Sexual Assault/Domestic Violence Center (also serves McPherson)	800-701-3630 or 620-663-2522
Iola	Hope Unlimited	620-365-7566
Kansas City, KS	El Centro, Inc. ¡Si Se Puede!	913-677-0100
Kansas City, KS	Friends of Yates Joyce Williams Center	913-321-0951
Kansas City, MO	Kansas City Anti Violence Project	816-561-0550
Kansas City, MO	MOCSA	816-531-0233
Lawrence	GaDuGi Safe Center	785-841-2345
Lawrence	Women's Transitional Care Services (also serves Ottawa)	800-770-3030 or 785-843-3333

Leavenworth	Alliance Against Family Violence (also serves Tonganoxie)	913-682-9131
Liberal	Liberal Area Rape Crisis and DV Services	620-624-8818
Manhattan	The Crisis Center, Inc (also serves Junction City)	800-727-2785 or 785-539-2785
Mayetta	Prairie Band Pottawatomie Family Violence Prevention Program	866-966-0173
Overland Park	Safehome, Inc. (Also serves Miami County)	888-432-4300 or 913-262-2868
Pittsburg	Crisis Resource Center of Southeast Kansas, Inc.	800-794-9148
Reserve	Sac & Fox STOP Violence Against Indian Women	785-742-0053
Salina	Domestic Violence Assoc. of Central Kansas	800-874-1499
Topeka	YWCA Battered Women's Task Force	888-822-2983 or 785-354-7927
Ulysses	DoVES of Grant County	620-356-2608
Wichita	Catholic Charities Harbor House	316-263-6000
Wichita	StepStone	316-265-1611
Wichita	Wichita Area Sexual Assault Center	316-263-3002
Wichita	YWCA Women's Crisis Center	316-267-SAFE (7233)
Winfield	Cowley County Safe Homes	620-221-HELP or (4357) 800-794-7672



SRS CONTACT INFORMATION

1-888-369-4777

SRS REGION OFFICES

<u>REGIONS</u>	<u>PHONE</u>
Central Office	(785) 296-4687
Kansas City Metro Wyandotte & Johnson counties	(913) 279-7345
Douglas, Leavenworth, Franklin & Miami counties	(785) 832-3710
South Central	(620) 342-2505 ext 207
Northeast	(785) 296-2230
Southeast	(620) 431-5002
West	(620) 272-5985
Wichita	(316) 337-7061