**ROUGHLY EDITED TRANSCRIPT**

**Recognizing and Responding to Caregiver Abuse**

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>> TIM FUCHS: Good afternoon, everyone. I'm Tim Fuchs with the National Council On Independent Living. I want to welcome you all to CIL Net's newest webinar and teleconference, Recognizing and Responding to Caregiver Abuse.

This webinar is being presented by the IL NET Training and Technical Assistance Project for CILs and SILCs. The IL NET is operated through a partnership among ILRU, NCIL and APRIL, with support provided by RSA at the U.S. Department of Education.

We are recording today's call, as we always do, so we can archive it on ILRU's website. We will be breaking several times during the presentation today to take your questions. If you're on the webinar today you can ask your questions in the chat screen, and the chat is, of course, the ‑‑ below the list of attendees. If you can't see it and you're using a screen reader, the text box under the list of attendees there. You can enter your questions at any time during the call, but we will wait to take them during the Q&A break. After you type your question, don't forget to hit enter and it will appear and we'll take them in the order that they were received. If you're on the telephone today, you can press star pound to indicate you have a question and I'll remind you of that each time we take a Q&A break. We'll take those in the order we get them. And let's see. Also, I want to make sure that each of you has the PowerPoint in front of you. If you're on the webinar, of course, the PowerPoint will display automatically, but if you're connected only by telephone today, that's fine, but you'll definitely want to have the PowerPoint handy, either up on your computer screen or printed out. The PowerPoint for today's presentation was sent to you in the confirmation email. If you don't have that for any reason or can't find the confirmation email, you can always email me at Tim@NCIL.org. I'll send it to you.

One more thing before we start, I just want to ask each of you to please fill out the evaluation form after today's call. So it's online. It's very easy to complete. There's two ways to get to the evaluation form. Again, that was also sent to you in a confirmation email. But it will also be on the last slide of our webinar. So when we close out today, it's a live link. You can click right on it. Just be aware that it will take you away from the webinar. It will open a new window on your browser. So just know that. You don't want to click it until the end of the call.

If you're participating in a small group today, that's great, we encourage it. But please do fill out the form as an individual. We want to hear what each of you thinks of the presentation. And it's short, it's easy to complete, we take them really seriously. We want to know what you think. That's the end of my short intro.

I'm pleased to introduce our presenters for today. We have a great group. Jan Derry, Erin Fontaine and Leslie Myers are with us. All three are part of NCIL's Violence and Abuse Task Force, but they are leaders in the arena.

Jan is the Executive Director of the

Northern West Virginia Center for Independent Living in Morgantown, West Virginia. Erin Fontaine is joining us from Access North Center for Independent Living in Northeastern Minnesota, where she is the IL program manager, and Leslie Myers, previously of IndependenceFirst in Milwaukee, is the Senior Program Associate of the Accessing Safety Initiative at the Center on Victimization and Safety at the Vera Institute.

So I want to thank Jan, Erin and Leslie for their hard work putting the presentation together and for being with us today and without any further ado I'll turn it over to Erin to get us started. Erin?

>> ERIN FONTAINE: Thank you, Tim. Can you hear me okay?

>> TIM FUCHS: Yes.

>> ERIN FONTAINE: To touch on our objectives which I'm sure you've seen ahead of time we're breaking this into four parts so we have time to ask questions in between. It's a pretty broad topic. So we'll start with recognizing different types of caregiver abuse and how it's similar and different from other forms of abuse. And talk about some ideas for education and how to create and adapt some policies and procedures at your local independent living center. And talk about the importance of trauma‑based interviewing. And to wrap up, just talk about some work that's happening locally in each of our areas and other parts of the country to address violence that's happening against people with disabilities, caregiver abuse and other types of abuse as well. So that's where we're going to start.

We're going to begin with some poll questions. So if we can go to the next slide. I know we have people from across the country here today, and I just want to kind of get a feel for what experience you all have around the issue of caregiver abuse. So I'm going to ask, have you or anyone at your independent living center been involved with work around violence abuse of people with disabilities? And if you are able to, it should pop up as a poll question and you can respond yes or no or choose not to vote. I'll give a couple minutes here.

It looks like... like we don't have anyone else. There's a couple more coming in.

Okay. So it looks like we have definitely over 80%, 83% so far out of the ones who voted that say definitely work that has been happening at your local independent living center.

And next slide.

The next question: How many people work for an independent living center that provides caregiver or personal assistant services?

It looks like we can probably move on from that one. It looks like pretty close to the same amount. A few less agencies, about 70% of you all joining us today are familiar with that.

Next slide.

How many people work with individuals with disabilities who receive caregiver or personal assistant services? I know each state has different terms and programs are always changing. But oftentimes a lot of the people we serve are utilizing caregiver services. And this looks like 100% so far who have voted this one. And I think we can close that out. I think the main thing we wanted to see and I think we can definitely recognize that that is occurring, that this is an issue we all face and we see on a regular basis, if not every day. It's a topic that is not something that a lot of people feel comfortable talking about. We don't want to think about the abuse that's happening, and it's overwhelming. There's a lot of different factors that come into place with reporting and we really want to empower people to be as independent as possible and focus on consumer control and education, but there's a lot that impacts all of our core services and the work that we do every day. So it's definitely an important topic.

If we can go to the next slide.

As we look for different statistics about caregiver abuse it's really hard to find good data, especially good current recent data. So just a few statistics that we wanted to point out. That more than half of all abuse of people with disabilities is estimated to be perpetrated by someone that they know, whether it's a family member or a peer, a caregiver, a professional that's either paid or unpaid in their life, a medical provider, or the other half. It definitely increases the likelihood of being victimized if you have a disability, and there's a lot of different barriers that we'll discuss a little bit more. Approximately 67% of perpetrators who have abused individuals with severe cognitive disabilities have accessed them through their work in disability services. And so we would like to believe that people who work in the field of human services and caregiver services are there because they want to help other people, but you do find that often times perpetrators do look to find that as a way to get access to an easy target, unfortunately. So the statistics are not anything that's really going to give us good hard data because a lot of things are underreported and unreported, but it's helpful to just kind of see it's definitely a large issue and although most forms of abuse are perpetrated by people that we know and are familiar with and not strangers that people in the media might portray.

Next slide.

What is caregiver abuse when we talk about domestic violence, sexual assault, lots of other types of abuse. We're focusing on the caregiver abuse. It may be a paid or unpaid relationship. It may be a family member who is that caregiver. It may be someone who is coming from an outside provider that has no previous relationship. But there's a misuse of that power and we're going to look at a bit at that dynamic.

So many times we hear the word abuse or violence and we think of the physical violence or the marks that are left behind or bruises, but there are so many other types of abuse that are just as powerful and hurtful. When we look at sexual assaults, we look at verbal and emotional abuse, which is often hard to document and prove when there is ‑‑ when you talk about he said, she said, things that are going on on a regular basis. Definitely financial abuse. And neglect. So those are some of the different types of abuse we're looking at. The next slide we're going to look at a power and control wheel that was specifically designed ‑‑ modified from a power and control wheel developed by domestic abuse intervention programs in Duluth, and so if you work at all with domestic violence agencies you may have heard of a power and control wheel and equality wheel that was designed to look at those dynamics between an abuser and their partner. And really looking at this at the intersection of disability and violence there has been a multiple different wheels modified. There are some with picture images, some with clearer, easier language to read and a variety of different options to help see how those dynamics plight. So in your materials you received as you tell it's hard to see this wheel on your screen and the print is not very legible, so you do have it as an attachment, as a PDF as well, but if you look in the middle it says power and control and it's looking at the different spokes. Violence, whether sexual, violence or whatever, is coming into play all around, full circle. That we look at the categories starting at the top and going clockwise we have intimidation, which happens in any relationship but the intimidation can be multiplied in a care giving role. Emotional abuse. Isolation. Minimizing, justifying and blaming. Withholding, misuse or delayed needed support, whether it's medications, whether it's their adaptive equipment, whether it's the support they might need. Economic abuse, whether it's Ms. Using someone's property, taking their income or checks and taking them to the bank or going to the pay for something and not giving them the rest of their money, whether that's borrowing their vehicle or their property and not returning it or damaging it. Using that relationship of caregiver privilege and treating that individual as if they are child‑like or that they have control in that relationship as they are the one who is providing the care, denying them their right to privacy, using coercion and threats. So we can see how all of those different dynamics that come into play in a care giving relationships, whether it is paid or unpaid, really take away power and control from a person with a disability who is receiving that support of personal care assistants, again whether it's paid or unpaid. So it's helpful for us working in an independent living center to be aware of some of those dynamics. We might be the one to most likely see those red flags as they're happening and witnessing them and being able to recognize and respond in that way. So if you take time when you have time after today to look over that a little closer and look at some of the bullets so you can get a better understanding. Also attached is the second page of it, which is not on our slide, but it's on your attachment, is an equality wheel and looking at how to use nonviolent methods and how to support people as a caregiver. So it's great information if you're doing training for caregivers or supporting for caregivers, using nonthreatening behaviors and the importance of respect and involvement and consumer choice and control in the care giving and care plan that they're working on. So that's helpful.

The next slide is briefly talking about overprotection. So many times when we do trainings or involvement with guardians, family members really wanting to protect a person with a disability, that there is really a concern that we can really be going too far. So if I am trying to prevent someone maybe from getting an education or knowing about their rights or understanding relationships or appropriate boundaries because I'm afraid that person isn't going to be able to fully understand the dynamics of that, then we have a huge concern about overprotecting someone and putting them at greater vulnerability and greater risk of abuse. And so we want to make sure that we're aware of that and that really knowledge is power and it's important that we educate.

Just some risk factors. Really important to realize that just the fact that I have a disability is not what is increasing my risk. Really the risk is there because of the societal and situational factors that come into play. So public attitudes about people with disabilities, often seeing someone as reliant on others for care and not able to be independent without that support. So many times there is isolation. So you may be the only people that you have a chance or have the opportunity to interact with or that you're getting to see on a regular basis are connected to your caregivers or work for the same company as your caregivers or involved in some other way with your caregivers where you might not have as much opportunity to interact with other support systems. The nature and severity of a person's disability may increase the difficulty of them being able to report. So if they have communication barriers, they may choose to see that person as an easier target because they may not be able to communicate or report the abuse that's happening. If a person has a mental health diagnosis, they may be seen that they may not be valid if they try to go through the court systems. So it's important that we provide education and awareness and help people get the support they need so that they can access whatever it might be, whether it's advocacy related to domestic violence or caregiver abuse or it's reporting through adult protective services or it's a legal concern. And I think a lot of times, too, talk about socialization of people with disabilities to be compliant. So many times we learn about all of these roles, position ‑‑ people in positions of power, whether that's teachers and social workers and case managers and law enforcement and we see all of these people who are in positions of power and that have this authority and control and it's hard to separate those things out and realize when maybe somebody is misusing, taking advantage of that position of power against another person. And so it's really important to be aware of all these additional risk factors so we can address those and provide more education and awareness. We've done a lot of focus groups in Duluth where we talked about what are some of the barriers, why might abuse not being reported on a regular basis? Because we know it's happening. A lot of times people say they might be attempting to make a report but that who they're reporting to may not be the appropriate source. They may not be aware of those red flags to watch for. They may be seen as a difficult client because they've had multiple concerns with caregivers who may be taking advantage of them. They may be concerned if they property that caregiver they might not get another caregiver and they need that support to remain independent. Concerns they may have Real retaliation by their caregivers. Just so many concerns around if they have children at home, that if there is a report that they may say if they're not able to care for themselves or protect themselves from this form of abuse maybe they're not able to take care of their children. Obviously all myths that are in place that are being perpetuated in our society over and over again. So the more we can provide that education and help people to get both services and support in place and be aware of the barriers so we can try to overcome them. Oftentimes even a place where to go. If their caregiver is their spouse or family member or if a live‑in caregiver, they have ‑‑ they don't have a place to leave to go to or they maybe don't fit in the services that are available at a domestic violence shelter. Each state and each local domestic violence resource has different guidelines of what they consider to be domestic violence but it's usually looking at and intimate partner relationship. And they may not be a caregiver as a partnership relationship. That's controversial in different agencies.

So that's to give you a basic overview of what to kind of look for and I think we can go to the next slide and see if we have any questions to address.

>> TIM FUCHS: Thanks, Erin. So, again, I see one question that we'll start with on the chat. But, again, you can type your questions there. We'll take them for the next few minutes. Again, if you're on the telephone today, you can press star pound and we'll take your questions in the order they were received. I'm going to start with this question from Higgins here, and Higgins asks: Of the 67% that you mentioned who are abused through work contact is there information to indicate a majority of the sites that that abuse happens in? In nursing homes, ILCs, et cetera? Erin I don't have a really good answer for that. I know when that Jan and Leslie and I were talking there is a lot of different statistics that vary and I think one said maybe 30 ‑‑ about a third is in a facility or institutional setting, nursing home setting. A third by caregivers. A third by family members or friends or people that are known to the individual. I think that we see so much different data that conflicts with each other to really be able to answer that question what percentage is happening in people's own homes or in the community because it's so underreported. I don't know if Jan or Leslie have anything to add to that.

>> JAN DERRY: This is Jan. In West Virginia when we did our statistical analysis we found that most of the reported case, again, what Erin said, so few were reported, are coming from the group home setting for your individuals with developmental disabilities or your psychiatric institutions was the largest statistics that we found.

>> TIM FUCHS: Okay. Thanks, Jan. That's helpful.

Liz Hunter‑ball is there any discussion at the federal level about responding to caregiver abuse similarly to the way we respond to domestic violence?

>> JAN DERRY:

>> JAN DERRY: I'm not aware of anything related to this other than elder abuse. So it's not an issue of national attention on a federal level for people with disabilities other than those living in nursing homes.

>> TIM FUCHS: We'll take a few more minutes to let you type your questions. If you're on the telephone you can press star‑pound. We'll wait about 30 seconds to make sure there are no more questions before we continue the presentation. We got a request for folks to turn up their microphones. I don't know if we can do that, but maybe we can all make an effort to talk a little bit louder so that folks can hear us.

I think we're probably going to get back to the presentation. I'll give it 10 more seconds here. Again, just a reminder, we will have several more Q&A breaks before the end of the call. Okay. I'm going to go ahead to slide 14 and we will get back to it.

>> LESLIE MYERS: Thank you, Tim, Erin, and everyone on the call. This is Leslie Myers with the Vera Institute of justice. You can go to the next slide.

Erin provide add really good overview of some of the topics that CILs may want to include in ongoing staff training opportunities like the signs of abuse, the risk factors, some of the barriers faced by survivors to disclosing. Additional training topics that could be considered are the types of questions to ask and the ‑‑ as well as self‑care and stress management. Agency policies and procedures around abuse and discloses of abuse and relevant state and local laws could also be reinforced on a regular basis during training.

Training is just a start, but there is much more that a CIL can do. A good place to start with preventing caregiver abuse is to use hiring processes that help eliminate abusers from being hired in the first place. It looked like we had about 17 CILs on the call that have personal caregivers on staff. So you want to look at your hiring process for caregivers and for all the positions within the CIL.

There are a number of basic screening practices that employers use, including employment and personal reference checks, interviews, confirming the person's education, written applications and possible on the job observation.

Some other frequently used practices include checking local, state and FBI criminal records, state child and dependent adult abuse registries, sex offender registries, Nurse's Aide Registries, motor vehicle records and professional disciplinary boards.

Some of the less frequently used mechanisms include alcohol and drug and psychological testing, mental illness, psychiatric histories and home visits.

These background checks are only as good as the information that is available. It is common for individuals who have abused other individuals to lose their jobs, but because of lack of police reports, charges being made or report to registries, these folks are often free to get another job as a caregiver. One of the best ways to build a strong foundation for safety of the consumers is through agency policies and procedures. Some examples of these include being clear owe what the responsibility staff have following disclosures of abuse or after observing abusive actions by others. Also what the agency's responsibilities are following reports of staff members who are abusive, which could include conducting their own investigation, contacting the police, assisting the consumer and making formal changes, terminating staff who are abusive and making sure that those individuals who are reported to any state registries that may be available. The actions of the agencies can help prevent the ‑‑ an abusive caregiver from moving on to another position when ‑‑ where they can continue to abuse individuals with disabilities in their care. Additionally CILs could offer and even mandate attendance at an employee assistance programs for caregivers to address any stress or personal issues they may have that may contribute to them treating their charge with inappropriate ways.

There might be a variety of people or ways ‑‑ variety of ways that people in the centers that are on this call today provide oversight of the caregivers who are hired through the CILs. You might want to look at those practices of your CILs to determine if the supervising staff meet with consumers alone or if they meet with the consumers when the caregiver is present. Best practice really does dictate that we offer a safe place to meet with consumers without the caregiver present so that consumers can freely discuss any problems that they have, they can feel more comfortable in a place where they can disclose abuse that might be occurring, and to ensure that consumers' safety and well‑being is being addressed.

Another thing that CILs can look at or what they have in place for staff members using caregivers in the workplace. Because what would happen if an abusive situation is occurring in that relationship. So CILs can take some proactive actions like creating guidelines for the caregiver staff interaction within the workplace, offering that staff person a safe place to disclose any problems they may have, and also offering employee assistance programs for both the staff member and for the caregiver.

Before I go onto my last slide in this Section, so far I've been kind of ‑‑ everything I have been saying has been related to CILs that have actual care giving programs where the caregivers are staff members, but all of these things also would be relevant to just providing advocacy and support to consumers who are using caregivers such as knowing these things you can inform them of what they might want to ask the agency that they do hire about what kind of background checks are done or to encourage them to talk to their ‑‑ the supervising nurse or supervising person over the caregiver and talking with them alone. So all of these things, while I have been talking mainly about programs that do have care giving services obviously some of the stuff can just be related to consumers who are using caregivers as a proactive measure.

So we can go onto the next slide now.

Your CIL can become a safe environment for individuals using personal care services by really promoting a culture of zero tolerance for abuse, neglect and exploitation by really having clear abuse/neglect policies and procedures that require the reporting of all incidents of suspected abuse and neglect, that the reporting requirements is consistently enforced, that offer protection for staff and clients who do report, and that does have consequences for those staff who do not report any suspected abuse or neglect. A zero tolerance will also create a culture within your CIL that really makes it unattractive to individuals who are abusers, similar to what Erin had mentioned at the beginning is that we do find that there are people who choose this line of work because of the access to easy victims, and by creating an environment that is zero tolerance, you will start weeding out those individuals and they will just not find your program very attractive, if that's what they're coming on for.

We can now go onto the questions if you want to go to the next slide.

>> TIM FUCHS: Okay. Thank you, Leslie. Again, if you all have any questions, you can press star‑pound. If you're on the phone. Or you can type them out in the chat. I'll give everyone a few seconds to type out their questions. If not, that's fine, too, we'll move on and we do have more Q&A breaks coming up. So we have about 30 more seconds. Know questions on the phone. A couple people typing.

Okay. Nothing has come up. Thanks so much, Leslie. We'll have more Q&A breaks moving forward.

I'm going to go ahead to slide 25 and turn it over to Jan, I believe. Is that right?

>> JAN DERRY: Yes.

>> TIM FUCHS: Thank you. Jan, are you there? You can go ahead. You may be on mute, Jan.

>> JAN DERRY: I am on mute. I am so sorry. [laughing] how is the volume now that I'm not on mute?

>> TIM FUCHS: Sounds good.

>> JAN DERRY: Sounds good. Okay. This is Jan Derry from West Virginia, wild, wonderful, West Virginia and I was thrilled to see the answers that so many CILs were doing work in this area, and as co‑chair of the task force, I'm hoping I can learn at some point what it is that you all are doing so we can benefit from your efforts to share with other NCIL member organizations. So I was thrilled to see that.

One of the things that I want to really point out with trauma‑based interviewing is the number one rule is that you start by believing. You may be the first person this individual is telling, and your reactions can determine how well this person is going to heal and the process for recovery. So if you have a negative reaction and don't believe that person, they will more than likely shut down and not even go further. I wanted to let you know trauma can create a physical, emotional and cognitive response as well.

Emotional trauma ‑ trauma can exacerbate mental health symptoms. There was a quote I learned when I first started doing this work that I ‑‑ trauma is to mental illness as smoking is to cancer. Let's just think about that for a minute. A lot of individuals that have come ‑‑ that have come in contact with our center who have significant mental health issues also have experienced trauma throughout their life, and the mental health symptoms have often been their method for dealing with that trauma. So it's important to realize that probably the first thing to remember is not say: What's wrong with you, which we wouldn't say that, but some people would. It's: What happened to you? Trauma can impact memory, and why that's important is because it can change the victim's account. So changes in their story should not be immediately perceived that she is lying or not telling the truth or has a misconception. Also re-experiencing trauma, there are triggers that happen, and so you have to realize that the traumatic event may have happened 20 years ago, may have happened last week, and they may have the one that happened 20 years ago may have successfully sought treatment and are in recovery but then they walk into an elevator and there is a gentleman there with a cologne on that he had that ‑‑ that the perpetrator was wearing at the time and it cot trigger an event. Symptoms may also cause someone to lose touch with the here and now. So if you see some changes in some of your consumer base and realize something is going on, it's a good indicator there might be something happening that you need to pay attention to. Emotional numbing is an avoidance, detachment. Watch for this. Self‑medication. Typically individuals dealing with traumatic events that are not getting the support they need may try self‑medication with alcohol or drugs. Some individuals use mutilation, self‑harm, and other things like that that are new behaviors that could be a real indicator that something is happening. Hypervigilance, jumpiness, being on guard, overreaction, including sudden unprovoked anger, anxiety, insomnia. So if you're trying to help identify and see that all of a sudden there's changes in behaviors that you have not ‑‑ you can't understand ‑‑ we have to realize most CILs don't have mental health professionals on staff and that most individuals, nearly one‑third of all rape victims develop PTSD, and so developing a relationship with a mental health provider is critical for part of that community support system. So it might be real helpful for you to be getting some of those resources in line before you need them.

Victims who have to worry about ongoing contact with their perpetrator, their post assault fears and hypervigilance might be extremely acute because they can't get away from it, and like Erin and Leslie shared, sometimes they have no choice.

So what to do? Again, I'm sorry this happened to you. You need to put the perspective in context, help them to understand how trauma is affecting them. So they may be having behaviors and not understand why they're having difficulty or what communication problems they may be having or their inability to cope with daily life could all be related to the how the trauma is affecting them. And so often victims will say, I think I'm losing my mind, I'm going crazy, and it's a natural reaction to trauma. Another important thing is that you need to affirm that although you cannot erase the event, we can find a place of coping with and overcoming the traumatic effects. Letting the person know that they can heal, they can recover and they can go back to having a fulfilling, complete life. Encourage the use of supports and community resources. Let them know that counseling is often an important part of recovery. You know, there's so much stigma associated with seeking mental health services, yet they're so critical in the recovery process.

Another thing you need to watch for is what's called vicarious trauma, or some people call it compassion fatigue, caring for yourself. You need to make sure that staff who are working in this situation and are directly involved in working with trauma victims, that they aren't suffering from compassion fatigue themselves. That there is a way for them to care for themselves. And ensuring confidentiality, especially in this world many of the participants on the call are from rural states and you have to realize that if someone wants to enter the system of victim services, whether ‑‑ I might be talking necessarily about sexual assault or domestic violence where there's a reason for medical intervention, they're going to end up with either the nurse at the hospital is somebody they know or a neighbor or someone at the pharmacy for getting medication. So the rumor mill can go really, really fast. It's really, really important that you realize that confidentiality is critical here.

Crisis intervention ‑ obviously there are three things you need to do. You're going to strive to display acceptance, empathy and support for this individual. Listen and believe. And ensure safety. You need to make sure that that person is safe to be talking about what they need to be talking about with you. And keep in mind that you're managing the situation. You're not going to resolve it. You're trying to stop the emotional bleeding and ensure guidance for the victim. And you want to take your guidance from the victim and the consumer as we would in a consumer‑directed service delivery system. We want to ensure that those who are providing the intervention at this point realize the best teacher is the individual who is speaking, the person who has been ‑‑ who is dealing with the crisis themselves. You need to also be clear about your role. You don't know what you don't know here. When I first got involved in this program working with sexual assault victims with disabilities, I had no idea what I was doing. So to think that all of a sudden you can change an intake form that says are you safe at home and if they answer no, if you don't have the steps in place to deal with what that answer is, then you could be retraumatizing that person and that's another door that's going to slam in their face. So you need to know exactly what it is that you can do. Obviously you're going to have to discuss the whole issue of reporting requirements and options. So it's important that you know what the mandatory reporting requirements are in your state. Provide a safe environment. Again, keep the personal assistant, the caregiver, the family member away that from individual so that they have the opportunity to share what it is that they want to tell you and to have a healthy ‑‑ to develop healthy coping strategies. One point to keep in mind is, remember, if you're working with someone who uses a sign language interpreter, more than likely that family that may have brought them in or a caregiver or somebody like that also uses sign language and understands sign language. So it's important that you keep the distance between and visual barriers between the individuals, too, so if you have a glass door or a glass window and they're signing and they can see everything that's being said. Another key thing is to do not judge. Self‑blaming is that often the reason for not reporting. So focus on survival and coping. Try to assist the individual at not taking responsibility for what happened. Often you hear things like if I hadn't gone there, if I didn't do this, if I didn't drink that, if I didn't allow them to do this. They take responsibility. It is never their fault. Disabilities may impact the process and crisis. It's real important to realize that individuals with DB or mental illness or communication barriers in crisis, those situations could get a lot worse. Knowledge is power. There ‑‑ no matter how many times we have to report that, emotional healing is as important as physical healing, and to know what supports are out there, whether it's medical, legal, emotional, and spiritual supports. Make sure your staff are aware what the resources are.

Safety planning. Safety planning is not something that you can do haphazardly. You do need to ensure a connection with victim services for training and resources on doing safety planning because it is a very thoughtful, deliberate process to create a plan. It's an ongoing process. It's not a one‑time event. And it changes as their life changes, as situations change, and each person is an individual. There is no set checklist, that what ‑‑ everyone needs to do, not what you believe is best for them, but what is ‑‑ what they believe is best for them. Often the service provider believes they know ‑‑ this is what you need to do. I'm telling you, this is where you need to go. This is how you need to respond to this. What to ask in a crisis. The most important thing is is there something we can he do to help you become safe? Provide time and space to prepare. Incorporate the unique needs of the individual through accommodations and helping them to determine ‑‑ know ahead of time, if a shelter is not accessible, where can a person go to ‑‑ what's been set up? Is there an MOU set up with a local hotel? This is something that you can do about help young to prepare for this work. Help them develop a checklist of what to take with them, whether it's important papers or their medications or contacts, insurance. You can put together this stuff that would be extremely helpful for them to look through and have prepared to go should they have to go in a hurry. And include resources that are available if needing. Safety solutions that represent a loss of independence is not a solution. Keep that in mind. A lot of professionals will believe if you're a person with a mental health disability and the crisis is now created an exacerbation of your mental health for your own safety we need to put you in a hospital. That may not be seen as a solution if it's a loss of independence.

Next slide, please.

As we said, knowledge is power. Reducing the risk of abuse, teaching consumers ‑‑ many individuals that we've come in contact, especially those that have come from the long‑term care system, whether ‑‑ or a group home setting with a deinstitutionalization here in West Virginia where a lot of people were moved out, there's been no teaching about healthy sexuality, teaching boundaries, about personal space. These kinds of things. Need to be part of curriculum for individuals, you especially if you're doing transition, if you're transitioning people out institutional settings, and they've never been taught anything other than learned depend say and let people do anything to you because that's what hams when you're in an institution. That needs to be key. Like Leslie shared the practices in place for hiring caregivers, raising public awareness. There are sexual assault months, DV months. It's really important that people with disabilities reach out and become a part of that activity so that people with disabilities see that this is an inclusive responsive system that includes them. Again, training staff. The first year we got involved in this program funded by OVW was spent in building our own competency. It's a whole different language. It's a whole different system than I was familiar with working in, and if you think IL has their own set of alphabet soup, the DV world, sexual assault world has their own alphabet soup, too. So you need to have some training. Guidelines within your agency has already been discussed, your reporting requirements, zero tolerance has already been addressed. And research what's being done in your state with new things like stop grants, prevention work, rural health grants. That's a whole different funding stream that we're typically not a part of, but I've learned that other centers have been involved and they end up getting a sexual assault advocate right on staff, and it's funded by their stop programs and there are other resources that perhaps Leslie can speak to be a little bit later. It's important that if ‑‑ when you're doing safety planning, if someone is in crisis at the time, that you address medical needs. I'm going backwards here because I forgot to mention it, and it's really, really important if you can help her develop a plan for immediate safety that includes immediate steps, any support person in her life or his life. I'm saying hush just to stop having to say him and her. Essential items that are needed if fleeing is necessary. And constantly keeping the referral available to rape crisis centers in your area. If you've got time to prepare and the person has time and it's not needing to flee, you know, identify those fears and threats and other obstacles to their own personal well‑being. Example, a courthouse is not accessible. How do they go to get a protective order. So perhaps finding out ahead of time, if your courthouse is not accessible and someone needs a protection order, how do they do that if they can't go and personally file it in your states. Identify safe communication mechanisms for this individual. Have a service provide ‑‑ if the domestic violence center is going to be sending information, obviously not having it come from an envelope that's labeled domestic violence center could be real important. And so ‑‑ determining with that individual, whether it's a post office box, what is the method they want you to use to communicate with them? Then if someone is preparing, help them to identify a signal for alerting someone that you might be in danger, whether it's a red towel in a window, someone that may be able to respond and call the police or something like that. And then think about planning an escape route. There are all sorts of other things that need to be considered and again I have to encourage you to reach out to your victim services individuals to assist in learning what should be included. Because you don't want to be responsible for doing a safety plan when you don't know what it is you're doing. I cannot stress enough the importance of working community, which is the next slide, which is where we're going to go. I'm going to stop with questions answers.

>> TIM FUCHS: Thanks, Jan. We have a few questions pending in the chat. I'll remind everybody if you're on the phone you can press star‑pound to ask a question on the phone. I'm going to jump right into these web questions. First question is from Karen Williams who is wondering if you can expand on vicarious trauma.

>> JAN DERRY: Sure. Vicarious trauma is when you are just so distraught about what the individual is dealing with, you are consumer base ‑‑ if you have three or four or five consumers coming to you ‑‑ I think we Dee this at CILs all the time, that we just get so wrapped up in their stories, in their lives, and we want to fix it all. And if someone is being traumatized to such a level that it affects you emotionally, then you are going to get burned out. You're going to get fried. You're going to have your own traumatic events and waking up in the middle of the night thinking, oh, I'm worried about what's going on. So you end up being the one that's also experiencing trauma. Does that make any sense?

>> TIM FUCHS: Yeah, I think that's helpful.

>> LESLIE MYERS: Jan, could I add something in there?

>> JAN DERRY: Please do.

>> LESLIE MYERS: Also I think that we know that the rates of violence against people with disabilities is higher than that of the general population, and because CILs have at least 51% of the staff are going to be people with disabilities, there is also the chance of triggering ‑‑ staff being triggered by what they hear because of a similar experience they may have had in their past.

>> TIM FUCHS: Good point. Thanks. Onto the next question from Liz Hunter‑ball. Liz is asking if you all can talk a little more about providing a safe environment. If I could frame that a bit since it's complex: Can you talk about how centers can find out more and where they can go to learn more about providing a safe environment?

>> JAN DERRY: Again, my first recommendation is that you instantly start developing a relationship with your victim services. Secondly, one thing I found that was really, really helpful, because I'm a member of our Sexual Assault Response Team, and one of the recommendations that was made was that we have the police come over to our center and help us look at our prehistoric block building with antique buildings ‑‑ I mean, antique windows, everything is really ‑‑ we're not one of these fancy nice centers. And help us look at the fact that we've only got two doors. What are our escape routes? Help us to develop an environment and a plan that should, like Leslie said, if it's a staff member and all of a sudden the caregiver sees their perpetrator coming into ‑‑ not the caregiver ‑‑ a consumer sees the caregiver coming into the building is there something we can he do? So having that assessment done of your center to look at what safety issues may exist.

Also, Leslie, didn't you create a document on this issue specifically about looking at your center's safety issues or did I make that up?

>> LESLIE MYERS: I'm going to say you made that up. On the accessing safety website you can find a number of existing tools that have been made through the OVW grant that have all looked at safety from different types of perspectives for their facilities. So that's one way to do it. Another thing is just the trust, building a trust with the individual helps to make them feel safe. And to also ‑‑ I always think about giving some control back. Abuse is about power and control, and if we can do that, if we can offer some control back to the individual. For instance, if I met with someone who I know has been abused, then I'm not going to just walk in and sit down. I'm going to ask them if it's all right if I sit down. So giving them some control back in their own lives and within the meeting that we're having with them, too.

>> TIM FUCHS: Great. Great information. Thanks. Another question ‑‑

>> ERIN FONTAINE: Just one more thing add, and I think it was kind of touched on, but I think looking at a safe space is so much more than the physical space but making sure we're providing an opportunity with open‑ended questions, making sure it's something that's coming up at staff meetings or staff trainings to be aware of, and that we're providing an opportunity for open‑ended questions, to be there to listen, to have those connections with the local agencies in your community that might serve survivors of abuse and to have ongoing open communication with the people that you serve so that they know that you're there to listen, that it is something that you and your agency are addressing, because so much, it's just a fear of the unknown and not sure what's going to happen if they Dee say something to you or if you will believe them or not. Owe sigh think the more that you can use open communication you're going to create that safe space and all of those other actors, looking at the big picture about the safety plan within the building and how you're set up with groups and meetings and things will all start to fall into place a little bit more if we can keep that basic thing in mind, too.

>> TIM FUCHS: Great. That's a good point. Thanks. Okay. This next point isn't a question so much as a comment but I wanted to highlight it. From Lou Ann in regards to the difference between the PA programs out there. Lou Ann just reminds everyone, I imagine many of you read this on the chat here, that in regard to background checks some states, such as Kansas, the PAs are not employees of the CIL and background checks are not required in order to ensure consumer control and choice. She goes on to say at the bottom that it may be important to just remind customers or consumers that they can request background checks, which can then be done. And so just a good point for centers that might have a different approach to PAs and not have background checks done right off the bat.

That was several minutes ago. I haven't seen any questions come in since then. And this still isn't our last Q&A break. So we'll goat to slide 32 now and Jan is going to continue. Jan?

>> JAN DERRY: So community collaboration, again, like I've said before, you don't know what you don't know. I sure as heck didn't know what I didn't know. So where do we start? There are lots of opportunities for grant programs happening out there to provide support for CILs that want to get involved in this work, but that's not where I recommend you start, because that is too iffy as to whether or not you'll be successful at obtaining that. It is a wonderful resource. I think you need to start by making connections, again, with victims services and understanding that system. And understanding what community resources, where are the gaps, where are the barriers within that system, where do you see that people ‑‑ where the system has failed? Under the grant program we did a community needs assessment and found out that very little existed for individuals with disability. Finding out what is there, how accessible are your shelters, how inclusive are the services, their policies, their procedures. It's a good place to start. I'm hoping that the 83% of the individuals that responded to this will give examples of local collaboratives that CILs are doing. I only know of a couple that were grantees that were involved when my program was under the OVW grant where I found that there was just an enormous amount of effort being done in cross training and collaboration and learning each other's language and learning each other's resources.

We're the experts on working with individuals with disabilities. The people with disabilities are the experts at identifying what their critical needs are. However, the individuals that work within the victim response systems, they're the experts in what they do, the legal systems. Pull your team together. I think we have a tendency to think we can fix everything, we're the experts on everything. I have breathing down, but short of that, I don't feel like I'm an expert at much of anything. So realize your limitations. It's key to realize that you have something to bring to the victim services arena, and they have something to give back to you.

So we're going to talk a little bit, and you can move right on to the next one, talk a little bit about what happened in West Virginia and how we got started and through a small ‑‑ I got involved in this because I happened to be the one and only CIL that responded to a survey that came out from the West Virginia foundation for rape information and services that was going out statewide funded by the developmental disabilities council to determine what's being done out in this field. And so as a result of that survey that I responded to, I ended up getting brought into it being the only disability service provider that was a CIL that responded. We found out that residents in group home settings were not allowed to be sexual. Because what we did was we studied all facilities, and what the study did, they studied all facilities, disability providers, long‑term care providers, special ed students were not included in any of the school sex Ed programs, and the only policy most providers had was to make sure that it didn't happen. That sex didn't happen between individuals. And so it became real clear that there was a huge gap in the understanding in that like Erin shared too many people believed in the world here that people with disabilities don't have sex, and so they don't need to be taught anything, which we all know is absolutely ridiculous.

We had key partners, and it's atypical what you might find as a partner. DHHR, our department of health and human services, all the ‑‑ epidemiology was the department that got involved in ours because it was considered ‑‑ it's an epidemic issue of violence and abuse and neglect and all that kind of stuff. And so we pulled together a very unique partnership of the USEDs in the state and Center for Independent Living, the ‑‑ and DHHR, and our mission and vision was to create a permanent systems change at all levels of sexual assault and disability systems that are fully integrated into existing structure of victim services. We didn't want a special structure. We weren't fighting for that. We wanted an inclusive system that existed for all victim services. And we expanded our local partnership to include all points of entry, improving accessibility. That was our goal, was where to people with disabilities access any types of services. So we did these pilot sites in three different counties where there was a comprehensive mental health center, where there was a CIL, where there was a rape crisis center and we pulled together different partners to see where the gaps in services are. Again, foster collaboration and bill sustainable common knowledge and ensure services and support is accessible and responsive.

Ah‑ha! Now it goes to Leslie.

>> LESLIE MYERS: All right. You can go ahead to the next slide. Thanks, Jan.

When I was ‑‑ started working at IndependenceFirst in 1998, I really also started working on violence against people with disabilities. I did a lot of work in our service area and beyond around this issue. So what happened in 2004 really came as complete surprise after six years of really working intensively with the local agencies and just to have everything fall apart like it did.

It looks like Jan is trying to move in on my story here, so you can go to the next slide.

In the case of Janet, this might be a little hard to read, Janet was a woman with an intellectual developmental disability whose husband had beaten her and her employer tried to help her to find help, which really ended up on my desk. First the domestic violence programs would not take her because her speech disability made it difficult for her to talk on the phone and they asked for help. Adult protective services wouldn't intervene because she was not on Social Security. And I love to tell this story, but we don't really have enough time for me to do so. So let's just say that it was ‑‑ that was when the dominoes really started to fall, and they continued to fall one right after another with help closing its doors at each step that we tried to take.

It took intervention by the state funder to make things start to happen in this emergency, but that intervention did have some conditions attached, and we ‑‑ we are ‑‑ we've all had to meet together to discuss what went wrong in Milwaukee, and as a result, 17 agencies came to that first meeting, which eventually evolved into a collaboration called DART which stands for Disability Abuse Response Team. DART eventually became a subcommittee of the Milwaukee commission on domestic violence and sexual assault and we continued to evolve the team, adding member programs as we needed them, and by 2010 we had 41 agencies that were part of DART.

All these agencies met regularly and none of them were funded to do so. We were able to get funding for a subset of the group, IndependenceFirst, sojourn you are family peace center, City of Milwaukee health department and Milwaukee county disability services received a grant in 2007 from the office of violence against women and we created MMDI access through that grant. IndependenceFirst also had received OVW, office against violence against women, funding twice to run what we call the DART transition house program for individuals with disabilities who were in domestic violence situations and needed a place to go after ‑‑ after their stay at shelter.

Erin do you want to talk about the work you're doing in Duluth?

>> ERIN FONTAINE: Yes. So you can go ahead ‑‑ go right to the next slide here. Just to kind of give you a little background, we actually have done several different smaller projects before we were awarded a disability grant project through office of violence against women. I started at our independent living center in 2003 and had really heard nothing of the intersection of disability and abuse at that point. Our local sexual assault agency, which is program to aid victims with sexual assault, had a smart team. Here of course we have their whole new set of acronyms to learn and the smart team in Minnesota is sexual assault multi‑disciplinary action response team, and their focus was pulling together advocates, law enforcement and criminal justice. People across the system in the hospital settings, a ‑‑ sexual assault nurse examiners were there for rape kits and working with victims at the time, really trying to see who are the underserved ‑‑ the underserved people in our community who are survivors, victims of sexual assault, and wasn't really looking at caregiver abuse necessarily but that it came up occasionally where it was a case of sexual assault that did involve a caregiver, a family member that was coming in. And so they were looking at several marginalized populations within our local community, focusing on trafficking victims, focusing on people with cognitive disabilities, people who are homeless and looking at so many times people were experiencing multiple barriers that were increasing their likelihood of being targeted as a victim. And so they were starting to recruit people to be part of this smart team and starting to look at providers who work with people with disabilities. So there were some, a residential provider, care providers, and a local ARC chapter and us as an independent living center had come on board to be involved with some of the work that was happening with the SMART team. In 2006 Safe Place which is a program out of Austin, Texas, that serves survivors of domestic violence, sexual assaults, and they have built in an ASAP program which is a safety awareness program, specifically working with survivors with disabilities had put out a proposal trying to do some ‑‑ train the trainer opportunities with teams through ARC, and we developed a local team out of Duluth that was led by our ARC North land and with ARC north land independent living center and had the opportunity to go down and learn more about cross training and team building and how to start of the collaborative work to make sure we are working together to address the needs in our community, and it really kind of got us all energized and excited to start doing some work and come back to our communities and do some focus groups and trying to do some basic needs assessment. Unfortunately we didn't have any funding and there are there were staff changes happening which made it difficult. But we had kind of started a group meeting on a quarterly basis called building bridges where we were meeting together, sharing resources, providing opportunity to do education for each other's agencies, staff, and really starting to build some of those networks slowly but surely without funding in place. In 2008 there was an opportunity through the office for victims of crime as a subgrantee through SAFE place again. I believe there were three or four sites across the country that were selected to try to do some replication work with Safe Place in Austin to look at how to ‑‑ obviously work together but how to really create the services available as more of a one‑stop shop or working within the domestic violence and sexual assault agencies to serve people with disabilities. And so a lot of great things were happening there. Able to get a lot of feedback from people with disabilities and survivors through interviews and focus groups and trying to select some data locally. We were getting some information about the number of people who were choosing to self‑report. Of course, it was optional. And anonymous. But at the time of receiving services through the sexual assault agency crisis line or coming in for advocacy services people were being asked if they ‑‑ if they would be interested in self‑reporting a disability. Sorry, that's not the proper language ‑‑ but making sure they weren't being discriminated based on that but that we were trying to get some information about the number of people served. We expected it to be underreported because concerns of sharing that and stigma that goes along with disability, especially mental health diagnosis, that many people would not want to report disability for a variety of fears. However, we found 50% of the people being asked coming in were self‑reporting a disability, and if we know that 18 to 20% of the general population would be considered to have a disability and over 50% of people who were experiencing abuse in our local communities were self‑reporting disability, it was obviously a clear area of need within our community, and I think that really helps the leadership, within our domestic violence agencies, sexual assault agencies to see this is a huge need. At that time we had applied through domestic abuse intervention programs as the lead agency along with our access north independent living center where I work. ARC North land. A safe haven, which is a shelter, domestic violence shelter and resource center. American Indian community housing organization. All together looking at what can he we do in our community to better serve survivors with disabilities and went through a whole three‑year process. We're just finishing up a one‑year no‑lost extension to finalize some work. A lot of things we talked about earlier that Leslie mentioned about developing strong policies and procedures, looking at how to create a safe place within our organizations, and looking at how we can continue to sustain the work in our community and build those relationships with these agencies and really finding that we're much better able to support survivors with disabilities ‑‑ there, of course, is opportunities to fall through the cracks in so many different areas with you will aft different barriers for reporting. So the more that we can increase awareness and do cross training. For example, the sexual assault agency trains new volunteers, a 40‑hour training they're required to provide and they cover all different kinds of areas of sexual assault, awareness and education and they have a component that's built in that has to do with disability awareness and we have staff from the independent living center come in to recognize warning signs, to talk about communication with people with disabilities, to talk about reasonable accommodations, to talk about first‑person language, to really help them get some awareness about people with disabilities and more comfort with the issues at the intersection of abuse and disability. It's been a great help in our community.

I think I talked about a little, too. When we did some focus groups the biggest things we found was fear. Fear, fear and fear. Fear of not being heard, of threats, fear of retaliation, emusment due to the stigma of disabilities, not sure where to go. So many times I've heard people say I've tried reporting to so many different people and just not getting anywhere. To get those resources that they need because they're just thinking ‑‑ being told it's related to their mental health or that they're not ‑‑ that they're to blame or ‑‑ a whole variety of things that are false due to lack of education and awareness of the issues.

I'm going to kind of skim over this, but some of the key findings we found and it's really important to look at each local community because you really need to develop your work in your community based around your needs and to get that buy‑in and involvement and really see success, you need to look at what is existing in or own communities and it's going to be different in every community but these are some of the things we saw as our biggest area of need and what we worked to address and we will continue to work to address. Lack of resources, and need for increased awareness and cross training, gaps in clear written policies and procedures, need for ongoing, increased relationship between people and roles and programs and looking at a vision for sustainability and barriers that exist to provide safe, accessible and welcoming services.

I just threw up here, this is our local collaboration right now called connections. We have created a web site which can be found at WWW.connectionsduluth.org. Really just kind of share some of the work we're doing locally here with a link to each of the partner agencies and trying to address what people would need to know about those services and how to access those services and looking at building from there. But it's primarily used by our partner agency staff to make referrals and get a good understanding of those resources to share with people they're serving.

We'll turn it back over there.

>> TIM FUCHS: Jan, are you covering this one?

>> JAN DERRY: Actually, I think Leslie was, but I was on mute and she might be on mute, too. So I'll just take it and go with it. Because we're running out of time here. Just wanted to let you know obviously that the violence and abuse task force started way back in 2006, and did a resolution at the annual conference. Since its inception the task force has obviously presented at workshops and conferences of NCIL and APRIL. We're constantly providing one ‑‑ one every our missions is to educate the membership and so we're writing articles for the WHAM. We want ‑‑ we encourage NCIL to take a stand on a current trends and issues of violence and abuse. We've done some resolutions that are available regarding abuse and violence in the ‑‑ and the no tolerance, on institutional settings as well as community‑based settings. We were very active with the reauthorization of the violence against women's act and task force members provided comments to the legislation action that was going on.

We meet ‑‑ we're always in need of input, and we meet on the first Thursday of every month at 2:00, and if you're interested in learning more about the task force, you can contact myself or you can Roberta Sick. We are the cochairs.

I don't know if we want to go to question and answers. If we're going to have time to share the ‑‑ we could just jump to the slide real quick and go back to questions and answers.

>> TIM FUCHS: That's fine if you want to touch owe resources.

>> JAN DERRY: Yes. One of the outcomes we did in West Virginia was this toolkit that was readily available to any center that is interested in having access to it, and it provides ‑‑ it's four books, it's in a toolkit. It's readily available on the FRIS website, which will be on the next slide. It has sexual violence, the disability community does not understand all the rules and ‑‑ different sexual violence laws and every state is different. So it provides training for the disability service provider as well as the sexual assault victims services provider that is readily available for you to train. It's training modules. It's on how to create access, developing transition plans, doing accessibility studies, policy reviews. It's a cool resource.

It's focusing on facilitating collaboration among partnering agencies in building accessible and appropriate services. One of the things we've done that continued to do cross training to every 6 annual assault response team, every shelter in the state. We all have an outreach and education goal in our 704 and in our standards and indicators. Make this the topic to start reaching out into your communities, to start making sure that the people who are doing victim services understand disability services.

The website to get to that tool ‑‑ back up, I'm sorry ‑‑ oh, it's still there. It's FRIS.org. Go to the resources and hit on the toolkit. It's on your handout. You can find it. We created some brochures specifically designed for individuals with disabilities. So you put the universal color on it blue, instead of teal, which is the sexual assault color, but it gets ‑‑ brochures that are available that you can look at and go to that site and download. There are lots of resources on that site that you can use to expand your own personal knowledge.

>> TIM FUCHS: Okay. Thanks, Jan, for the quick review of the resources. We're going to take the last few minutes here and go to questions. I understand that we have a question in the ‑‑ on the phone. So that was a few minutes ago. Let's go there now and get that line unmuted and see if the caller is still there.

>> PARTICIPANT: This is Carolyn, a CDS specialist in southwest Missouri, and I understand the resources ‑‑ resources available for the consumers with sexual abuse and violence and harassment and whatnot, but what I'm coming up against is our consumers are able to hire their own attendants, and now I have attendants coming back to me saying, how do I approach my consumer ‑‑ they're saying things that are not appropriate. Or they're doing things that are not appropriate. Is there education out there for our consumers readily available to help them understand what sexual harassment is to our employees? Because they hire their own employees. We don't do that for them. Does that make sense?

>> TIM FUCHS: It makes sense. Any tips from you all?

>> JAN DERRY: I think that there's a um inform different things ‑‑ probably online that you can look at. I don't know any off the top of my head anything that I can suggest, but there's a number of things that have been done online that might be helpful.

>> TIM FUCHS: And I don't have much time to give detail but Lou Ann offered online that Kansas has a self‑direction tool that I am assuming includes tips on ‑‑ like that for consumers. You can get that from the KACIL website, the Kansas association for centers of independent living.

Also a popular question, and I think I know the answer on the chat, has been if the toolkit that Jan mentioned is free? And Jan said that it is free to download. I just wanted to make sure anybody who wasn't reading the chat was aware of that.

Thanks so much. No other questions on the phone. And ‑‑ Erin one other thing to add about resources, Safe place in Austin Texas, you had a link for their website, but they had several fact sheets that were helpful for people who are managing their own caregivers, some tips as far as when you're hiring caregivers and some things about managing your own care that might be helpful as well.

>> TIM FUCHS: Safe Place is a fantastic resource. Good. Well, it is 4:31. So alas I'm glad we have gotten through the questions because we are out of time. So I'm going to begin to wrap up here. I want to thank you, Erin, Leslie and Jan for putting this presentation together. Really fantastic. Thanks also for offering your contact information, which is here on slide 55. Don't forget, you can always email me if you have questions about today's presentation or our larger training program IL NET, if I can't answer your question I'll pass it on to someone who can. My email is of course, Tim@NCIL.org. Thanks to all of you for taking time to join us today here on slide 56 is the evaluation form that I mentioned at the beginning of the call. And, again, if you're participating in a small group today, if you would, please fill this out as an individual so we know what everyone thinks. Thanks so much for participating. The archive of this webinar will be available for you to review or to share with your colleagues within 48 hours at the end of the call. And you can access that on ILRU's new website. Go to trainings and then on demand trainings and you will see it listed when it is finished. So thanks so much everyone. Have a wonderful afternoon. We'll talk to you soon. Bye‑bye.