



**Adult Advocacy
Centers**

White Paper

Adult Advocacy Centers: A Comprehensive Response for Adult Crime Victims with Disabilities

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Introduction

According to the Center for Disease Control and Prevention (CDC), 61 million adults—one in four—have a disability (Okoro, et al., 2018), making people with disabilities the largest under-served minority group in the United States (Drum, et al., 2009). The CDC defines disability as “any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions)” (US Dept of Human Services, 2010). This definition of disability uses a “medical model,” and focuses on the individual as the source of challenges in negotiating the physical and social environment. In other words, something within the individual is broken and needs to be fixed in order to maximize that person’s ability to be successful in their life activities. Disability advocates and allies have offered a new perspective on disability that recognizes the broad range of human experience, of both the physical body and the internal workings of the mind. As opposed to a medical model, the “social model” of disability suggests that the limitations experienced by any individual with regard to accessing the physical and social environment are due to society’s failure to consider and accommodate the many ways in which any one human may differ from others (Goering, 2015; Sinclair, 1998). Within the social model, an “impairment” becomes simply a description of the part of the body or sensory system that is non-standard. Disability is then defined as the “disadvantage or restriction of activity caused by a contemporary social organization which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities” (Oliver, 1996, p. 22). In her paper regarding the social



model of disability, author Sara Goering points out why shifting perspective of the disability from within the person to the responsibility of society is essential.

The point of making and emphasizing this distinction is to show how much and sometimes all of what is disabling for individuals who have impaired bodies has to do with physical and/or social arrangements and institutional norms that are themselves alterable (e.g., stairs vs. ramps; presentation of data using only auditory means vs. universal design for communication, restrictive definitions of job requirements vs. expansive accommodations for different modes of performing work, etc.). (Goering, 2015)

This paper will describe the impact of physical, social and attitudinal barriers to safety and justice that face individuals with disabilities who are victims¹ of abuse, violent crime and exploitation. It will examine the risk of victimization for individuals with disabilities, discuss issues that contribute to those risk factors, and identify barriers to the investigation and prosecution of these crimes. Finally, the Adult Advocacy Centers' model will be presented as a comprehensive framework, grounded in universal, multi-sensory and trauma-responsive principles, designed to support crime victims with disabilities as they navigate the criminal justice and victim services systems.

Disability in the United States

Statistics on disability can be inconsistent from study to study because the term “disability” is not consistently defined, and sample groups often vary. What existing research makes clear, however, is that disability impacts individuals across all age, gender, race, ethnic and socio-economic lines. Using an analysis of information gathered through a 2016 survey by the Center for Disease Control and Prevention, researchers found that among people who report serious limitations in function, 46% report mobility disability, 39% report limitations in problem-solving or concentration, 26% report limitations in hearing, 21% report limitations in vision and 43% report more than one limitation (Okoro, et al. 2018). However, research also shows that disability is more prevalent among groups that are marginalized, especially elder adults, women and some minority populations—40% of adults ages 65 and older, 25% of women and 40% of non-Hispanic American Indians/Alaska Natives have disabilities (Okoro, et al., 2018). Nationally, African Americans experience disability at 2.5 times the rate of white Americans (Ross & Bateman, 2018).

Having a disability subjects an individual to significantly greater risk for disparities in health and well-being, healthcare access, education, housing and employment. In fact,

1 The terms “victim” and “survivor” are both used to describe an individual who has been affected by crime. The AACs use both terms interchangeably due to the diverse cultural populations that it serves.

people with disabilities have the highest rate of poverty as a demographic group (DeNavas-Walt, et al., 2013). In addition to, and in part because of, these disparities, individuals with disabilities experience severe limitations in their access to safety and justice, becoming victims of abuse and violent crime at a rate 2.5 times greater than individuals without disabilities (Harrell, 2014). Limitations to safety for this population are exacerbated by myths, misperceptions and historical stereotypes that permeate the systems that are meant to provide justice and services. The professionals who staff these systems often receive little, if any, education or training on disability. As a result, these systems often fail to provide basic prevention information in accessible formats, disbelieve allegations, decline to pursue the prosecution of perpetrators and fail to develop and provide adequate support services for victims with disabilities.

Victimization of Individuals with Disabilities

Since 1973, the U.S. Department of Justice has issued the National Crime Victimization Survey (NCVS) to gather data on criminal victimization across demographics (Morgan & Oudekerk, 2019). Data from the NCVS is considered the most comprehensive source of statistics on criminal victimization in the United States. However, the NCVS did not include specific questions on the victimization of individuals with disabilities until 2009, limiting the data required to support needed change. Since then, the NCVS data has shown that the rate of victimization of individuals with disabilities is at least twice that of non-disabled individuals. In the most recent analysis of NCVS data (Harrell, 2017), individuals with disabilities living in the community were found to experience 2.5 times the rate of violent victimization relative to people without disabilities. Even more concerning, the NCVS showed that people with disabilities were victims of the most serious violent crimes—rape/sexual assault, robbery and aggravated assault—at more than three times the rate of the non-disabled population. Perpetrators of violence against individuals with disabilities were more likely to be well known to or acquaintances of the victim than in crimes against non-disabled individuals. Importantly, the NCVS also showed that 20% of victims with disabilities felt that they were targeted specifically because of their disability.

In addition to collecting data on crime victims with disabilities as a whole, the NCVS breaks down the statistics by specific disability categories: cognitive, independent living, ambulatory, vision, self-care and hearing. For the period 2011 through 2015, individuals with cognitive disabilities experienced the highest rate, by a significant margin, of both serious violent crime (rape, sexual assault, robbery and aggravated assault) and simple assault. This group was followed, in order, by those with disabilities in independent living, ambulation, vision, self-care and hearing. Most violence against individuals with disabilities is committed against those with multiple disabilities (Harrell, 2017). Research has also shown that people with developmental disabilities are more likely to experience abuse that is more severe and lasts for longer periods, and that they are more likely to become

victims of multiple incidents of abuse, and to be victimized by multiple abusers (Schaller & Fieberg, 1998; Sobsey & Doe, 1991; Young et al., 1997).

While the data from the NCVS regarding the risk of victimization for individuals with disabilities is alarming, it is also limited. The NCVS relies on self-report and only gathers information on individuals with disabilities ages 12 and older who are living in the community. It does not capture information on the victimization of individuals with disabilities who are younger than 12 years old, or those who are homeless or live in institutional settings like nursing homes, residential facilities or hospitals. Because many individuals with disabilities reside in such settings, the data from the NCVS likely significantly under-identifies the extent of victimization of individuals with disabilities and leaves out several segments of the disability population that are under-served and under-protected by justice and victims advocacy systems.

Children with Disabilities

While this paper focuses on adults, from a prevention perspective it is vital to recognize the compounding risk factors for abuse on children with disabilities, as there is substantial research to show that early victimization significantly increases the likelihood of later victimization in crimes like sexual assault and human trafficking (Ports, et al., 2016; Papalia, et al., 2017; Arata, 2006; Reid, et al., 2017). According to the U.S. Census Bureau (2011), 5.2% of children ages 5-17 have a disability. However, federal child maltreatment data show that 14.1% of maltreatment cases involve a child with a disability (U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, 2015). A study in Minnesota found that one third of child maltreatment reports in that state involved a child with a disability (Hall-Lande, Hewitt, Mishra, Piescher, & LaLiberte, 2015). Other studies have also shown that children with disabilities as a whole are at a significantly increased risk of victimization. One study involving more than 50,000 children found that children with disabilities experience maltreatment at a rate 3.4 times that of their non-disabled peers. Broken down by category of maltreatment, children with disabilities are four times more likely to be emotionally abused, 3.8 times more likely to experience abuse or neglect and three times more likely to be sexually abused. It was also found that almost two thirds, 63%, of children with disabilities experienced multiple forms and multiple episodes of maltreatment (Sullivan & Knutson, 2000). The CDC has identified additional categories of disability that put children at risk. The agency found that children with disabilities that impact behavior, including attention deficit/hyperactivity disorder, are vulnerable to physical abuse by parents or caregivers who struggle to cope effectively with challenging behaviors. In addition, they note that children who are more reliant on adult caregivers are more likely to experience neglect or sexual abuse, and that children with communication challenges—communication disorders or hearing disabilities—are at

greater risk for sexual abuse (Centers for Disease Control and Prevention, 2019).

Institutional Care

For the purposes of this paper, institutional settings include facilities operated or licensed by the state to provide residential long-term care for adults with disabilities. These facilities include, but are not limited to, nursing homes, intermediate care facilities for adults with intellectual and developmental disabilities (ICFI/DD) and state-operated institutions.

The CDC reports that there were approximately 1.3 million nursing home residents in 2015, with another 811,000 individuals in residential care communities, virtually all of whom have a disability (CDC, 2019). Among nursing home residents, 16.5% were under the age of 65 (National Center for Health Statistics, 2019). The National Ombudsman Reporting System, which collects data on complaints regarding the care of nursing home residents, shows that in 2017 approximately 201,460 complaints of maltreatment were made to Ombudsman programs, with approximately 7% involving abuse, gross neglect or exploitation (Administration for Community Living, 2020). In a study conducted in 2000 involving interviews with 2,000 nursing home residents, 44% said that they had experienced abuse, and a staggering 95% said that they had either experienced or witnessed neglect (Broyles, 2000). In addition, some research suggests that resident-to-resident abuse in nursing homes is more common than physical abuse by staff (Pillemer, et al., 2012; Rosen, et al., 2008). Distressingly, 50% of nursing home staff surveyed in one study admitted to having abused or neglected residents during the prior year (Ben Natan, 2010). In 2017, CNN examined inspection reports for nursing homes from the Centers for Medicare and Medicaid Services from the years 2013 to 2016. During that period, the federal government cited over 1,000 nursing homes for “mishandling or failing to prevent alleged cases of rape, sexual assault and sexual abuse at their facilities,” with almost 100 having been cited multiple times during that period (Ellis & Hicken, 2017). CNN pointed out that these numbers are likely an underestimation of the extent of the problem, since they only include cases that were reported. According to the National Research Council, “a vast reservoir of undetected and unreported elder mistreatment in nursing homes may exist. Because nursing home residents as a class are both extremely physically vulnerable and generally unable either to protect themselves or report elder mistreatment they experience, the physical and emotional costs of elder mistreatment in such environments are likely to be very high” (Bonnie, et al., 2003).

While the number of individuals with intellectual or developmental disabilities (I/DD) living in institutions has declined since the deinstitutionalization movement began 40 years ago, in 2018 approximately 70,000 individuals with I/DD nationwide lived in settings of 16 or more residents (Braddock, Hemp, et al., 2017). National data on abuse and neglect in state-operated facilities for I/DD is scarce. The Department of Health and Human Services does not require states to submit data on claims of abuse and neglect of individuals with I/

DD. To the extent that individual states collect data, there is no uniformity in how it is collected or in how the terms “abuse” and “neglect” are defined (Carroll et al., 2009).

The number of people with mental illness receiving institutional care at any given time is difficult to estimate due to the constant cycle of admission and discharge from psychiatric hospitals and other residential settings. The 2018 National Mental Health Services Survey (Substance Abuse and Mental Health Services Administration (SAMHSA), 2018) found that 129,115 people received inpatient hospital mental health treatment that year. In addition, more than 58,000 individuals received mental health care in a residential treatment setting. Lengths of stay, however, were not reported. Little research has been conducted on the extent to which individuals with mental illness experience victimization in an institutional setting. In a 2005 study, 142 adult psychiatric patients reported high levels of victimization in psychiatric settings, including 31% reporting physical assault, 8% reporting sexual assault by another patient and 3% reporting sexual coercion by staff (Frueh et al., 2005). The lack of research in this area is likely the result of several factors, including the failure of the psychiatric community to provide transparent information on issues related to abuse, negative stereotypes that paint individuals with mental illness as not believable, lack of information for those seeking mental health care about how to report allegations of abuse and neglect and limited support for individuals who do report. Despite the scarcity of research, experts recognize that the problem is likely pervasive (Barnett, 2020).

Homelessness

Homelessness disproportionately impacts individuals with disabilities, though quantifying the problem is difficult because of the transient nature of homelessness and inconsistency in the definitions of disability used by researchers. In its 2018 annual report on homelessness, the Department of Housing and Urban Development (HUD) estimated that on any given day, people with disabilities make up 24% of the homeless population (Henry et al., 2019). In 2019, HUD reported a homeless population of over 5 million people, including almost 100,000 chronically homeless individuals with disabilities (Henry et al., 2020). A variety of factors can contribute to homelessness among individuals with disabilities. Individuals who receive supplemental security income (SSI) have income restrictions to maintain their benefit, as well as limits to how much they can save to plan for financial crises. In addition, many shelters are inaccessible, and shelter staff are not trained to work with people with disabilities (Vinoski Thomas & Vercruyssen, 2019).

Data from the Census Bureau’s 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC), considered the most comprehensive collection of information on homelessness to date, found that 30% of chronically homeless people had a mental health condition, while 60% had experienced lifetime mental health problems. The survey also found high levels of chronic and potentially debilitating physical health conditions among the older homeless population. A review of research published from 2007 to 2017

found that cognitive impairment is both a risk factor to and a cause of homelessness (Stone, et al., 2018). For veterans, who make up approximately 9% of the homeless population, research has shown that 53% have disabilities (United States Interagency Council on Homelessness, 2018; Disabled Veterans National Foundation, 2019). A study conducted in Washington, DC, found that 64.8% of homeless veterans reported a history of traumatic brain injury (TBI), relative to the 10-12% of veterans overall (District of Columbia Traumatic Brain Injury Implementation Project, 2010).

Because the percentage of people who are homeless and have a disability is so significant, it is important to consider this population when attempting to quantify the extent of victimization of people with disabilities as a group. Data from the NSHAPC showed that 54% of those responding to the survey report experiencing violent victimization at least once while homeless, with 21% reporting physical assaults and 11.4% of women reporting sexual assault. One study found that 32.3% of women who are homeless and 27.1% of men who are homeless reported sexual or physical victimization in the past year (Kushel, et al., 2003). In another study, 23% of women who are homeless and 21% of men who are homeless reported being either sexually or physically victimized in the last month, with 9% of women reporting having been sexually victimized (Wenzel et al. 2000). While there is no definitive research that differentiates between crime victims with and without disabilities who are homeless, the high number of individuals with disabilities who are homeless, combined with the fact that having a disability in itself results in increased risk of victimization, supports the need for further research and focused attention.

Mental Illness

The Americans with Disabilities Act includes “mental impairment” under the definition of disability (Americans with Disabilities Act (ADA), 1990). According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) 2017 National Survey on Drug Use and Health, 19% of adults experience some form of mental illness, with 4.5% experiencing severe mental illness (National Institute of Mental Health (NIMH), 2017). The survey also found that 13.3% of adolescents ages 12 to 17 had experienced a major depressive episode (MDE) in the past year, with over 70% of those experiencing MDE with severe impairment. One study found that individuals with severe mental illness were 2.5 times more likely to be victims of violent crime than the general population (Hiday, et al., 1999). Another study found that 60% of newly hospitalized psychiatric patients reported intimate partner violence and/or victimization by family members (Cascardi, et al., 1996). A study involving 936 patients from 16 mental health agencies in Chicago found that more than 25% of persons with severe mental illness had been victims of a violent crime in the past year – a rate more than 11 times higher than the general population (Teplin, L., McClelland, Abram, K., Weiner, D. 2005). A review of multiple studies found that rates of victimization of those with mental illness ranged from 2.3 to 140 times higher than the general

population due in part to the presence of additional risk factors, such as substance use/abuse, homelessness and engagement in criminal activities (Maniglio, 2009).

Elder Americans

According to the U.S. Census Bureau, nearly 58.5% of people ages 65 and older have at least one disability. Of those, women over 65 are significantly more likely than men to have multiple disabilities, primarily because women have a longer life expectancy than men. Approximately 30% of adults between the ages of 65 and 69 report a severe disability. For adults 70 and over, that number rises to more than 50%. Among adults 65 and older, 9.4% report difficulty with vision. They also report having difficulty hearing at 5 times the rate of those under age 65 and are four times as likely to be deaf. Nearly 40% report difficulty walking a quarter mile or climbing a flight of stairs, with 58% of those reporting that they were unable to do so at all (US Census Bureau, 2018). It is estimated that 5 million adults 65 or older have Alzheimer's disease or some other form of dementia (CDC, 2019), with that number expected to nearly triple by 2050 (Alzheimer's Association, 2020).

An estimated 1 in 10 elder adults are the victims of elder abuse or neglect (Lachs & Pillemer, 2015). A national study of elder adults living in the community found that the one-year prevalence for emotional abuse was 4.6%, 1.6% for physical abuse, 0.6% for sexual abuse, 5.1% for neglect, and 5.2% for current financial abuse by a family member (Acierno et al., 2010). In another study, researchers asked adults ages 57 to 85 who were living in the community about their experiences of maltreatment in the past year. Nine percent of respondents reported verbal abuse, 3.5% reported financial mistreatment and 0.2% reported physical maltreatment (Laumann et al., 2008). Another study, involving 6,674 community-dwelling adults over 65, found that nearly half of people with dementia were abused or neglected by caregivers. That study also highlighted the health impact of elder abuse. It found that victims of elder abuse were three times more likely to die prematurely, three times more likely to be hospitalized and four times more likely to be admitted to a nursing home than their non-abused peers (Dong & Simon, 2013).

A 2009 study by MetLife Mature Market Institute focusing on financial exploitation of the elderly found that the annual cost to victims was conservatively \$2.6 billion dollars. The study also estimated that only 20% of cases of financial exploitation are ever reported (MetLife Mature Market Institute, 2009).

Getting hard data on elder abuse, as with other forms of abuse, can be difficult for a number of reasons. Research has shown that there is a significant disparity between the number of cases of self-reported abuse and cases of abuse documented by investigative agencies, including Adult Protective Services and law enforcement. This reveals a dangerous failure on the part of the systems designed to protect the elderly to identify those at risk. In 2011, researchers conducted the New York State Elder Abuse Prevalence Study involving 4,156 elder adults or their proxies and 292 agencies from across the state. The

goal of the study was not only to quantify the problem of elder abuse in New York but also to identify the extent to which elder abuse goes unreported to authorities. The study found “an elder abuse incidence rate in New York State that was nearly 24 times greater than the number of cases referred to social services, law enforcement or legal authorities” (Lifespan of Greater Rochester, Inc. et al., 2011). Researchers identified several causes of the disparity, including inconsistent data collection requirements and methods among agencies, as well as reluctance on the part of victims to seek help due to fear, shame and lack of knowledge about how and where to seek assistance.

Risk Factors

“I use the term ‘disabled people’ quite deliberately, because I subscribe to what’s called the Social Model of Disability, which tells us that we are more disabled by the society that we live in than by our bodies and our diagnoses.” – Stella Young

Whether adult or child, housed or homeless, living in the community or in an institutional setting, and regardless of disability type, having a disability puts an individual at a significantly increased risk of victimization. Understanding the risk factors, as well as societal assumptions that increase risk, is foundational to addressing risks and promoting autonomy, safety and justice for people with disabilities.

Often, descriptions of the factors that elevate the risk of victimization for individuals with disabilities both subtly and directly misattribute the source of the problem to the victim or to the victim’s disability – the victim “should have known better” or “anyone would lose their temper if they had to deal with that behavior.” Under that view, the solution to the problem focuses on “fixing” the victim. The term “vulnerability,” often used to describe risk factors associated with victimization of individuals with disabilities, implies weakness and dependency. In fact, vulnerability to crime is not unique to people with disabilities but is experienced by all humans at various times in their lives and for various reasons. “Failure to recognize vulnerability to victimization as part of the human experience reinforces the notion that the vulnerability of people with disabilities is universally different than the vulnerability of ‘able-bodied’ people” (Fitzsimons, 2017).

This paper seeks to refocus the search for solutions on fixing the systems that have fallen short in their jobs to educate, protect and support all members of society equitably. With this perspective in mind, the term “risk factors” will be used to describe the societal and systemic perceptions and actions that underlie the increased incidence of victimization for individuals with disabilities.

Foundational to the increased risk of victimization is the dual perception of individuals with disabilities as both objects of pity and sources of inspiration. In those roles, people with disabilities are “otherized” and therefore, to the extent that they require accommoda-

tion or support, those needed resources are seen as extra effort and expense rather than part of the cost of providing safety and security to all citizens. In 1998, the National Organization for Victim Assistance (NOVA), through a grant from the Department of Justice Office for Victims of Crime (OVC), organized one of the first national forums to examine the intersection of justice and disability regarding individuals with disability as victims of crime, not perpetrators. The symposium brought together leaders in disability advocacy, victim assistance and research to examine issues of access to justice and victim services. Among the many findings from the symposium, three primary societal myths were identified as underlying the increased risk of victimization and the barriers facing individuals with disability to justice and services: (Guidry, 1998)

- People with disabilities are “suffering.” As such, provision of services and access to systems is seen as “charity,” rather than an equal extension of the legal rights and protections due to all citizens. The report concludes, “Being kind to a person with a disability is not an acceptable substitute for the provision of civil rights protections.”
- People with disabilities lack the ability and judgement for self-determination in all areas of their lives, including physical, mental, sexual and financial. “Although individuals with severe cognitive impairments may need greater support and advocacy services, this does not impede their ability or preclude their right to participate actively in decisions affecting their lives.”
- People fear both victims of crime and people with disabilities “as though their distresses are contagious.” Both groups are therefore seen as outside society’s perception of normal. “When the two forces of stigma are joined, victimization and disability attitudinal barriers to providing healing and justice can seem even more formidable.”

Reflecting on these myths, the report concludes, “Improving service delivery to people with disabilities must become a priority because the crime victims’ rights movement is founded on the premise that every crime victim deserves fundamental justice and comprehensive, quality services.”

Another impact of society’s “otherized” view of individuals with disabilities is that they are seen as “easy targets” for perpetrators. Whether due to societal myths or communication barriers, individuals with disabilities are seen as unable to report crimes committed against them. These same myths and barriers result in the view that individuals with disabilities are poor reporters of their own experiences and therefore not credible, especially those with cognitive or psychiatric disabilities (Glover & Reed, 2006). The experience of having been disbelieved in the past, and the shame and guilt that accompany that experience, reduce the chances that the person will make the effort to be believed in the future. Perpetrators often take advantage of this view by impressing on the victim that no one will believe them and by using the prejudices of witnesses and law enforcement against the victim. The NVAC report found that more than 20% of unreported crimes against peo-

ple with disabilities went unreported due to the victims' belief that law enforcement would not help them (Harrell, 2017).

The perception of individuals with disabilities as “easy targets” for victimization is further perpetuated by societal views on sexuality and disability. Individuals with disabilities are commonly thought of as perpetual children, asexual or hypersexual (Esmail et al., 2010). As Shildrick (2013) describes it, “Both sex and disability threaten to breach certain bodily boundaries that are essential to categorical certainty and, as such, they provoke widespread anxiety.” The result is that individuals with disabilities are often excluded from accessible education on healthy sexuality and relationships (Barnard-Brak et al., 2014), which may create susceptibility to manipulation and deception and increase the potential for high-risk sexual behaviors (Lindberg & Maddow-Zimet, 2012; Pennsylvania Coalition Against Rape, 2016).

Social isolation has been identified as a significant risk factor for interpersonal victimization across the population (CDC, 2018). Reasons for social isolation can be as basic as lack of mobility or accessibility, but they can also be complex. People with disabilities and their families confront societal factors specific to disability that further contribute to isolation from family and community (Lightfoot, 2014). These additional factors may include negative societal views of disability and its causes, as well as inadequate access to the services and supports that would help them build and maintain social connectedness. Other factors, like the added time and resources that can be required to care for and supervise a family member with a disability, reduce opportunity for social engagement and create caregiver stress. Financial, physical and emotional stress, as well as concern for the future, can significantly increase risk of maltreatment (Children's Bureau, 2018). In addition, many people with disabilities live, work and spend their free time in facilities and programs designed only for individuals with disabilities (e.g., classrooms, day programs and workshops, nursing homes and institutions), resulting in both physical and social segregation (Vera Institute on Justice et al., 2017). When victims are isolated from the family and friends who typically form the foundation of a social safety net, abuse goes undetected and unreported. Perpetrators may create further isolation by restricting the victim's ability to seek help for themselves by controlling their means of communication and mobility. Phones and computers can be broken or taken, motorized wheelchairs can be left uncharged, and crutches and walkers can be kept out of reach. Social isolation is often compounded by geographic, economic and political isolation, raising the risk of victimization even further (Baylor College of Medicine, Center for Research on Women with Disabilities, 2020).

According to the NVCS, 65% of abuse and violent victimization of individuals with disabilities is committed at the hands of someone known to the victim – family members, intimate partners, friends or acquaintances (Harrell, 2017). This is significantly higher than for victims without disabilities (43%). One major factor in the increased risk is that individuals with disabilities are often dependent on a greater number of people for care and support. These can include family members, teachers, therapists, transportation drivers

and personal care aides. As noted earlier, a study of nursing home residents found that 44% said that they had personally experienced abuse, and 95% reported experiencing or witnessing neglect (Broyles, 2000). In an article aptly entitled, “Bring My Scooter So I can Leave You Now,” researchers share the perspectives of women with physical and cognitive disabilities on abuse at the hands of personal assistance providers (Saxton et al., 2001). Several key themes regarding increased vulnerability to abuse emerged from the interviews. These included social and personal boundary confusion, uneven power dynamics, expanded forms of abuse and the complexity of using family and friends as providers. A 2016 investigative advisory from the Department of Health and Human Services Office of the Inspector General (OIG) recognized the severe impact of inadequate oversight of personal care providers, citing “high improper payments, questionable care quality and high amounts of fraud” ((Department of Health and Human Services Office of Inspector General, 2016). The report included numerous examples of gross neglect and abuse identified in the context of investigations. When a person with disabilities depends on others for basic care, housing, financial security, companionship and sometimes intimacy, they can be afraid to lose caregiving support and emotional attachment. Ultimately, individuals with disabilities may feel that they need to accept some level of abuse in order to maintain the support that the abuser provides (Hassouneh-Phillips & McNeff, 2005).

In a 2001 report on Crime Victims with Disabilities, the National Research Council identifies learned acquiescence, or passive submission, as an important socially mediated risk factor. “People with disabilities are often taught unquestioning compliance but rarely taught assertiveness and choice making” (National Research Council, Committee and Law and Justice, Commission on Behavioral and Social Sciences and Education et al., 2001). Autonomy, personal space and choice-making are set aside as others take control of an individual’s body and belongings in the context of personal care and activities of daily living. The tendency of caregivers to substitute their own judgement and opinions for those of the person in their care leads to a loss of the sense of agency. The recognition that one has a right to one’s own thoughts and opinions fades. The over-use of behavior plans, especially as a substitute for the more time-consuming task of teaching language, leads to a hesitance to say “no” or disagree on rules or policy. Lack of training on human and civil rights, or on the self-advocacy skills needed to assert those rights, leaves individuals with disabilities in a position of both physical and psychological dependence on others and therefore at greater risk of victimization.

Access to Justice – Reporting, Investigation and Prosecution of Crimes Against People with Disabilities

Little data exists on how often crimes committed against individuals with disability are reported to law enforcement or other investigative authorities. The NCVS found reporting of violent crimes overall was statistically the same whether or not the victim had a disability,

and that only 39% of sexual assaults reported to the police. Other research has found that anywhere from 14 to 39% of sexual assaults are reported (Kilpatrick et al., 1992). However, research specifically focused on crime victims with disabilities, particularly with regard to sexual assault, suggests that the numbers are even lower. A study of college students with disabilities who had been victimized found that only 27% reported the crimes (Findley et al., 2016). Another study found that only 3% of sexual abuse cases involving individuals with developmental disabilities were reported (Valenti-Hein and Schwartz, 1995).

There are many reasons why crimes against individuals with disabilities are under-reported. In a report for the U.S. Department of Justice looking at the criminal justice response to sexual crimes committed against adults with disabilities in New York, researchers identified two primary causes of under-reporting, reflecting the impact of systems failure and historical discrimination on the safety of individuals with disabilities. “Two themes emerged related to disclosure unique to victims with disabilities. One was the fear that they wouldn’t be believed, based on a history of not being believed in general because of their disability. Another was that disclosure would not be believed because of the sexual nature of the assault and others’ stereotypes about people with disabilities” (Browne et al., 2016). Other reasons included:

- Challenges in communication or mobility—lack of access to means of reporting
- Lack of understanding of what constitutes abuse or neglect
- Not knowing how or where to report abuse
- Guilt or shame; fear of being blamed
- Dependence on the offender/caregiver
- Fear of retaliation; threats of harm by offender
- Fear of being homeless or losing support of family or care provider—personal and financial dependence
- Fear of losing custody of children
- Fear of loss of independence

(Office for Victims of Crime, 2012; Smith et al., 2017; Morgan & Oudekerk, 2019)

Even when cases are reported, few result in criminal prosecution or justice for the victim. Preconceptions and prejudice about the victim’s ability to testify, law enforcement and justice officials being unaware and untraining regarding disability, and ambiguity around agency jurisdiction all contribute to the failure to follow through with cases involving victims with disabilities. Many federal data collection systems on crime, such as the national Human Trafficking Reporting System, do not include information on victims’ disability status. In the New York study, from 2008 to 2013, 70.5% of reported cases involving the victimization of individuals with disabilities were closed with no charge, and only 4.9% of

cases progressed beyond investigation (Browne et al., 2016). Other research suggests that perpetrators who are convicted in crimes against people with disabilities are likely to be given shorter sentences than abusers of individuals without disabilities (Office for Victims of Crime Training and Technical Assistance Center, 2021).

In each state, reports of abuse and neglect of individuals with disabilities can involve multiple agencies, both administrative and law enforcement. This approach can be beneficial because agencies with training and expertise in disability, including Adult Protective Services, Child Protective Services or the Office of the Inspector General, are often better equipped to handle the initial processing and information gathering in these cases. However, territorialism and overwhelming caseloads can cause such cases to fall through the cracks. In many states, mandated reporters are instructed to notify child or adult protective services when they have a reasonable suspicion that a crime against a person with a disability has occurred. In these situations, protective services play a foundational role in determining whether there is sufficient cause to pursue an investigation and to refer the case to the police. However, protective services workers can be reluctant to refer cases to the police for fear that law enforcement will “antagonize families and undertake heavy-handed, punitive interventions, interfering with their attempts to protect children and repair families” (Cross et al., 2005, p. 237). When referrals are made by protective services, the criminal justice system often fails to follow through, for many of the reasons discussed above. An analysis of cases processed by the Rhode Island Department of Elderly Affairs, for example, found that they received approximately 900 calls per year and substantiated about 85% of them. However, only about 70% of those cases were investigated by police. Fewer than 2% of cases resulted in criminal charges, and many fewer resulted in conviction (Meirson, 2008). Finding data on the impact of multiple agency involvement is difficult because there is little consistency from state to state on jurisdiction or on how crimes are defined. One study concluded that the most effective approach might be to include law enforcement in the initial reporting, rather than rely on single agency reporting (Daly et al., 2017, p. 157).

In 2002, the American Bar Association (ABA) recognized that inaccessible courtrooms are equivalent to inaccessible justice (Hurder, 2002). Citing research it had conducted in 1993, the ABA recognized that barriers to mobility or lack of accommodation for vision impairments would make attendance and participation in court difficult or impossible. Without accommodations and trained interpreters, individuals with communication disabilities or who are hard of hearing would be unable to participate in court proceedings and the judicial process. Individuals with cognitive disabilities may struggle with interacting with lawyers or understanding court proceedings if information is not presented in plain language. The report also recognizes the challenges faced by individuals with psychological disabilities, who may struggle with attention or concentration or who are expected to make rapid decisions. In its report on “Accessible Justice,” the New York Lawyers for the Public Interest (NYLPI) declared, “Access to justice is a fundamental right. It cannot be achieved when people with

disabilities are denied equal access to courts” (Pant et al., 2015). While pressure from groups like the ABA and NYLPI have pushed courts to improve accessibility, there is still a long way to go. For instance, in Queens, New York, half of the courthouses continue to have limited accessibility for people with mobility disabilities (Chung, 2020).

The Adult Advocacy Centers’ Model

In 2019, the Adult Advocacy Centers (AACs) were formed through a Victim of Crime Act (VOCA) grant from the Ohio Attorney General’s Office to re-envision the broken systems currently in place for crime victims with disabilities and establish a new, accessible framework for reporting crimes, engaging with the investigative and prosecutorial phase, and providing support for victim services. Recognizing the barriers that have historically infringed on equal access to justice and healing for crime victims with disabilities, the AACs are using the principles of universal, multi-sensory and trauma-informed design in their plans. The AACs’ goal is to address as many disparities in attitudes and accessibility as possible in the pursuit of equal justice and equal access to hope and healing for crime victims with disabilities. Some of the AACs’ ongoing work and plans include creating brick-and-mortar centers and mobile forensic units, developing adapted protocols for forensic interviewing and providing ongoing training and technical assistance for multi-disciplinary teams and partners.

Adult Advocacy Centers

The goal is not to avoid falling or needing help. The goal is to be seen, asked, heard, believed, valued as we are, allowed to exist in these exact bodies, invited to the party, and encouraged to dance however we want to. — Rebekah Taussig, Sitting Pretty: The View from My Ordinary Resilient Disabled Body

The AACs have plans to develop a series of regional centers that will provide a collaborative setting for multi-disciplinary teams of highly trained professionals, including:

- Law enforcement
- Prosecutors
- Forensic interviewers
- Adult protective services
- Medical forensic nurse examiners
- Victim advocates
- Mental health clinicians
- Disability specific agencies

Each center will be fully accessible, exceeding the requirements of the Americans with Disabilities Act (ADA), both inside and out, to accommodate all individuals regardless of disability, using the principles of universal design. Attention will be paid to the environment, both external and internal, reducing sensory distractions and potential trauma triggers, to provide an atmosphere of safety and welcome. The centers will include multiple forensic suites, with varied trauma-responsive interior design strategies adapted to support all types of disabilities. Several of the suites will include specialized design elements to accommodate those with specific disabilities, including serious mental illness, sensory disabilities, physical mobility disabilities, and those who are deaf, blind and DeafBlind.

Each suite will include a fully accessible forensic interviewing room. These rooms will be built with state-of-the-art audio-visual equipment and the capacity to support all communication needs. Forensic interviews will be conducted using adapted protocols by certified forensic interviewers with advanced disability-specific training. In addition, each suite will have an accessible medical forensic exam room designed to meet the accommodation needs of victims with disabilities in a trauma-responsive way. These rooms will be staffed with medical forensic nurse examiners trained to provide disability-sensitive forensic examinations. The exam rooms will be equipped with state-of-the-art technology for the collection of forensic evidence and the provision of care for any immediate medical needs.

Another barrier to the successful investigation of crimes involving victims with disabilities, and the provision of appropriate services for them, is the lack of intake protocols designed to identify needed accommodations and supports. The AACs are developing assessments and intake protocols that will maximize the ability of staff to gather information needed to support the investigation, and to help identify the unique needs of each individual regarding mobility, sensory and communication accommodations. To ensure continuity of care and support for the victim, and to assist in the coordination of cases for the multi-disciplinary team (MDT), the AACs plan to develop an internal case management system. Also, resources and information for victims and for their support teams will be available in accessible formats for all disabilities.

The needs of crime victims extend far beyond the immediate needs associated with the investigation of a crime. As such, the AACs are using a disability lens to develop and support services and trauma-specific aftercare that will meet the complex needs of crime victims with disabilities. In addition, building connections to the community, organizations and agencies that assist and advocate for people with disabilities and victims is essential in the AACs' model. The AACs are developing partnerships with disability-specific organizations, community mental health agencies, legal services, education entities, housing and benefit support organizations, and other local and state agencies that serve individuals with disabilities and victims of crime. By building these partnerships, the AACs hope to facilitate a holistic approach to the support of victims, with the goal of increasing access to needed services and resources and decreasing risk factors for future victimization.

Often, law enforcement, prosecutors, forensic interviews, medical care providers and victim advocates cite lack of training for their reluctance to engage in cases involving crime victims with disabilities. To address those concerns directly, each center will house specialized training facilities for law enforcement and investigators, medical and mental health professionals, forensic interviewers, victim services providers, as well as victims and allies. Recognizing that safety needs for individuals with disabilities exist in many areas, each training facility also will be designed to serve as an accessible disaster relief shelter. In the event of a disaster, the facilities will be staffed by professionals trained in disability-sensitive disaster preparedness.

Even with the development of fully accessible centers, some crime victims with disabilities will be unable to access the centers due to challenges, including location and availability of transportation, severity of a disability or medical condition, or other factors that preclude travel to a center. The AACs recognize that it is the obligation of society to provide access to justice and support for crime victims, regardless of disability status or location. Therefore, the AACs have plans to develop a fleet of adapted recreational vehicles (RVs), available to travel throughout the state to provide mobile and accessible medical forensic examinations and forensic interviews. Like the centers, each mobile unit will have the equipment and materials required to ensure accommodation for sensory, communication, mobility, and therapeutic needs.

Adapted Forensic Interview Protocols

Central to the successful prosecution of crimes committed against people with disabilities is often the ability of investigators to get a full understanding of both the details of a crime and the victim's experience of the crime. A forensic interview is a structured approach to questioning a victim or witness of crime that elicits information without influencing the interviewee's responses. Few forensic interview protocols have adaptations available that accommodate for differences in communication styles and methods. The AACs has partnered with forensic, legal and disability experts to develop disability-specific adapted forensic interviewing protocols. These protocols address communication accommodations for interviews with individuals with developmental and intellectual disabilities, individuals who use little or no speech, individuals with psychiatric disabilities or dementia, and individuals with disabilities who are survivors of human trafficking.

Research and Education

The AACs are spearheading the development of disability-specific and inclusive education and resources on issues related to the investigation and prosecution of crimes against people with disabilities, as well as the provision of accessible aftercare services. The agency's staff and consultants are constantly engaged in research to ensure that the AACs are responsive to the

most current legal, forensic and disability-specific information, forensic or technological advances, and innovation in the provision of support and services for crime victims with disabilities. Their research is regularly compiled into articles, trainings and printed materials designed to be shared with the criminal justice, victim services and disability communities.

Trainings

The AACs are creating, coordinating and delivering advanced disability-specific training on a wide variety of topics related to disabilities. Some current and future trainings include:

- Criminal Justice
 - New investigative techniques and technology
 - Adapted forensic interviewing protocols
 - Legal issues in the courtroom
- Forensic Medicine
 - Adapted protocols for crime victims with disabilities
 - Disability-specific medical issues
 - Supporting crime victims with disabilities
- Victim Services and Aftercare
 - Trauma-responsive care
 - Advocacy and support throughout the legal process for victims with disabilities
 - Supporting crime victims with disabilities
 - Adapted trauma interventions
 - Adapted mental health interventions
 - Accessible disability-specific resources

To ensure the integrity and expertise of the trainings provided, the AACs have developed a network of top experts and consultants in the fields of disability, crime prevention, trauma, medical, criminal justice and accessibility. Most importantly, the AACs' model involves extensive collaboration with people with disabilities, including victims themselves.

Conclusion

“Equal justice under law is not merely a caption on the facade of the Supreme Court building; it is perhaps the most inspiring ideal of our society. It is one of the ends for which our entire legal system exists . . .” – Justice Lewis F. Powell, Jr. (August 1976)

Equal justice under the law is challenged when access to justice is surrounded by physical, procedural, attitudinal, communication and psychological barriers. This has been the experience of many individuals with disabilities who have sought justice as the victims of crime. The barriers arise when society instills people with disabilities with the belief that information about healthy sexuality and the right to say “no” does not belong to them, that compliance is required, that bodily autonomy is not a right afforded them, that reports will go unheard and that demands for justice will go unanswered. Barriers to justice are strengthened when individuals with disabilities are singled out by perpetrators as easy marks for victimization because perpetrators are aware of society’s indifference to the abuse of disabled bodies. Barriers can appear insurmountable when the systems that are supposed to ensure equal justice are inaccessible, unaccommodating, and staffed by investigators and prosecutors who have neither the training nor the patience to listen to voice of the victim, in whatever manner that voice is expressed.

The Adult Advocacy Centers were developed to break down those barriers through a victim-centered, disability-informed approach to achieve justice and support for victims of crimes with disabilities. The AACs’ facilities and service models are thoughtfully designed to be accessible to all, whether in the regional centers or through mobile units. Its protocols, resources, and information are adapted to meet the communication needs of the individual. Its partners are engaged to ensure that expertise and experience are the foundation of every decision. Its training and education opportunities are provided to both internal and community professionals involved in criminal justice, victim services and disability services agencies and other organizations that support victims with disabilities.

Equal justice moves one step away from aspiration and one step closer to realization when our systems flex to accommodate everyone. The AACs are an important part of the bridge to that brighter future.

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