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Introduction

Purpose and Acknowledgments

This guide was created to assist Ohio’s Forensic Nurse Examiners (FNEs) as they provide medical forensic care involving crime victims with disabilities. These exams pose difficult and complex challenges, and this guide aims to simplify the issues using references, practical advice and tactics.

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The AACS would also like to thank consulting authors Ruth Downing, MSN RN CNP SANE-A and Laura Kaiser, BSN RN SANE-A.

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**Agency Reference Guide**

Below is a chart that includes agencies that may be able to assist forensic nurse examiners when providing medical forensic care when a crime involves a victim with a disability.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Link</th>
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<tbody>
<tr>
<td>Adult Advocacy Centers</td>
<td>adultadvocacycenters.org</td>
</tr>
<tr>
<td>Academy of Forensic Nursing</td>
<td>goafn.org</td>
</tr>
<tr>
<td>Area Agency on Aging</td>
<td>ohioaging.org/area-agencies</td>
</tr>
<tr>
<td>Disability Rights Ohio</td>
<td>disabilityrightsohio.org/contact</td>
</tr>
<tr>
<td>Forensic Nursing Network</td>
<td>forensicnursingnetwork.org</td>
</tr>
<tr>
<td>International Association of Forensic Nurses</td>
<td>forensicnurses.org</td>
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<tr>
<td>Ohio Chapter of the International Association of Forensic Nurses</td>
<td>ohioiafn.org</td>
</tr>
<tr>
<td>Ohio Alliance to End Sexual Violence</td>
<td>oaesv.org</td>
</tr>
<tr>
<td>Ohio Association of County Boards of Developmental Disabilities</td>
<td>oacbdd.org/main/member-directory</td>
</tr>
<tr>
<td>Ohio Attorney General’s Office</td>
<td>ohioattorneygeneral.gov/Individuals-and-Families/Victims</td>
</tr>
<tr>
<td>Ohio Attorney General’s Office – Sexual Assault Forensic Examination (SAFE) Program</td>
<td>ohioattorneygeneral.gov/Individuals-and-Families/Victims/Sexual-Assault-Forensic-Examination-(SAFE)-Program</td>
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<tr>
<td>Ohio Crime Victim Justice Center</td>
<td>ocvjc.org</td>
</tr>
<tr>
<td>Ohio Department of Aging</td>
<td>aging.ohio.gov</td>
</tr>
<tr>
<td>Ohio Department of Developmental Disabilities</td>
<td>dodd.ohio.gov</td>
</tr>
<tr>
<td>Ohio Department of Health</td>
<td>odh.ohio.gov</td>
</tr>
<tr>
<td>Ohio Department of Mental Health and Addiction Services</td>
<td>mha.ohio.gov</td>
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</table>
Disclaimer

The contributors to the forensic nurse examiner’s guide, including the AACs, cannot guarantee the accuracy of the referenced information, websites or statements. The information provided is accurate at the time of publication, but it is subject to change. Forensic nurse examiners and other users of this guide are encouraged to contact the AACs to contribute information or to report inaccuracies. It is the goal of the AACs to continually update materials with the expertise of those in the field.

Definitions and Types of Disabilities

To be protected by the Americans with Disabilities Act (ADA), a person must have a disability, which is defined by the ADA as a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. More specific definitions are listed below.

Please note the definitions and types of disabilities listed below have been created from various resources. It is not an exhaustive list, and terminology may differ depending on the local practice, policy, and procedure.

Developmental Disability

Examples of a developmental disability include, but are not limited to, autism, cerebral palsy, spina bifida, hearing loss and fetal alcohol syndrome. The Ohio Revised Code (ORC) §5123.01(Q) defines a developmental disability as a severe, chronic disability that is characterized by the following:

1. It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness, as defined in division (A) of section 5122.01 of the Revised Code.
2. It is manifested before age twenty-two.
3. It is likely to continue indefinitely.
4. In the case of a person six years of age or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person’s age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least sixteen years of age, capacity for economic self-sufficiency.
**Dual Diagnosis**

Dual diagnosis is a term applied to the co-existence of intellectual or developmental disabilities and a mental health diagnosis. The types of psychiatric disorders a person with intellectual or developmental disabilities experience are the same as those in the general population, although an individual’s life circumstances or level of intellectual function may alter the appearance of the symptoms. Persons with a dual diagnosis can be found at all levels of intellectual and adaptive functioning. Some common mental health diagnoses include: depression, bipolar disorder, anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder, psychotic disorder, schizophrenia, schizoaffective disorder, personality disorders, substance abuse, sleep disorders and eating disorders.

**Intellectual Disability**

ORC §5123.01(N) defines an intellectual disability as a disability characterized by having significantly subaverage general intellectual functioning existing concurrently with deficiencies in adaptive behavior, manifested during the developmental period.

**Mental Illness**

ORC §5119(A)(15) defines mental illness as a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life.

**Older Adults**

An older adult is defined in ORC §2913.01(CC) as a person who is 65 years of age or older. Many older adults develop disabilities as they age. For the purposes of this guide, “victims of crime with disabilities” includes older adults with disabilities.

**Physical Disability**

A physical disability is a condition that affects a person’s mobility, physical capacity, stamina or dexterity. Examples of a physical disability include a brain or spinal cord injury, amputation or arthritis.

**Sensory Impairment**

Sensory impairments affect one or more senses. Sensory impairments may affect how a person gathers information because a reduction or loss of one or more senses may result in communication difficulties. Examples of a sensory impairment include blindness, sensory processing disorder, hearing impairment or loss, macular degeneration and nystagmus.

**Crime Statistics Involving People with Disabilities**

The rate of violent victimization against people with disabilities was more than twice the rate for those without disabilities from 2009 to 2015. In 2015, nearly 30 of every 1,000 people age 12 or older with a disability reported violent victimization, compared to 12 out of every 1,000 people age 12 or older without a disability. Between 2011 and 2015, 20% of crime victims with disabilities believed they were targeted because of their disability, (Bureau of Justice Statistics, 2017).
One study of 936 patients from 16 mental health agencies (outpatient, day and residential treatment) in Chicago, IL, concluded 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 study of 523 adults with a psychiatric disorder were asked to complete an online survey. Results show 25% of respondents reported having been a victim of violence by a relative. (Labrum, T., 2020).

More than 12.4% of the U.S. population is age 65 and older. Elder abuse affects an estimated 5 million people each year. Compared with non-abused peers, elder abuse victims are 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. Studies estimate that roughly half of people with dementia are abused or neglected by caregivers (Dong, X., & Simon, M., 2013).

In a study of over 6,000 older adults, elder abuse was independently associated with an increased rate of hospitalization, regardless of the level of medical comorbidities, cognitive and physical impairment, or psychosocial factors (Dong, X. Simon, M., 2013).

Relevant Law for Cases in Which the Victim Has a Disability

Ohio Revised Code (ORC)
A link to ORC citations can be found at codes.ohio.gov. The following is a list of citations that a forensic nurse examiner should familiarize themselves with and know how each relates to the care they provide to their patients:

**ORC Citations Related to Victims of Sexual Assault**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Section Title</th>
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<tbody>
<tr>
<td>ORC §2151.421</td>
<td>Reporting child abuse or neglect</td>
</tr>
<tr>
<td>ORC §2907.27</td>
<td>Testing and treatment for venereal diseases and HIV</td>
</tr>
<tr>
<td>ORC §2907.28</td>
<td>Payment for medical examination and test of any victim or accused</td>
</tr>
<tr>
<td>ORC §2907.29</td>
<td>Hospital emergency services for victims of sexual offenses</td>
</tr>
<tr>
<td>ORC §2921.22</td>
<td>Failure to report a crime or knowledge of a death or burn injury</td>
</tr>
<tr>
<td>ORC §109.68</td>
<td>Statewide sexual assault examination kit tracking system</td>
</tr>
<tr>
<td>ORC §2933.82</td>
<td>Retention of Biological Evidence</td>
</tr>
<tr>
<td>ORC §5101.63</td>
<td>Reporting abuse, neglect, or exploitation of adult</td>
</tr>
<tr>
<td>ORC §5101.99(A)</td>
<td>Whoever violates division (A) or (B) of section 5101.63 of the Revised Code shall be guilty of a misdemeanor of the fourth degree</td>
</tr>
</tbody>
</table>
ORC Citations Specific to Victims with Disabilities

<table>
<thead>
<tr>
<th>Citation</th>
<th>Section Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORC §2903.10</td>
<td>Definition of a functionally impaired person, caretaker defined</td>
</tr>
<tr>
<td>ORC §2903.16</td>
<td>Failing to provide for a functionally impaired person</td>
</tr>
<tr>
<td>ORC §2903.33</td>
<td>Patient abuse and neglect in care facilities definitions</td>
</tr>
<tr>
<td>ORC §2903.34</td>
<td>Patient abuse or neglect</td>
</tr>
<tr>
<td>ORC §2903.341</td>
<td>Patient endangerment</td>
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</table>


Victim Rights and Marsy’s Law

Victims with disabilities are afforded the same protections and rights as all victims under the Ohio Constitution, Article I, Section 10(a), and ORC Chapter 2930, but there are some things to keep in mind when working with victims with disabilities.

Communication should be directly with the victim, even if the victim has a guardian, unless the victim, by Ohio law or Ohio Rules of Professional Conduct, directs otherwise.

Notices and case updates sent to the parents of adult victims with disabilities are not sufficient unless approved by the victim.

Per ORC §2930.02, if a victim designates a victim representative and informs the prosecutor or court of the designation, prosecutors must direct all notices to the victim representative. Additionally, all rights should be granted to the victim representative. Prosecutors should not refuse to provide information to a properly designated victim representative.

According to Ohio Rules of Professional Conduct Rule 4.2, if the designated victim representative is an attorney, prosecutors are required to follow the Ohio Rules of Professional Conduct regarding contacting a represented party.

Marsy's Law gives Ohio's crime victims specific constitutional rights in the criminal justice process. These rights are listed below.

- The right to be treated with respect, fairness and dignity throughout the criminal justice process
- The right to information about the rights and services available to crime victims
- The right to notification in a timely manner of major proceedings and developments in the case and the right to be notified of all changes to an offender’s status
- The right to be present at court proceedings and provide input to a prosecutor before a deal is struck
- The right to be heard at pleas or sentence proceedings or any process that may grant an offender's release.
- The right to restitution
Special Considerations When the Victim Has a Disability

Vulnerabilities of People with Disabilities

Some people with disabilities have been subjected to “Do as you are told” conditioning, meaning if they do not follow the rules, there may be consequences, such as reprimands, loss of privileges or basic freedoms.

Additionally, some people with disabilities are isolated, increasing their vulnerability for victimization. People with disabilities may also need to depend on others to ensure that their needs are met. This dependency limits their ability to resist or disclose abuse. People entrusted with providing care and support for persons with disabilities may be the perpetrators of sexual violence or other forms of abuse. People with disabilities may also have lower incomes, which is associated with a greater likelihood of financial, emotional and physical abuse and neglect.

A history of abuse is also a risk factor for further abuse. Understanding the dynamics of abuse may be more difficult when a person has an intellectual disability or processing delays and has not received guidance or counseling. People with disabilities may not have been provided adequate sex education or may be viewed as asexual. They may not fully understand inappropriate touching, unhealthy relationships or their right to privacy. As forced or coerced sexual contact may create pleasurable physical sensations or desired attention, this may increase vulnerability to misinformation, deception and grooming by a perpetrator.
People with disabilities may be reluctant to disclose abuse. They may feel it is very important to have a partner, just like people without disabilities. They may not want to be perceived as a victim or lose their status as a partner. They may be over or under medicated, decreasing their ability to make choices or the ability to resist an abuser (California Coalition Against Sexual Assault, 2010).

People with disabilities also may be unable to notify authorities, a supportive family member or a support person of their abuse. This may be due to isolation or difficulties with communication. They may be afraid of harm or retribution by a perpetrator, including threats of harm to their service animal. The perception of powerlessness as well as a lack of understanding of their individual rights may prevent disclosure of abuse. If they do disclose, they may not be believed, or untrained responders may not consider them to be an accurate historian or a “good witness.”

Access to Care and the Adult Advocacy Centers (AACs)

Reasonable Accommodations

The fundamental purpose of the ADA is to provide the choice of integration for persons with disabilities into all facets of society, including health care. “Physical or mental disabilities in no way diminish a person’s right to fully participate in all aspects of society,” as stated in Chapter 126, Section 1201 of the American Disabilities Act, 2008.

Services provided by the AACs will be designed to accommodate all disability types and will include features like wheelchair access, waiting rooms designed for people with sensory concerns, adjustable lighting, the availability of sensory items, and space designed to accommodate interpreters and family members.

These accommodations will allow patients with disabilities to have full participation in the medical and forensic examination process. For example, a patient who cannot see will received detailed verbal information or information in Braille and will be permitted to have their service animal present during the examination.

Forensic nurse examiners are encouraged to meet with patients with disabilities to discuss what accommodations they may need. Providing these accommodations will allow crime victims with disabilities to have full participation in the medical forensic examination process. For example, a patient who has anxiety may need to have a trusted person present during their examination.

Determining Capacity to Consent

The assessment for capacity should be Individualized and conducted in a way that is mindful of the person’s communication methods and of the sensitive nature of the topics involved. It is important to ensure that communication needs are not mistaken for diminished capacity. Nurses should communicate using plain language, known terms or pictures to ensure understanding. It is also important to assess for knowledge of information relevant to care. Consent forms need to be provided in accessible formats, including Braille or a larger font size. While explaining the process of the exam, assess the patient for understanding. The chart on the following page includes suggested conversation guidelines for confirming capacity.
### Behaviors Suggesting Capacity Is Present

| An individual has an understanding of key information | ● Describe current medical problems  
● List treatment options offered, including no treatment  
● Name major risks and benefits of recommendations, including no treatment |
| An individual has an understanding of the situation and consequences | ● Explain how current medical problems impact life  
● Discuss likely outcomes of treatment options, including no treatment  
● Articulate reasons provider recommends a particular option |
| An individual can use reasoning | ● Explain factors considered when making a choice  
● Discuss goals and values influencing decision  
● Connect choice to likely outcome  
● Determine if choice aligns with previously stated goals and reasoning |
| An individual can make and express a choice | ● Able to communicate decision  
● Indicates chosen alternative decisions |

(Scott, 2008)

If it is determined that the patient lacks capacity to sign a consent for the exam, the forensic nurse examiner will need to locate the Power of Attorney (POA) or guardian of person. Forensic nurse examiners will need to obtain the signature of the either the POA or the guardian of person on consent documents. It would also be appropriate to seek written consent from the patient to ensure they are treated with dignity and respect. If a guardian or POA is signing the consent, the nurse will need to request a copy of the legal document showing the patient has a legitimate POA or guardianship. A copy of these legal documents should be obtained and added to the patient’s records. Once a copy of the legal documentation is obtained, verbal consent can be obtained via phone with two witnesses.

While it is necessary to have written consent from the POA or the guardian of person, if applicable, continued patient consent is also needed throughout the exam. If the patient decides to move forward with the exam, the forensic nurse examiner must explain each process and verify understanding by the patient before proceeding. The patient is able to decline any portion of the exam, even if they have a POA or guardian.

### Cultural Humility

Although providing all reasonable accommodations will promote inclusive care for patients with disabilities, exercising cultural humility is also necessary to further reduce inequalities and potential re-traumatization. Cultural humility is an attitude and practice that promotes positive interactions among individuals from different cultures. Cultures may include race, ethnicity, disability, religion, social class, LGBTQIA+ or an intersection of two or more cultures. Practicing cultural humility marks the path to establishing a respectful and productive relationship.
between a healthcare professional and a patient with a disability.

Individuals with disabilities are at risk of stigmatization, so patients with disabilities may not self-identify as having a disability. Like other populations that experience prejudice, discrimination and stereotyping, or solely due to personal preference, the degree to which a person identifies with a disability may vary. For example, many individuals who are Deaf distinguish themselves as part of a culture rather than as having a disability. Deaf culture includes the unique characteristics found among the population of people who are Deaf. Deaf culture can be viewed as a way of life due to a shared language, values, traditions and social norms.

Regardless of how a patient with a disability self-identifies, the forensic nurse examiner should provide information, examples and explanations for the medical forensic exam, and the array of accommodations available, while trying to be sensitive to an individual’s cultural sensitivities (Prosecutor’s Guide for Crimes Involving Victims with Disabilities, 2020).

Eliminating Harmful Language

Historically, stigmatizing and derogatory terms such as “afflicted,” “idiot,” “lunatic” and “moron” were used to reference people with disabilities. These offensive labels evoke shame and have dehumanizing and traumatizing affects. Inconceivably, victims with disabilities continue to face prejudice and injustice. The healthcare system is no exception.

Although Rosa’s Law was effective beginning October 2010 and required the terms “mental retardation” and “mentally retarded” to be stricken from federal records, Ohio continues to have laws on the books that use derogatory language. For example, ORC § 2945.491 uses “mentally retarded.” Although Ohio House Bill 53, which passed 32-0, removed the offensive words “lunatic,” “idiot” and “insane” from state law, it did not change language in the Ohio Constitution. As a result, the Ohio Constitution, Article 5, Section 6, continues to be entitled “idiots or insane persons.” Derogatory terms and any similar terms or language are not acceptable and only serve to magnify a traumatic event. When caring for a person with disabilities, a forensic nurse should be identified as a Forensic Nurse Examiner rather than a SANE. For some, “SANE” may have the connotation for a mental stability examination.

Person-First and Identity-First Language

The ways people think about and label themselves are highly personal. In the disability community, some people prefer to use person-first language when talking about themselves, while others prefer identity-first language. Patients have the right to choose how they would like to be addressed.

Person-first language means to emphasize the person rather than the disability (Ohio Developmental Disabilities Council). For example, you would say “person with a disability” rather than “disabled person,” or “person with a mental health condition” rather than “mentally ill person” (ddc.ohio.gov/Portals/0/pf-lang-trifold-12-15.pdf). People who prefer person-first language typically feel that their disability is just one part of who they are, but it does not define them as a person.
Identity-first language means to emphasize a disability as the defining part of who someone is. For example, you would say “autistic person” rather than “person with autism,” or “Karen’s autistic son John” rather than “Karen’s son John who has autism” (dentityfirstautistic.org). This preference is particularly common in certain disability communities, including the autistic community, the Deaf community, the blind community and among many disability activists. People who prefer identity-first language typically feel that their disability is an intrinsic part of who they are and how they see and interact with the world.

To determine what a person prefers, it is best to simply ask them, then respect their preference. The same approach should also be used for personal pronouns (he/him, she/her, they/them, etc.).
Medical Forensic Examination for Patients with a Disability

Medical Forensic Care in a Hospital or Facility Setting

Forensic nurses examiners with specialized training to work with persons with disabilities should provide the medical forensic examination in an environment that provides privacy and quiet, while including appropriate accommodations. This comprehensive, trauma-informed approach provides optimal outcomes and begins the healing process following trauma.

Respect for the autonomy of persons is central to clinical ethics. Among the principles of ethical conduct, which derive from autonomy, are respect for self-determination, shared decision making, informed consent and confidentiality. Healthcare providers ought to honor these principles and accept the patient as an equal partner for making decisions (Center for Practical Bioethics, 2015). The goal of health care for patients with disabilities is to improve their well-being, function, and participation in family and community (Kripke, 2018).

The Examination Space

Consider the environment of the examination room and adapt as much as possible to accommodate for any potential physical or sensory needs. Some common accommodations to consider are listed on the next page.
A Forensic Nurse Examiner’s Guide to Caring for Patients with Disabilities

- Fluorescent lighting can be irritating for people with sensory issues, and the buzzing from lights can be distracting. To provide an accommodation, use incandescent or full spectrum lighting, dim the lights if possible, and ensure that the examination room is as far away from noise and interruptions as possible
- Allow enough space for a wheelchair to get to the exam table
- Provide an examination table that can be adjusted to accommodate transfer from a wheelchair. Offer headphones to decrease noise
- Install calming art on the ceiling
- Provide space for an interpreter, advocate, support person or service/emotional support animal
- Advocates should be available to provide comfort and support. Offer sensory tools, such as fidget toys or a weighted blanket
- Staff should not wear perfumes or have strong odors in the exam room

**Interacting with Patients with Disabilities**

When meeting a patient, the forensic nurse examiner should identify themselves, and explain their role and the purpose of the meeting. Building rapport is essential. Patients should be offered the services of an advocate or support person of their choosing. Consider that patients may have experienced trauma in the past, possibly even in a medical setting, which can add to their initial fears. Patients should be asked what can be done to make them more comfortable. Collaboration with the victim advocate will allow for a less stressful examination. The victim advocate can assist by helping to identify stress or discomfort and offering suggestions or recommending a break.

Ask the patient if you have permission touch them, and do not touch or move their wheelchair or other personal items without permission. Persons with mobility disabilities perceive their wheelchair as a part of them, so asking if you can touch or manipulate their wheelchair is demonstrating respect.

To reduce anxiety, a variety of sensory items should be available for the patient to choose from, such as squishy balls, fidgets, headphones, a brush, a weighted lap pad or blanket, coloring books or playing cards. Sensory tools can help calm a patient, allow them to gain a sensory output through habitual behavior, or turn their focus to the tool during an uncomfortable time. Encourage the use of comfort items, such as a favorite item, music, doll or snack. Show the patient the instrument or procedure you will use and allow the patient to touch and explore it. Describe the steps involved and what can be expected prior to proceeding (Health Care Access Research and Developmental Disabilities, 2016).

Individuals with mental illness may experience a variety of symptoms at the time of the examination, including heightened anxiety, mood disturbance, paranoia or cognitive disorganization. In a similar manner to other patients, comfort or sensory items may help to calm the individual. Likewise, providing information and reassurance, and repeating the information and reassurance, if necessary, may be helpful. Help the individual to feel as safe as possible.

The Ohio Protocol for the Sexual Assault Medical and Forensic Examination provides details on the examination, the collaborative response, and evidence-based practices in trauma-informed care for the sexual assault patient. This protocol should be followed with adaptations for people with disabilities.
The examination may take a longer period of time to complete. Allow for extra breaks. This allows the patient to process what is happening and to prepare for the next step. Explain every step and ask for permission to continue. The patient has a right to decline any portion of the examination, and this must be respected.

Once the exam is complete, patients may require additional time and assistance when taking medications. Follow-up communication needs to occur with the patient and their caregiver or guardian, if applicable. Discharge paperwork should be provided in a format based on the communication needs of the patient.

**Emerging Trends for Forensic Nurse Examiners for Patients with Disabilities**

In the past, only Child Advocacy Centers (CACs) had the capacity for wrap-around multidisciplinary services for victims of crime in Ohio. People with disabilities over the age of 21 who were sexually assaulted were typically evaluated in emergency departments. Emergency departments may lack the accommodations needed by people with disabilities, including a quiet space without interruptions and examination tables to accommodate people with limited mobility.

The AACs will provide the environment and accessibility for people with disabilities, an on-site multi-disciplinary team to provide wrap-around services, supports and resources in one location. Forensic interviewers with training specifically for crime victims with disabilities will limit the number of times the victim needs to disclose the abuse or assault.

Forensic nurses examiners who are immersed in the care of patients with disabilities will increase awareness of trauma-informed care and advance the healthcare response to this patient population. As a member of the multi-disciplinary team in each community with an AACs, forensic nurses examiners will collaborate with community services and resources for the health and safety of people with disabilities. The use of new technologies for communicating with these individuals will enhance trauma-informed care.

**Communication Guidelines and Technologies**

Understanding how to best communicate with a patient is key to providing the best care. This may include finding out how the patient expresses “yes” and “no” and identifying if this is the only way they can communicate. Inquire if the person prefers to communicate by speaking, blinking, pencil tapping, pointing to pictures, or something else. Consulting with the patient advocate or residential facility may also assist with communication needs. If the patient has an electronic device, assure that a charger is available. It can be beneficial to ask if the patient has attention issues, as they may benefit from frequent breaks during the exam.

When speaking, sit at eye level with the patient. Speak to adults as adults, not as children, regardless of their disability. Make sure to use active listening skills. If you do not understand what they tell you, do not pretend that you understand. It may be necessary to have the person repeat statements or use other forms of communication. This may require patience.
Try to gain as much of the history of the assault from the patient first. Communicate directly with patients, even those with cognitive or language disabilities, using simple terminology. Try not to use slang or words with multiple meanings. When speaking with an individual who is hard of hearing, face the individual and wait to speak until they are looking at you. Speak slowly and clearly. It is not necessary to raise your voice. Offer choices and allow additional response time. When an individual has a vision impairment, clearly announce your name and the names of others in the room and describe the surroundings.

Ask about any communication device the person uses, which can include but is not limited to one or more of the following:
- Voice output devices
- Electronic communication device
  - Augmentative and Alternative Communication Devices
- Letter boards
- American Sign Language (ASL Interpreters)
- Hearing aid
- Facial expressions
- Hand or body gestures
- Use of Pictures
  - Picture Exchange Communication System (PECS)
- Handwritten communications
- Large print
- Braille

People with disabilities may not want to say they do not understand the questions being asked of them. It is important that the nurse forensic examiner try asking the same question in different ways if it seems they are not understanding. Do not make assumptions of the patient’s understanding; instead, provide additional opportunities for the patient to confirm their level of comprehension of the questions asked. If the person is unable to communicate, direct communication should continue, even if the person does not respond.

Caring for persons with disabilities may require the use of adaptive techniques to provide developmentally specific care. This may include the use of books, sensory items and role play to assist the person in feeling more comfortable with procedures, tests and treatments (Rees & Deutsch, 2020). Persons with sensory or physical disabilities need to be cared for using appropriate equipment that will assist with comfort and autonomy during the exam process (Mont, Macdonald, White, & Turner, 2013). It is essential to be flexible while providing care for people with disabilities. Adaptation to potential variables during the medical and forensic examination will provide the best trauma-informed care for the individual.

**Interpreter Services for Victims Who are Hard of Hearing or Deaf**

People who are hard of hearing or Deaf may use a variety of means to communicate. Many use American Sign Language (ASL). It is important to know the ASL interpreters in the local community and
collaborate with them. Interpreters need to be available prior to the exam to assist with consents. Let the patient know that interpreter services are available. It is the hospital or facility's responsibility to obtain an interpreter, if needed. The interpreters will need to understand the process of the medical and legal examination for the sexual assault patient, as well as confidentiality issues.

If the patient is hard of hearing or Deaf, it is suggested that the forensic nurse examiner should provide care in a room that is well lit, has few visual distractions and is big enough to accommodate an interpreter, if needed.

When providing care, it is important to maintain eye contact with the patient, not the interpreter, and to refer to the patient in the first person rather than looking at the interpreter when asking questions.

In some situations, when the victim with a disability is Deaf or hard of hearing, two interpreters may be necessary. A Certified Deaf Interpreter (CDI) is an individual who is Deaf or hard of hearing and has been certified by the Registry of Interpreters for the Deaf. In these situations, the CDI will work with a hearing interpreter in an effort to obtain the best interpretation. Situations that may necessitate the use of a CDI include, but are is not limited to, when the individual uses non-standard signs, has limited communication, or is deafblind (Prosecutor’s Guide for Crimes Involving Victims with Disabilities, 2020).

It is the responsibility of the hospital or facility to provide or arrange for services for people with disabilities. For example, if a patient requires that their paperwork and consent forms is presented in a more accessible format, the provider must ensure those items are available. The forensic nurse examiner and victim advocate can collaborate to ensure the patient’s rights are protected.

**Project FIND and the Adult Advocacy Centers**

Project FIND is a forensic interview protocol created by the AACs in collaboration with national experts and local stakeholders to meet the specific needs of crime victims with disabilities. Project FIND training includes a stringent and mandatory certification process with a specifically designed curriculum that trains interviewers to gather information in the most reliable and legally defensible manner.

Agencies that have participated in Project FIND training include county boards of developmental disabilities, mental health organizations, law enforcement, the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Developmental Disabilities, and other community organizations serving individuals with disabilities. As of the writing of this guide, the AACs are offering Project FIND training free of charge throughout the state of Ohio, thanks to the support of the Ohio Attorney General’s office through a Victims of Crime Act (VOCA) grant.

In addition to providing forensic interview services for crime victims with disabilities, the regional AACs will offer medical exams and evidence collection by forensic nurse examiners. Each center will be universally designed and offer complete accessibility. Multi-disciplinary teams (MDTs) will be present at each location and will provide assessments, safety plans, and services that use trauma-informed design. The AACs hope to build partnerships with forensic nurses examiners to better serve crime victims with disabilities throughout the state. Contact the AACs for more information about Project FIND training.
Community Partners

In addition to the AACs, forensic nurses examiners may gain needed information and assistance by contacting community partners that work with people with disabilities. In particular, it is recommended that nurses work with the Ohio Department of Developmental Disabilities and the County Boards of Developmental Disabilities, the Ohio Department of Mental Health and Addiction Services and the Alcohol, Drug and Mental Health Boards, the Ohio Department of Health, the Ohio Department of Aging and regional Adult Protective Services organizations. Collaborative relationships are also needed with prosecutors as well as local, county, state and federal law enforcement. Brief summaries of some of these community partners and how their partnership may be beneficial to Ohio’s forensic nurse examiners are shared below.

The Ohio Department of Developmental Disabilities and the County Boards of Developmental Disabilities

The Ohio Department of Developmental Disabilities provides resources for service providers, including trainings, health and safety alerts, and a robust reporting system for abuse. They also offer supports across the lifespan for people with disabilities who have been determined eligible for county board services. They oversee a statewide system of supportive services that focus on ensuring health and safety, and providing opportunities for meaningful employment.
The County Boards of Developmental Disabilities provide assessments, service planning and coordination to adults and children with intellectual and developmental disabilities, as well as oversight and assistance to service providers.

All 88 county boards of developmental disabilities employ or contract with Investigative Agents (IAs). IAs complete administrative investigations regarding Major Unusual Incidents (MUIs). MUIs involve allegations of abuse, neglect, misappropriation or any other violation as defined as a MUI in the Ohio Administrative Code (OAC). IAs are trained and certified, per ORC 5126.221.

IAs conduct interviews, photograph the scene of the incident, identify causes and contributing factors and ensure that a prevention plan is put into place to address the safety needs of the patient. IAs are knowledgeable regarding the service delivery system and are trained to collect evidence and records relevant to allegations of abuse. Specific documentation that is required to be collected, according to OAC §5123-17-02, includes, but is not limited to, incident reports, nursing notes, progress reports, interview notes, details regarding the physical environment and evidence, and relevant photographs.

County Boards of Developmental Disabilities may contract with Councils of Governments (COGs) for administrative and investigative tasks. COGs were created under the authority of Chapter 167 of the ORC and support county boards of developmental disabilities. Currently in Ohio there are 8 COGs: Clearwater COG, Mid-East Ohio Regional Council of Government (MEORC), North East Ohio Network (NEON), Northwest Ohio Waiver Administration Council (NOWAC), Southern Ohio Council of Government, Southwest Ohio Council of Government, the Employment Connection of Hocking, Perry and Fairfield Counties (TEC Ohio) and WestCON.

The Ohio Department of Mental Health and Addiction Services and the Alcohol, Drug and Mental Health Boards

OhioMHAS provides services to adults with mental illness at six Regional Psychiatric Hospitals (RPH). Reporting of incidents involving patient abuse and neglect is addressed in OAC §5122-3-13. All reported incidents of patient abuse and neglect in the RPHs are investigated by OhioMHAS special police. When cases include evidence of criminal activity, they are reviewed and referred to investigators at the Ohio State Highway Patrol (OSHP). The OhioMHAS police chief as well as OhioMHAS’ legal counsel, will work directly with forensic nurses upon request. In addition, all patients can report rights violations to the Rights and Recovery Administrators (RRAs) available at each RPH.

Ohio also currently has 50 Alcohol, Drug Addiction and Mental Health (ADAMH) Boards. These boards are statutorily empowered to plan, develop, fund, manage and evaluate community-based mental health and addiction services. ADAMH Boards typically offer support groups, suicide prevention, counseling, advocacy and case management.

The Ohio Department of Health

The Ohio Department of Health (ODH) is a cabinet-level agency, meaning the director reports to the governor and serves as a member of the Executive Branch of Ohio’s government. ODH’s
mission is to protect and improve the health of all Ohioans by preventing disease, promoting good health and assuring access to quality care.

The Abuse, Neglect, Misappropriation, and Exploitation program at ODH conducts investigations into allegations of abuse, neglect, misappropriation and exploitation arising at nursing homes and assisted living facilities pursuant to sections 3721.21 to 3721.26 of the Ohio Revised Code. The rules pertaining to these allegations are found in Chapter 3701-64 of the Ohio Administrative Code.

ODH provides comprehensive sexually transmitted infections (STI) testing at Sexual Health Clinics. They also license and regulate assisted living facilities.

ODH also coordinates updates to the Ohio Protocol for Sexual Assault Forensic and Medical Examinations. The purpose of this protocol is to provide comprehensive, standardized, non-judgmental, equitable treatment of survivors of sexual assault. The protocol was developed in conjunction with multiple state agencies, including the Ohio Attorney General’s Office, Bureau of Criminal Identification and Investigation, the Ohio Alliance to End Sexual Violence, the American Academy of Pediatrics, Ohio Committee on Child Abuse and Neglect, the Ohio Chapter of the International Association of Forensic Nurses and the Ohio Chapter of the American College of Emergency Physicians. It is intended to facilitate the provision of consistent, comprehensive healthcare treatment, including emotional, social and crisis intervention, and information about available follow-up services in the community.

The Sexual Assault Advisory Board of Ohio (SAABO) ensures continued evaluation of the protocol in meeting current practice, identifies and handles complaints and concerns, and introduces subject matter that will aid in the implementation of the protocol.

The Ohio Attorney General’s office requires hospitals to use the Ohio Protocol for Sexual Assault Forensic and Medical Examinations if they wish to be eligible for reimbursement of costs the of evidence collection from the Ohio Victims of Crime Compensation Fund. It is unlawful to bill the victim or the victim’s insurer for the cost of a sexual assault examination conducted to collect evidence.

The Ohio Department of Aging

The Ohio Department of Aging administers programs and services to meet the needs of older Ohioans. These programs are funded by the federal Older Americans Act, Medicaid and other sources. It is a cabinet-level state agency, with the director appointed by the governor. Staff supports programs and services for older adults and their families. Its advisory council helps the director develop policies, programs and priorities based on the needs in their communities. Area Agencies on Aging contract with service providers in their communities. Services include home delivered meal programs, education to prevent falls and transportation to medical appointments, shopping, etc. They can also provide home maintenance and repair programs and caregiver support services and resources. Area agencies help individuals and families plan for long-term care needs with free long-term consultations. For those eligible for Medicaid, Area Agencies on Aging provide access to home and community-based long-term care services. Locations for Area Agencies include Lima, Rio Grande, Cambridge, Dayton, Toledo, Marietta, Columbus, Cincinnati, Uniontown, Youngstown, Ontario and Cleveland.
**Adult Protective Services**

Adult Protective Services (APS) are provided by the County Departments of Job and Family Services. Services are provided to the elderly who are in danger of harm, unable to protect themselves or have no one else to assist them. County Departments of Job and Family Services are mandated to investigate and evaluate all reports of suspected abuse, neglect and exploitation of vulnerable adults ages 60 and over.

Investigations of reports alleging abuse, neglect and exploitation are mandated to be initiated within 24 hours, if any emergency exists, or within three working days after the report is received by the County Department of Job and Family Services. Upon completion of the investigation, the County Departments of Job and Family Services determine whether or not the adult who is the subject of the investigation needs protective services. APS contact information can be found online at [jfs.ohio.gov/County/County_Directory.pdf](http://jfs.ohio.gov/County/County_Directory.pdf) or by calling 1-855-OHIO-APS (1-855-644-6277).

Social, medical and mental health care professionals are mandated by law to immediately report suspected abuse, neglect (including self-neglect), or exploitation to the County Departments of Job and Family Services. Other mandated reporters include attorneys, peace officers, senior service providers, coroners, clergy members and professional counselors.
Resources and References

Glossary of Common Terms

Please Note: This list of definitions has been created from various sources used in this guide. It is not an exhaustive list, and terminology used in any particular program may differ from this and may be determined by local practice, policy and procedure.

**Accessible**: In the case of a facility, readily usable by a particular individual; in the case of a program or activity, presented or provided in a manner that makes it easier for a particular individual to participate, with or without auxiliary aid(s); in the case of electronic resources, accessible with or without assistive technology.

**Access barriers**: Any obstruction that prevents people with disabilities from using standard facilities, equipment or resources.

**Accommodation**: Modifications or adjustments to a program, service or the environment to make it easier for a person with a disability to participate in the same manner as anyone else.

**Adaptive technology**: Hardware or software products that provide access to a computer that is otherwise inaccessible to an individual with a disability.
**Americans with Disabilities Act of 1990 (ADA):** A comprehensive federal law that prohibits discrimination on the basis of disability in employment, public services, public accommodations, services operated by private entities and telecommunications.

**Assistive technology:** Technology used to assist a person with a disability, e.g., wheelchair, hand splints or computer-based equipment.

**Braille:** System of embossed characters formed by using a Braille cell, a combination of six dots consisting of two vertical columns of three dots each. Each simple Braille character is formed by one or more of these dots and occupies a full cell or space. Some Braille may use eight dots.

**Capacity:** An adult's ability to demonstrate specific knowledge, as determined by a clinician.

**Captioning:** Text that is included with video presentations or broadcasts that enables people to read what is being said.

**Communication device:** Hardware that allows a person who has difficulty speaking clearly to use words or symbols for communication. May range in complexity from a simple picture board to complex electronic devices that allow personalized, unique constructions of ideas.

**Competency:** The ability to understand and process information. Only the court can determine if a person is declared incompetent.

**Deaf or hard of hearing:** Complete or partial loss of the ability to hear caused by a variety of injuries or diseases, including congenital defects.

**Disability:** Physical or mental impairment that substantially limits one or more major life activities; a record of such an impairment; or being regarded as having such an impairment (Americans with Disabilities Act of 1990).

**Discrimination:** Act of treating someone differently on a basis other than individual merit.

**Forensic interview:** An interview conducted by a trained forensic interviewer that gathers factual information from a victim using non-leading questions in a legally defensible and developmentally appropriate manner. Project FIND is a new forensic interview protocol that was designed specifically for crime victims with disabilities.

**Guardianship or Guardian of Person:** A mechanism by which a court grants certain powers to a family member, other individual, governmental agency, or institution to control the affairs of a person (ward) who is incapable of managing care for themselves. Courts generally require medical reports about the mental capacity of the proposed ward before appointing a guardian.
Identity-first language: A language construct that puts a person's disability label first, such as in “disabled woman” or “Autistic man.” A person may prefer identity-first language because they believe their disability is an inherent part of their identity. Some disability communities, including the Deaf, blind, and Autistic communities, are more likely to prefer identity-first language. However, as views vary from person to person, it is important to ask each individual what their preference is for identifying language. See also: Person-first language.

Large print: Most ordinary print is six to 10 points in height (about 1/16 to 1/8 of an inch). Large type is 14 to 18 points (about 1/8 to 1/4 of an inch) and sometimes larger.

Mainstreaming, inclusion: The inclusion of people with disabilities, with or without special accommodations, in programs, activities and facilities with their non-disabled peers.


Mobility impairment: Disability that affects movement ranging from gross motor skills, such as walking, to fine motor movement involving manipulation of objects by hand.

Person-centered planning: A process that focuses on the goals that are important to a person, while emphasizing what they can do rather than what they cannot do. The planning process emphasizes active listening by an individual's team members, with an emphasis on the person acquiring skills they wish to learn, using a multi-disciplinary team model of support.

Person-first language: A language construct that puts the person before their disability label, such as in “woman with Parkinson's disease” or “man with bipolar disorder.” A person may prefer person-first language because they believe their disability does not define them. As views vary from person to person, is it important to ask each individual what their preference is for identifying language. See also: Identity-first language.

Physical or mental impairment: Any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; hemic and lymphatic; skin; and endocrine; or any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities (Americans with Disabilities Act of 1990).

Plain language: A method of communication that emphasizes understanding. Communicators should use familiar terms and clear language.
**Power of Attorney (POA):** An instrument by which one person (the principal) transfers authority to make decisions, such as medical care, end of life decisions or financial management, to another person (the attorney in fact). The authority must be created while the principal has mental capacity and can be revoked at any time while having capacity. There is no court oversight of POAs.

**Qualified individual with a disability:** An individual with a disability who, with or without reasonable modification to rules, policies or practices, the removal of architectural, communication or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (Americans with Disabilities Act of 1990).

**Reader:** A volunteer or employee of an individual with a disability (for instance, someone with a visual impairment or learning disability) who reads printed material out loud in person or records it to audiotape.

**Reading system:** Hardware and software designed to provide access to printed text for people with visual impairments, mobility impairments or learning disabilities. Character recognition software controls a scanner that takes an image of a printed page, converts it to computer text using recognition software and then reads the text using a synthesized voice.

**Refreshable Braille display:** Hardware connected to a computer that echoes screen text on a box with cells consisting of pins that move up and down to create Braille characters.

**Screen enlargement:** Hardware or software that increases the size of characters and text on a computer screen.

**Screen reader:** Software used to read text on a computer screen out loud, often used by people with visual impairments or learning disabilities.

**Section 508 of the Rehabilitation Act:** Legislation that requires federal agencies to develop, procure and use accessible electronic and information technology.

**Sensory impairment:** A disability that affects touch, sight or hearing

**Service animals:** Under Titles II and III of the ADA, a dog or miniature horse that is individually trained to do work or perform tasks for the benefit of an individual with a disability; under the Air Carrier Access Act, any animal that is individually trained or able to provide assistance to a person with a disability, or any animal that assists persons with disabilities by providing emotional support.

**Sign language:** Manual communication commonly used by Deaf or hard of hearing people. The gestures or symbols in sign language are organized in a linguistic way. Each individual gesture
is called a sign, and each sign has three distinct parts: the handshape, the position of the hands and the movement of the hands. American Sign Language (ASL) is the most commonly used sign language in the United States. It is different from English. Deaf people from different countries speak different sign languages.

**Specific learning disability**: Disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language, which may manifest itself in difficulties listening, thinking, speaking, reading, writing, spelling or doing mathematical calculations. Frequent limitations include hyperactivity, distractibility, emotional instability, visual and/or auditory perception difficulties and/or motor limitations, depending on the type of learning disability.

**Telecommunications Relay Service (TRS)**: A nationwide service that allows people who are Deaf or hard of hearing to communicate over the telephone. The service may be provided in a number of different forms, depending upon the needs of the individual, including teletypewriter (TTY), voice carry over, captioned telephone service and video relay service.

**Traumatic Brain Injury (TBI)**: Open and closed head injuries resulting in impairments in one or more areas, including cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual and motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital, degenerative or induced by birth trauma.

**Trauma-informed**: Services, practices, assessments, etc., that incorporate knowledge about trauma, such as prevalence, impact, and recovery, in all aspects of service delivery. Trauma-informed practices minimize re-victimization and facilitate recovery.

**Universal design**: Designing programs, services, tools and facilities so that they are useable, without modification, by the widest range of people possible, with consideration for a variety of abilities and disabilities

**Vision impairments**: Complete or partial loss of ability to see, caused by a variety of injuries or diseases, including congenital defects. Legal blindness is defined as visual acuity of 20/200 or less in the better eye with correcting lenses, or the widest diameter of visual field subtending an angular distance no greater than 20 degrees.

**Vocational Rehabilitation Act of 1973**: Legislation prohibiting discrimination on the basis of disability, which applies to any program that receives federal financial support. Section 504 of the Act is aimed at making educational programs and facilities accessible to all students. Section 508 of the Act requires that electronic office equipment purchased through federal procurement meets disability access guidelines.
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