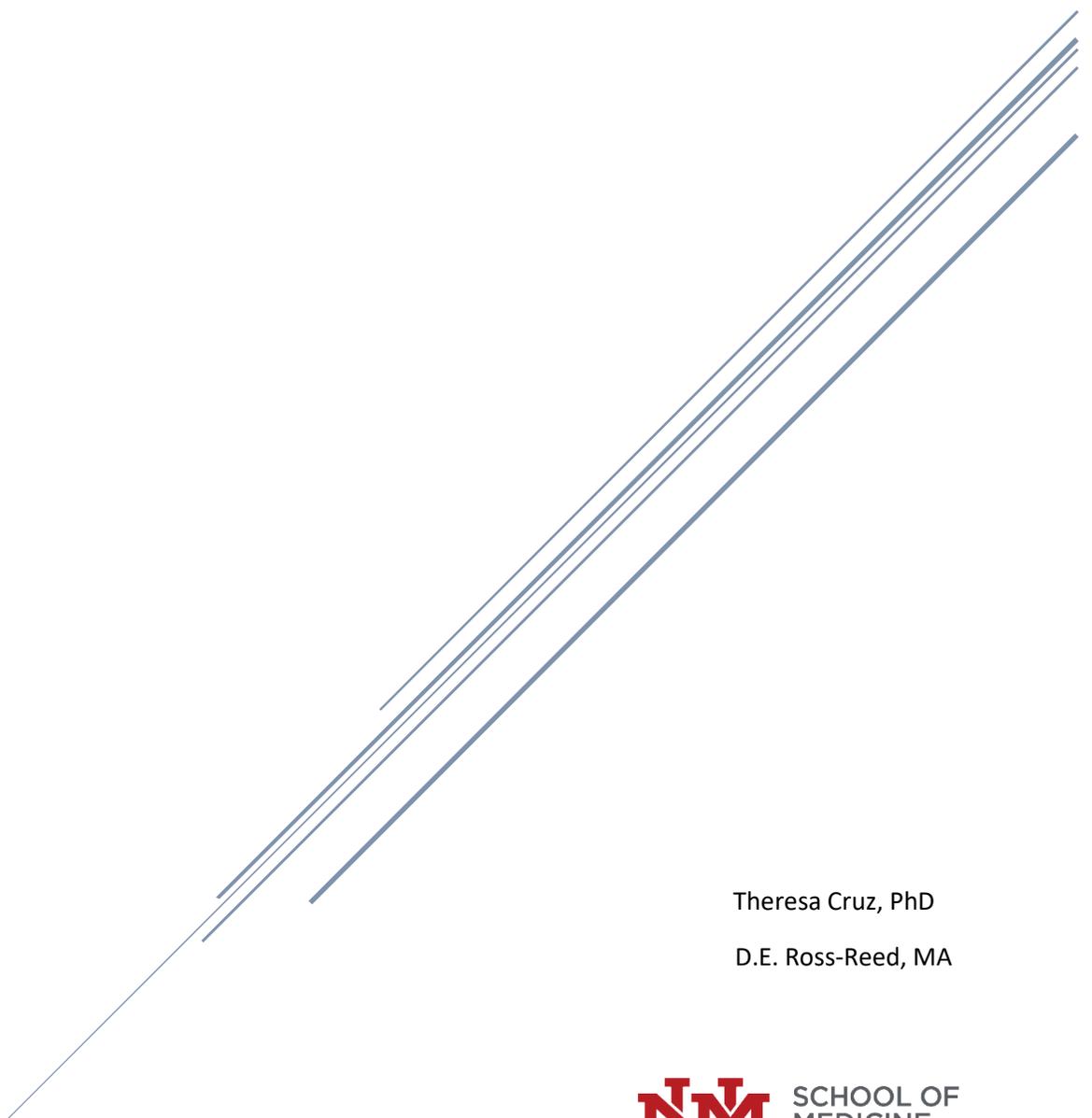


SEXUAL VIOLENCE AMONG NEW MEXICANS LIVING WITH INTELLECTUAL/ DEVELOPMENTAL DISABILITIES

Policy and Practice Recommendations for Primary Prevention



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SCHOOL OF
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Executive Summary

Sexual violence among people living with intellectual and developmental disabilities (I/DD) is highly prevalent in New Mexico and in the United States. More than one in four New Mexican adults with I/DD report a history of forced sex or attempted forced sex, compared to fewer than 1 in 10 among people without I/DD. Power imbalances between caregivers and clients, lack of sexuality education for people with I/DD, isolation, gaps in caregiver training, frequent staff turnover, a culture of ableism and compliance, and underreporting of sexual violence all contribute to disparities in sexual violence victimization.

Strategies that have shown the most promise to reduce sexual violence victimization among people with I/DD include:

- developing and implementing legislative and organizational policies
- providing education to people with I/DD and their caregivers
- fostering critical collaboration
- enhancing research
- adopting trauma-informed practices in organizations that serve people with disabilities

People representing a variety of agencies and sectors in New Mexico convened in December 2018 to discuss ways to enhance primary prevention efforts and reduce sexual violence among people living with I/DD in New Mexico. Recommendations from this learning community included:

- strengthening policies and procedures related to both prevention and reporting
- enhancing education about sexual violence for caregivers and special education teachers
- creating meaningful collaboration across sectors
- enhancing research including better data collection
- creating a strategic plan for prevention of sexual violence among people with disabilities

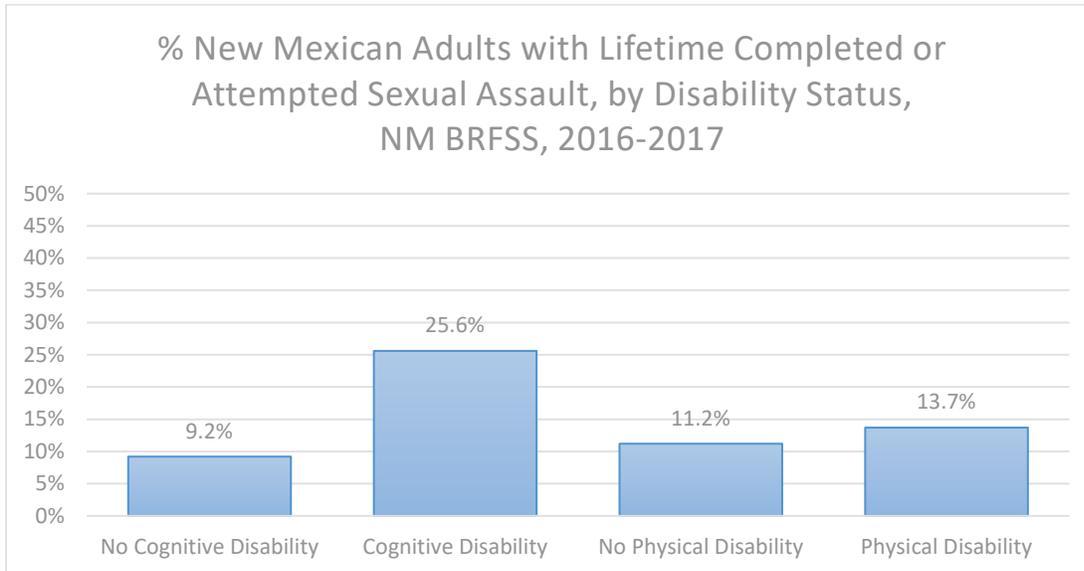
Next steps include developing and implementing a plan for addressing these recommendations.

Introduction

Sexual violence is a critical public health issue in the United States; data from a 2010 national survey indicate that more than one in four women and more than one in ten men have experienced unwanted sexual contact during their lifetime.¹ Among people living with disabilities, the rate of sexual violence is much higher. Women with disabilities were more 3.3 times as likely to have experienced recent rape, and men with intellectual disabilities were 4.2 times as likely to have been made to penetrate a perpetrator, compared to people without disabilities.² Department of Justice statistics from 2009-2015 indicate that people with multiple disabilities are at highest risk, with 65.4% reporting a lifetime history of rape or sexual assault.³

In New Mexico in 2016-2017, adults with a cognitive disability were 2.8 times more likely to have experienced completed or attempted sexual assault in their lifetime, with 25.6% of adults with a cognitive disability reporting sexual assault compared to 9.2% of adults without a cognitive disability.⁴ Additionally, adults with a physical disability were 1.4 times more likely to have experienced completed or attempted sexual assault in their lifetime, with 13.7% of adults with a physical disability reporting sexual assault compared to 11.2% of adults without a physical disability (Figure 1). Prevalence of prior year sexual assault or attempted sexual assault was 4.3 times higher among adults with a cognitive disability compared to adults without a cognitive disability.⁴ Among youth in 2013, lifetime history of forced sex was 3 times higher for students with a long-term emotional problem or learning disability.⁵

Figure 1. Percent of New Mexican Adults Reporting a Lifetime History of Completed or Attempted Sexual Assault, by Disability Status, NM BRFSS, 2016-2017.



The long-term impact of sexual violence victimization on suicide risk, mental health, and substance abuse is well documented. Numerous correlational studies show that sexual violence victimization is associated with suicide ideation and attempts,⁶⁻⁸ and with stress, depression, post-traumatic stress disorder, anxiety disorders, and chronic major depression.⁹⁻¹¹

People living with I/DD are more likely to have an increased number of risk factors that are associated with sexual assault victimization, including low income, prior victimization, and substance use.¹² The

California Coalition Against Sexual Assault (CALCASA) names additional environmental-level reasons that sexual violence is higher among people with disabilities. People who live in controlled environments, such as group homes or with family members, are frequently rewarded for compliance. In these environments, people with disabilities may be at risk of having basic freedoms removed for non-compliance with requests for sexual favors. People with I/DD may have caretakers with inappropriate physical boundaries who perform daily hygiene tasks such as bathing and clothing. Frequent turnover among caregivers, which stems from lack of training and low pay, may result in agencies employing caretakers without conducting rigorous background checks. Additionally, people with I/DD are at risk for re-victimization because they may not be seen as credible historians of their own experiences, they may be over- or under-medicated, and/or they may lack the ability to physically resist or call for help.¹³ Law enforcement officers without sufficient training on working with people with I/DD may not consider survivors to be credible witnesses and consequently may fail to file charges against perpetrators.¹⁴

Ableism, defined as “the oppression of or discrimination against people with disabilities, grounded in beliefs that cast people with disabilities as weak, abnormal, or less capable than those without disabilities”¹⁵ may result in the belief that people with disabilities are asexual or not sexually attractive, and that sexuality education is not necessary or appropriate.¹³ For this reason, people with disabilities may lack an understanding of healthy sexuality and, conversely, what constitutes sexual abuse. They often receive little or no education around healthy sexuality or healthy relationships.^{12,16} Perpetrators and caregivers who fail to see healthy sexuality as a part of a person with I/DD’s life may believe that sexual harassment and unwanted sexual touching is a compliment. Lack of reporting may also contribute to re-victimization. Sexual violence is underreported among people with disabilities, sometimes because the perpetrator is a caregiver or family member and the survivor may feel unsafe asking for help.¹⁷ Underreporting may also be associated with serial perpetrators seeking out caregiver positions to have contact with potential victims, knowing that there is low risk of repercussions.¹³

Best Practices in Systems-Level Primary Prevention of Sexual Violence among People Living with Intellectual and Developmental Disabilities

Leading sexual violence prevention organizations including CALCASA and the National Sexual Violence Resource Center (NSVRC), alongside disability advocacy organizations such as The Arc, have made recommendations and compiled resources for prevention of sexual violence among people living with disabilities. These resources include guidance documents suggesting policies and practices that states and agencies can adopt to reduce sexual violence in this population. The recommendations below appear in guidance documents released by states, disability service agencies, and violence prevention coalitions from 2010-2019, as well as academic research published during the same time frame. There are currently no evidence-based policies or practices for prevention of sexual violence specifically among people living with disabilities. This reflects the logistical difficulty of conducting outcome-based research and program evaluation with this population as well as lack of funding available for longitudinal studies.¹² Additionally, many programs focus on risk reduction, rather than primary prevention.¹⁵ Recommendations for prevention among people with I/DD draw from community input as well as evidence-supported prevention strategies developed for other populations.

A comprehensive approach to violence prevention that includes efforts to impart change at the individual, relationship, community, and societal levels has the greatest potential for reducing sexual violence perpetration and victimization at the population level.¹ For people living with I/DD, this means

engaging entire systems including caregivers, families, and clients.¹² Comprehensive strategies and approaches may include creating or strengthening legislative and organizational policies; providing direct education to people with I/DD as well as service providers and caregivers; and fostering critical collaboration. Because the prevalence of violence against people with I/DD is so high, it is also important to address gaps in reporting of violence victimization. Additional research can also identify trends in victimization, inform interventions, and strengthen service delivery.

Legislative and Organizational Policy

Agencies that serve people with I/DD may be privately owned and managed, or they may be run by state agencies such as the NM Department of Health's Developmental Disabilities Supports Division. Because many services for people with I/DD are managed or overseen by state departments, and staff are employed by or contracted with state departments, legislative policies at the state level can create substantive changes in service delivery. One recommended state level policy is the creation of explicit agreements for direct care workers regarding equality, consent, and healthy and appropriate staff-client interactions.¹⁸ Agreements about consent should emphasize the need for affirmative consent to any sexual activity.¹⁹ Policies should also ensure that service providers receive education and training about sexual abuse, ableism, and healthy boundaries. Evaluation of this type of training indicates that it may improve attitudes toward people with disabilities; however, one half-day training session may not be sufficient to impact knowledge about sexual abuse among people with I/DD.¹⁵ A sufficient dose of prevention education, usually over multiple sessions, is recommended to change complex behaviors such as sexual violence.²⁰

State-level policy can also ensure that people admitted to an I/DD facility have access to sexuality education.²¹ Because students are frequently opted out of health or sex education classes in school,¹⁹ adults with I/DD may have never received any sexuality education. This can result in gaps in understanding about healthy expressions of sexuality and affirmative consent.

Inadequate levels of staffing may lead to excessive stress for direct care workers and contribute to a culture that devalues people with I/DD. High turnover may also result in staff who have not received all necessary training in recognizing and reporting sexual abuse.¹⁵ Legislative appropriations can improve pay for direct care workers employed and contracted by state governments. This may improve quality of care, staff retention and employment longevity, as well as compliance with policies.¹⁴

Legislative policy can influence the handling of reports of sexual assault. Caregiver consent may be required for people living with I/DD to receive medical or legal services; however, states can enact legislation that ensures that survivors have access to a rape kit and counseling without consent of their guardian.²¹ Reporting requirements can also be streamlined across agencies, minimizing confusion about protocol and mandatory reporting requirements, and states can adopt a "no wrong door" policy ensuring that reports of sexual violence are ultimately filed with the correct agency, regardless of which agency initially received the report.¹⁴ Establishing and posting whistleblower protections, in which staff can report abuse or suspected abuse without fear of retaliation, can identify perpetrators and improve client safety.¹⁸

Policies within organizations serving people with I/DD have additional potential to reduce sexual violence. By including information about the impact of ableism and discrimination on people with disabilities in training materials and posted policies, agencies can create a shift in organizational culture

that reduces oppression and victimization.¹⁵ Norms change may also be achieved by adopting policies and practices that empower people living with disabilities to know and assert their rights and to advocate for their needs.²¹ A clearly worded policy around inappropriate touch between caregivers and clients (including hugs, kissing, or other intimate forms of affection) should be put into place and made public and accessible.¹⁸ Agencies can create opportunities for people with disabilities to integrate into the community, reducing isolation -- a risk factor for sexual and relationship violence.²¹

Due to the high prevalence of sexual assault among people with I/DD, tertiary prevention (minimizing harm to those who have been assaulted) is often discussed in recommendations for prevention. Organizations that are trauma-informed recognize the impact of trauma on individuals and communities, are able to identify signs of trauma and respond appropriately, and actively resist re-traumatization.²² Organizations can adopt trauma-informed care policies and can emphasize their commitment to trauma-informed care in their programming and interactions with staff. Similarly, policies that ensure adequate staff training to provide trauma-informed care and empathetic response to reports of sexual violence are crucial.²¹ Specific policies are outlined below:

Recommendations for Legislative and Organizational Policies

- Include explicit agreements for direct care workers in state-run facilities around equality, consent, and healthy interactions
- Provide access to sexual education for persons receiving I/DD services
- Improve pay for direct care workers to improve care, employment longevity and compliance
- Adopt a policy that promotes self-advocacy
- Discuss the impact of ableism and discrimination on people with disabilities in official documents and training materials
- Create and make public a policy around inappropriate touch
- Provide sexual assault survivors with I/DD access to a rape kit, a sexual assault exam by a trained professional, and counseling without needing the consent of a guardian
- Streamline reporting requirements across state agencies
- Adopt a “no wrong door” policy that ensures reports of sexual violence are filed with the correct agency, regardless of which agency initially received the report
- Establish and post whistleblower protections
- Explicitly name a focus on trauma-informed care in administrative rules, training and programming
- Work with the criminal justice system to ensure that law enforcement and prosecutors receive training on working with people with I/DD
- Enhance staff capacity for an empathetic, supportive response to sexual assault disclosure

Education for People Living with I/DD and Caregivers

Agencies that serve people with I/DD can provide education around healthy relationships and red flags for sexual violence (OH, IL). This type of education can empower people with I/DD to communicate about sexuality and sexual violence (NJ) and advocate for their needs and desires.

Advocates emphasize that sexuality education for people with I/DD should be grounded in the belief that sexuality is a critical part of a person's identity and well-being. Programs should focus on people with I/DD feeling empowered to make decisions about their bodies and feeling respected in choices about their sexuality.¹⁸ Throughout this process, people with I/DD should feel free to explore, identify, and define their sexuality without judgement.²¹ Respect for individual sexual differences should be encouraged, and education should be inclusive of a variety of diverse sexual and gender identities.¹⁸ Education should be made available in languages that clients speak and should be accessible; education using adaptive technology for people with a variety of disabilities is increasingly available.¹⁵

Sexuality education may include education about basic rights as well as strategies for self-protection.¹⁴ People living with I/DD who are survivors of sexual violence may not realize that intimate touching can be a part of a consensual, pleasurable sexual encounter; sexuality education can help people realize that this type of sexual activity can be a typical expression of intimacy.¹⁸

Advocacy organizations also emphasize that healthcare providers and allies should receive education and training about how to communicate about healthy sexuality as well as how to communicate about sexual violence.¹⁹ Research suggests that caregivers for people living with I/DD often lack general knowledge about sexual violence.¹⁵ Prevention education for caregivers and other professionals should be of sufficient dosage. A one-time training session does not appear to be effective for increasing knowledge about sexual violence.¹⁵ It is recommended that caregivers also are trained in trauma-informed care and receive education about ableism and discrimination as a routine part of professional development and training.¹⁸ Families who are trained to recognize the signs of abuse and report sexual violence can reduce re-victimization.¹⁴

The lack of privacy among people with I/DD who live in group settings can contribute to the risk of sexual violence.¹⁵ Education for caregivers and support staff around the need for privacy can shift organizational norms towards a culture of consent. For example, staff can model consent by asking clients for permission to engage in contracted activities such as bathing and changing.²¹

Recommendations for Education for People with I/DD, Caregivers, and Allies

- Provide sexuality education for people with I/DD that is grounded in empowerment, respect, and the belief that sexuality should be nurtured and valued as a critical part of a person's identity, well-being, and choice
- Provide education around healthy relationships and red flags for abuse
- Educate individuals about active consent
- Help individuals understand that intimate touching, if consented to, is a normal means of sexual expression
- Improve communication around sexuality and sexual violence
- Offer adaptive technology-assisted programs when appropriate
- Equip healthcare providers with communication skills and resources to talk about sexual violence
- Train staff to promote more equity among staff members and people with disabilities
- Teach staff to respect the need for privacy; teach and model healthy boundaries
- Educate direct care providers on the principles and tenets of trauma-informed care
- Educate staff about ableism and discrimination

- Educate families and care providers about signs of abuse, how to plan against abuse, and how to contact authorities about apparent abuse

Collaboration and Research

Prevention of sexual violence requires a coordinated effort within organizations that includes working on policy, training and education, and norms change.¹⁸ State governments, rape crisis centers, advocacy groups, and organizations that serve people with I/DD can work together to create and administer free, accessible trainings about sexual violence prevention.¹⁴ It is crucial that people living with I/DD are involved in this process at every step and are compensated appropriately for their time and expertise.²¹

There are substantial gaps in the research surrounding prevalence and prevention of sexual violence among people living with disabilities. States can prioritize funding for data collection to better understand the circumstances around sexual assault against people living with I/DD.¹⁴ Through collaborative research, trends can be identified and addressed, and research-supported interventions can be designed, implemented, and evaluated to add to the prevention knowledge base. Most prevention programs for this population that have been implemented and evaluated are focused on risk reduction rather than primary prevention.¹⁴

Recommendations for Collaboration and Research

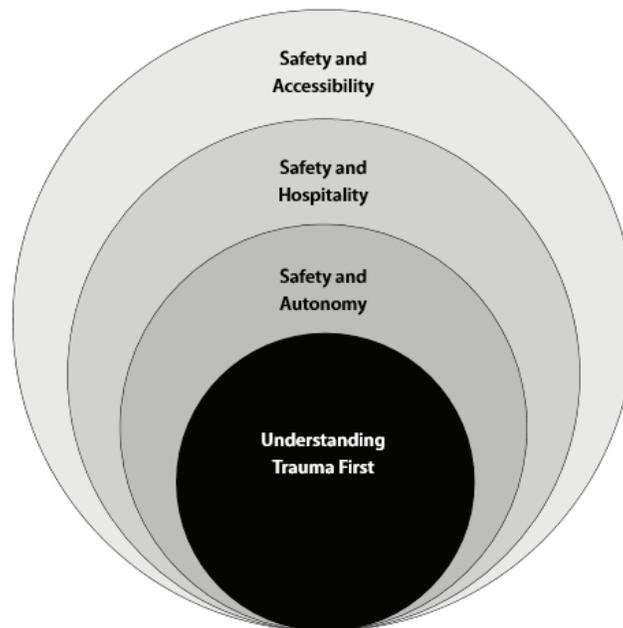
- Make sure self-advocates are involved in and driving the process from the beginning, and pay them appropriately
- Collaborate among service agencies to respond in ways that are victim-centered, supportive and empowering so the victim can lead their own recovery process
- Create collaborations between states and organizations in the I/DD system to create and promote free, accessible trainings for community members
- Prioritize funding for research and data collection on sexual abuse against people with disabilities
- Identify and address trends of sexual abuse against people with disabilities
- Set aside funding for development and evaluation of prevention and risk reduction programs for disability communities

Trauma-Informed Care Principles

Because experiences of violence are common and pervasive among people with disabilities, and assaults are infrequently reported, advocacy groups recommend that organizations working with these populations adopt trauma-informed care principles to ensure that clients are not inadvertently re-traumatized.¹⁴ A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence, and Sexual Assault Organizations,²³ prepared by Wisconsin’s Violence Against Women with Disabilities and Deaf Women Project, outlines four conditions critical to a trauma-informed organization (Figure 2). Although

this model was developed for care centers, the principles can be generalized to any organization serving these populations.

Figure 2. Model of Conditions Critical to a Trauma-Informed Care Center.²³



Understanding Trauma First

In a trauma-informed organization, understanding trauma and the impact it has on individuals who have experienced trauma is the framework within which all else is understood, developed and implemented within the program. Using trauma-informed care means putting the victim/survivor's perspective first; everything that is implemented and considered should take into consideration the victim's perspective. Everyone in the organization should be aware of the impact of trauma when they interact with a survivor.

Safety and Autonomy

In a trauma-informed care framework, safety is defined from the survivor's point of view. Interactions between staff and survivors should convey an emphasis on the autonomy, self-determination and safety of the survivor. Survivors are given necessary information in order to make informed decisions about their health and recovery. Privacy and safety can be respected and valued by staff through a commitment to maintaining client confidentiality within and outside the organization. Allowing and encouraging survivors to set the agenda and pace for their treatment helps them feel in control. Non-judgmental reactions to survivors with disabilities creates an emotionally safe environment in which clients feel free to express themselves and their needs. For example, a trauma-informed approach would reframe a perception that a client is being difficult through the lens of understanding that they are making decisions that make them feel safe and in control of their situation.

Safety and Hospitality

Inclusivity and hospitality are important aspects of a trauma-informed organization. Inclusivity and hospitality refer to equalizing power dynamics between people by being respectful, welcoming and thoughtful towards people that are generally underserved, not heard, or not understood. Collaboration and sharing of power is essential to meaningful participation. This involves creating a space for people to participate in ways that are meaningful to them. There should be a sharing and balance of power between service providers and survivors in a way that remains perceptive to the individual needs of the survivor while also maintaining uniformity and consistency among all clients. Transparency when speaking to others fosters a sense of personal safety, choice, and autonomy. Recognizing that abuses of power and control have been central to survivors' experiences of victimization, and committing to minimizing power imbalances inherent in service organizations, is central to trauma-informed care.

Accessibility

Accessibility refers to standards encompassed in the Americans with Disabilities Act as well as the development of policies and procedures within organizations that are trauma-informed. Physical spaces as well as the people providing services should be accessible (open and trauma-aware) to the people that the center serves.

Preventing Sexual Violence among People with I/DD: Learning Community Discussions and Recommendations

In December 2018, the New Mexico Department of Health (NMDOH) convened a learning community to discuss prevention of sexual violence among people living with I/DD in New Mexico. The learning community included self-advocates as well as representatives from the NMDOH Office of Injury Prevention, the University of New Mexico Prevention Research Center (UNM PRC), NMDOH Developmental Disabilities Supports Division (NM DDS), NMDOH Epidemiology and Response Division, the NM Children, Youth, and Families Department, the NM Office of the Attorney General, Easter Seals, the Arc of New Mexico, and A Better Way of Living.

After hearing presentations from the UNM PRC and NM DDS, the group divided into two workgroups to discuss ways to move forward. The first group discussed ways to increase awareness among DD providers regarding sexual violence, the need for prevention, and services available to people living with disabilities who have been assaulted. The second group discussed potential state- and organizational-level policies that may be a good fit for New Mexico.

Increasing Awareness of Sexual Violence and Primary Prevention

Sexuality Training. In the current New Mexico Developmentally Disabled (DD) waiver, sexuality training is required for case managers but optional for direct support personnel. The DDS Division Director expressed that this is the result of insufficient financing to support this training, and turnover of direct support staff. One participant relayed her experience with attending sexuality training, noting that “not a single person with direct care was there;” rather, all that attended were administrative staff. This person also noted that the training did not emphasize that all acts of sexual violence, not just rape, need

to be investigated. The participant also felt that training did not adequately address ableism, and that individuals with I/DD should have the same access to justice that “any of us” has.

Sexual violence prevention training/awareness. The group discussed ways to incorporate sexual violence prevention training into current training for case managers, direct support personnel and guardians. One participant noted that any changes would have to go through bureaucratic review, which is time-consuming. For instance, the training division with NMDOH/DDSD would have to oversee changes to training protocols. An additional barrier was the amount of training that is already expected and this would need to be added. Another participant noted that training provided to guardians is not taken advantage of, with many of the same people attending the training sessions each time. The group discussed strategies to get parents and guardians involved in sexual violence prevention, perhaps by inviting Parents Reaching Out New Mexico.

The group also discussed the content of a sexual violence prevention training. Ideas included providing both an introduction and broader training with direct care providers, making training mandatory for managers, and including topics such as healthy relationships and healthy sexuality. It was suggested to use scenarios during training sessions, although one participant mentioned that there was often a disconnect between what people say when given scenarios and what they actually do in a real situation. The group recommended having a designated coordinator in a funded position to coordinate training.

Leadership. It was also stressed that leadership needed to emphasize the importance of sexual violence prevention as a priority and needed to demonstrate that the issue was serious through action and modelling. Policies could be implemented regarding client sexuality and rights to privacy. One participant cited that less than 25% of agencies nationally have policies on sexuality among individuals with I/DD.

Prevention in the Education System. The group discussed educating children, beginning in elementary school, regarding appropriate boundaries. There was a recommendation to include rape crisis centers and sexual violence prevention agencies in prevention efforts for people with I/DD. Currently, agencies implement programs in schools that discuss the topic of having boundaries, being respectful, healthy sexuality, and how it is okay to say “no,” but it is unclear if students with disabilities are included in these sessions or if there are curricula being used that are specific to young children with I/DD.

Training for teachers and school administrators was also recommended. It was further suggested that the UNM Department of Education modify how they train special education teachers. One participant stated that current teaching emphasizes compliance as a virtue which could make individuals with I/DD more susceptible to sexual assault.

Collaboration. Cross-collaboration across sectors emerged as a need moving forward. Development of a task force or other team including multiple state agencies as well as other partners was suggested. Participants suggested including people working on early childhood wellness, including home visiting programs, as well as juvenile probation, public schools, NM DOH, CYFD, foster care and group homes. It was also suggested that legislative appropriations should explicitly include collaboration and prevention. In addition to prevention, the group also recognized a need for collaboration and commitment to resolving reported incidents in a more timely fashion. Currently, the average turnaround time for investigating a reported incident was stated by a participant to be 7 months to 1 year.

Legislative Policy. The learning community participants recommended that a previous memorial regarding sexual assault prevention be reviewed, contextual differences between the past and present considered, and the memorial revised for the 2020 legislative session. The memorial (SM61), introduced in 2018, called for the establishment of a task force to address sexual assault against people with disabilities. The memorial died in committee. Participants also suggested creating a multi-sector working group for prevention of sexual violence among people with disabilities, with or without passage of a memorial. A priority for this group should be the development of a comprehensive strategic plan for New Mexico that includes improvements in data collection and overall assessment of the wellbeing of individuals with I/DD.

Training. The policy subgroup spoke of the need for organizational policies regarding staff training. The urgency of mandatory training for direct care staff and law enforcement officers was reinforced. Participants reported that the current fee structure for individual training sessions is cost prohibitive for many agencies. Potential funding streams as well as training methods to make training more affordable were discussed. For example, an online training platform was said to be under consideration by the Bureau of Behavioral Support. To ensure the quality of trainings, one participant expressed that training coordinators should be hired to oversee sessions.

Conclusions

Primary prevention of sexual violence among people living with disabilities is critical to their health and well-being. Interventions at the policy and community level, and changes to reporting procedures combined with direct education of individuals with disabilities, their families, caregivers, and service providers hold promise for prevention of sexual violence. These primary prevention strategies should be complemented by the use of trauma-informed care principles when working with the I/DD community.

The learning community identified several areas of work specific to New Mexico. This included creation of a cross-sector task force or other collaborative effort to reduce sexual violence among New Mexicans with I/DD, starting with development of a statewide strategic plan. In addition, prioritizing this issue at the leadership level across state agencies was seen as critical to making lasting changes. Furthermore, training of direct care staff and sexual health education for individuals with I/DD were seen as priorities. Taking a comprehensive approach, with multi-level strategies, holds promise for prevention of sexual violence among persons living with I/DD and reduction of the long-term mental and physical health consequences.

Resources

Toolkits, strategic plans, sample policies

Illinois Imagines Toolkit

<https://icasa.org/resources/illinois-imagines>

Sexual Abuse of Individuals with Developmental Disabilities: Analysis and Recommendations for Ohio

http://www.disabilityrightsohio.org/assets/documents/dro_sexual_abuse_combined_report.pdf

Massachusetts Association of Approved Private Schools: Sex Abuse Prevention Resources

<https://maaps.org/sex-abuse-prevention-resources/>

STOP SV: A Technical Package to Prevent Sexual Violence

<https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf>

The Arc of New Jersey's White Paper on Sexual Violence Against People with I/DD

<https://www.arcnj.org/information/sexual-offenses.html>

Media Coverage of Sexual Violence among people with I/DD (contains helpful links)

NPR series on sexual violence among people with intellectual disabilities

<https://www.npr.org/series/575502633/abused-and-betrayed>

Sexuality Education Curricula

Planned Parenthood Developmental Disabilities and Sexuality Curriculum

<https://www.plannedparenthood.org/planned-parenthood-northern-new-england/local-education-training/development-disabilites-sexuality>

Stop Abuse for Everyone (SAFE): Disability Services

<https://www.safeaustin.org/our-services/prevention-and-education/disability-services/>

Empowerment Self-Defense Training

Triangle, Inc: IMPACT:Ability

<https://triangle-inc.org/impactability/>

Resolve

<http://resolvenm.org/take-a-class/empowerment-self-defense/>

Resources for health care professionals to talk about SV with clients with DD/ID

The Arc's National Center on Criminal Justice and Disability: Talk about Sexual Violence

https://www.thearc.org/file/nccjd_sexual-violence/ARC-BRC-finalreport-6-FINAL.pdf

Trauma-Informed Care/Supporting Survivors

Creating Access: Supporting Survivors of Sexual Assault with Disabilities

<http://www.calcasa.org/wp-content/uploads/2010/12/Disabilities-Info-Packet-Final-Upload-12.29.10.pdf>

SAMHSA Principles of Trauma-Informed Care

https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/guiding_principles.html

A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence and Sexual Assault Organizations

https://www.nsvrc.org/sites/default/files/publications/2018-04/Disability_Trauma-Informed-Guide.pdf

References

1. Basile KC DS, Jones K, Freire K, Dills J, Smith SG, Raiford JL. S Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2016.
2. Basile KC, Breiding MJ, Smith SG. Disability and Risk of Recent Sexual Violence in the United States. *Am J Public Health*. 2016;106(5):928-933.
3. US Department of Justice, Bureau of Justice Statistics, National Crime Victimization Series, 2011-2015.
4. New Mexico Behavior Risk Factor Surveillance Survey (BRFSS). 2016-2017. Santa Fe, NM: New Mexico Department of Health, Personal Communication with BRFSS Epidemiologist on January 8, 2019.
5. New Mexico Youth Risk and Resiliency Survey (NM-YRRS). Santa Fe, NM: New Mexico Department of Health and New Mexico Public Education Department; 2013.
6. Borowsky IW IM, Resnick MD. Adolescent suicide attempts: Risks and protectors. *Pediatrics*. 2001;107(3):485-493.
7. Ullman S BL. Sexual Assault History and Suicidal Behavior in a National Sample of Women.pdf. *Suicide Life Threat Behav*. 2002;32(2):117-130.
8. Afifi TO EM, Cox BJ, Asmundson GJG, Stein MB, Sareen J. Psychiatric Disorders and Suicide Ideation and Attempts Associated with ACEs. *Am J Public Health*. 2008;98(5):946-952.
9. Kilpatrick DG, Ruggiero KJ, Acierno R, Saunders BE, Resnick HS, Best CL. Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology*. 2003;71(4):692-700.
10. Santaularia J JM, Hart L, Haskett L, Welsh E, Faseru B. Relationships between sexual violence and chronic disease: a cross-sectional study.pdf. *BMC Public Health*. 2014;14(1):1286-1293.
11. Stahlman S, Javanbakht M, Cochran S, Hamilton AB, Shoptaw S, Gorbach PM. Mental Health and Substance Use Factors Associated With Unwanted Sexual Contact Among U.S. Active Duty Service Women. *J Trauma Stress*. 2015;28(3):167-173.
12. Wacker J, Macy R, Barger E, Parish S. Sexual assault prevention for women with intellectual disabilities: a critical review of the evidence. *Intellect Dev Disabil*. 2009;47(4):249-262.
13. California Coalition Against Sexual Assault. *Creating Access Supporting Survivors of Sexual Assault with Disabilities*. 2010. <http://www.calcasa.org/wp-content/uploads/2010/12/Disabilities-Info-Packet-Final-Upload-12.29.10.pdf>. Accessed January 10, 2019.

14. Disability Rights Ohio. Sexual Abuse of Individuals with Developmental Disabilities. https://www.disabilityrightsohio.org/assets/documents/dro_sexual_abuse_combined_report.pdf. Published April 2015. Accessed January 17, 2019.
15. Stone M. Preventing Sexual Violence Against People With Disabilities: Empowerment Self-Defense, Risk Reduction Education, and Organizational Change. In: *Sexual Assault Risk Reduction and Resistance*. 2018:353-378.
16. Stein S, Kohut T, Dillenburger K. The Importance of Sexuality Education for Children With and Without Intellectual Disabilities: What Parents Think. *Sexuality and Disability*. 2017;36(2):141-148.
17. Starford M JC, Davis LA. *Talk About Sexual Violence – Final Report*. Sacramento, CA: Board Resource Center and The Arc’s National Center on Criminal Justice and Disability; 2017.
18. Massachusetts Association of Approved Private Schools. Sex Abuse Prevention Resources. Retrieved from <https://maaps.org/sex-abuse-prevention-resources/> on January 17, 2019.
19. Board Resource Center and The Arc’s National Center on Criminal Justice and Disability. Talk About Sexual Violence – Final Report. https://www.thearc.org/file/nccjd_sexual-violence/ARC-BRC-finalreport-6-FINAL.pdf. Published September 2017. Accessed January 17, 2019.
20. DeGue S, Valle LA, Holt MK, Massetti GM, Matjasko JL, Tharp AT. A systematic review of primary prevention strategies for sexual violence perpetration. *Aggress Violent Behav*. 2014;19(4):346-362.
21. Illinois Imagines. Our Rights Right Now! Overview Guide. 2010. <http://icasa.org/resources/illinois-imagines/materials-toolkit-and-other-material>. Accessed January 10, 2019.
22. Substance Abuse and Mental Health Services Administration. Guiding Principles of Trauma-Informed Care. SAMSHA News. 2014; 22(2). Retrieved from https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/guiding_principles.html on January 17, 2019.
23. Disability Rights Wisconsin, Wisconsin Coalition against Domestic Violence, Wisconsin Coalition against Sexual Violence. A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence and Sexual Assault Organizations. https://www.nsvrc.org/sites/default/files/publications/2018-04/Disability_Trauma-Informed-Guide.pdf. Published December 2011. Accessed January 17, 2019.