

# **CHAPTER NINE: SEXUAL ASSAULT & FAMILY VIOLENCE SPECIAL TOPIC/ VIOLENCE AGAINST PEOPLE WITH DISABILITIES, DEAF INDIVIDUALS, AND/OR ADULTS IN LATER LIFE**

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## **Learning Objectives: Understanding Violence Against People with Disabilities, Deaf Individuals, and/or Adults in Later Life**

**By the end of this section, the student will be able to identify and discuss the following terms, concepts and practices as they relate to the violence against people with disabilities, Deaf individuals and/or adults in later life:**

- A. Types of Disabilities**
- B. Aging Overview**
- C. Dynamics of Sexual Assault/Family Violence in the Lives of People with Disabilities, Deaf Individuals, and/or Adults In Later Life**
  - 1. Power and Control Wheel on Abuse of People with Developmental Disabilities by a Care Provider (Violence/Non-Violence)**
  - 2. Power and Control Wheel on Family Violence in Later Life**
- D. Working Collaboratively with Other Investigative Agencies when Investigating Reports of Suspected Abuse, Neglect or Exploitation of People with Disabilities, Deaf Individuals, or Persons over Age 65**
- E. Sexual Assault Investigation and Capacity to Consent**
- F. Ensuring Accessible Services**
- G. Ensuring Accessible Response to Crime Victims with Disabilities**
- H. Safety Planning**
- I. Texas Laws**

### **Prevalence of Abuse**

People with disabilities, Deaf individuals and adults over 65 are at increased risk of abuse, neglect, and assault. The crimes against them are frequently not reported or prosecuted.

In a large-scale national study, 70% of people with disabilities surveyed reported that they had been victims of abuse. Of those, 51% reported physical abuse, 42% sexual abuse, 37% neglect, 32% financial abuse, and 87% verbal-emotional abuse. More than 90% of people with disabilities surveyed reported experiencing abuse on multiple occasions. Incidents of abuse were not reported in about half of cases, and reported abuse resulted in arrests only about 10 percent of the time.<sup>1</sup>

An eight-year survey of college students at Rochester Institute of Technology indicates that Deaf and hard-of-hearing individuals are 1.5 times more likely to be victims of relationship violence

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<sup>1</sup> Baladerian, N.J., Coleman, T.F., & Stream, F. (2013). *Abuse of people with disabilities: Victims and their families speak out. A report on the 2012 national survey on abuse of people with disabilities.*

including sexual harassment, sexual assault, psychological abuse and physical abuse in their lifetime.<sup>2</sup>

Adults in later life are frequently crime victims of random violence, including assault, robbery, and rape, as well as abuse, exploitation, and mistreatment by someone who provides care. One national study reported that between 7.6-10% of adults over 60 experienced such abuse in the previous year; another that only one in 14 incidences are reported to authorities.<sup>3</sup> In a national study of 2,000 interviews with nursing home residents, 44% of people reported being abused, and 95% reported being neglected.<sup>4</sup>

Texas is home to more than 3.1 million residents age 65 or older and an estimated 5 million people with disabilities.<sup>5</sup> In fiscal year 2015, Adult Protective Services (APS) completed 11,935 investigations in intellectual or mental health disability settings, including state hospitals, schools, and centers; and confirmed 1,192 cases. APS also completed 78,180 investigations in 2015 of abuse, neglect or exploitation in the homes of adults age 65 and older and/or adults with disabilities ages 18-64. APS validated 43,759 of these allegations.<sup>6</sup>

In an early study of abuse against people with disabilities, researchers provided some evidence that 39-68% of girls and 16-30% of boys with developmental disabilities would experience some form of sexual abuse before 18 years of age.<sup>7</sup> Further, abuse of people with disabilities is most common in congregate residential settings, such as group homes or institutions. Researchers Furey, Niesen, and Strauch (1994) suggested 82% of all cases of abuse and neglect of adults with developmental disabilities were carried out in these settings. The most common victims were people who were unlikely or unable to report the abuse.<sup>8</sup>

The University of Alberta Violence and Disability Project analyzed reports of 100 women and adolescent girls with developmental disabilities who were sexually assaulted.<sup>9</sup> Only 33% of the reports resulted in formal charges. Overall, convictions occurred in just 11% of the cases. The available research demonstrates that law enforcement's role in conducting thorough investigations can greatly aid prosecution and conviction of perpetrators who abuse people with disabilities.

Some laws may refer to a crime victim with disabilities and/or an adult in later life as an "incapacitated adult." The definition of "incapacitated adult" is "an adult who, because of a physical or mental condition, is substantially unable to provide food, clothing or shelter for

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<sup>2</sup> National Domestic Violence Hotline. (n.d.) *Abuse in the Deaf community*. Retrieved March 16, 2016, from <http://www.thehotline.org/deaf-services/abuse-in-the-deaf-community/>

<sup>3</sup> National Center on Elder Abuse, Administration on Aging. (n.d.)/ *Statistics/data: Elder abuse: The size of the problem*.

<sup>4</sup> Broyles, K. (2000). *The silenced voice speaks out: A study of abuse and neglect of nursing home residents*.

<sup>5</sup> U.S. Census Bureau, 2014.

<sup>6</sup> Texas Department of Family and Protective Services (2016). *2015 data book*.

<sup>7</sup> As cited in Thornberry, C., and Olson, K. (2005). The abuse of individuals with developmental disabilities. *The Developmental Disabilities Bulletin*. (Vol. 33. No. 1&2). Retrieved March 22, 2016 from <http://files.eric.ed.gov/fulltext/EJ844468.pdf>

<sup>8</sup> Ibid.

<sup>9</sup> Sobsey, D. (2000, Fall). Faces of Violence Against Women with Developmental Disabilities. *Impact*, 13(3), 2-3, 25.

himself or herself; care for the person's own physical health; or manage the person's own financial affairs; or a person who must have a guardian appointed for the person to receive funds due the person from any governmental source.” (Texas Estates Code § 1002.017)

In order to effectively respond to and investigate domestic/sexual violence crimes against persons with disabilities, Deaf individuals and/or adults in later life, law enforcement personnel need to be familiar with the following:

- information about various types of disabilities and the physical and cognitive changes that occur with the aging process;
- dynamics of domestic and sexual violence when the crime victim has a disability, is Deaf, and/or is an older adult; and
- accessible responses to crime victims with disabilities, from the initial call throughout the investigation process.

### **Types of Disabilities**

Approximately 19% of the population lives with some type of disability.<sup>10</sup> As a group, people with disabilities are as varied and diverse as people without disabilities.

Disabilities can be classified as:

- *developmental*: present at birth or manifests before the age of 22;
- *acquired*: manifests at any age as a result of an injury sustained during a car accident, severe fall, or violent crime;
- *visible*: an outside observer can readily discern it (i.e., cerebral palsy, amputated limb);
- *hidden*: an outside observer might never be aware of a hidden disability (i.e., learning disability, hearing loss, cancer);
- *single*: presence of only one disability; and
- *multiple*: diagnosis or manifestation of two or more combined disabilities. A person with multiple disabilities may have both hidden and visible disabilities as well as acquired and developmental disabilities.

When a person acquires a disability as a result of a crime, they may be coping with both the trauma of the crime and the changes in their life due to this newly acquired disability. Disabilities can be categorized as: developmental-intellectual-cognitive, physical, mental illness, sensory, age-related, or hidden, as follows.<sup>11</sup>

### **Developmental, Intellectual, and Cognitive Disabilities**

Developmental, intellectual, and cognitive disabilities are sometimes used interchangeably, but they actually refer to different diagnostic terms.

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<sup>10</sup> U.S. Census Bureau, 2014

<sup>11</sup> Robbi, N.J. and Mastroleo, C.S. (2005). *Responding to violent crimes against persons with disabilities: A manual for law enforcement, prosecutors, judges and court personnel*. Abramson, W.H. (Ed.) Austin, TX: Disability Services ASAP (A Safety Awareness Program) of SafePlace.

*Developmental disabilities* are severe, chronic disabilities that are attributed to a mental and/or physical impairment. They substantially restrict the individual's functioning in several major life activities, begin before the age of 22, and are likely to be life-long.<sup>12</sup>

People with developmental disabilities have considerable difficulty in three or more of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and/or economic self-sufficiency.

Common physical developmental disabilities include cerebral palsy, seizure disorder, sensory disabilities, and muscular dystrophy. Developmental disabilities that have physical and mental impacts include Down syndrome and fetal alcohol syndrome.<sup>13</sup>

An *intellectual disability* is a developmental disability that is characterized by significant impacts on adaptive behavior and intellectual functioning. Intellectual functioning refers to general mental capacity in the areas of learning, reasoning, problem solving, planning, judgment, academic learning, and learning from experience.<sup>14</sup> People with this disability may not meet the level of personal independence and social responsibility expected for their age, culture and/or peers. An estimated 1-3% of the population is diagnosed with an intellectual disability, which include Autism Spectrum Disorder, Down syndrome, Fragile X syndrome and Fetal Alcohol Spectrum Disorder (FASD), according to The Arc of the U.S.<sup>15</sup>

Unfortunately, some individuals with intellectual and/or developmental disabilities have spent a great deal of time in environments where they have been taught to comply with authority figures and are expected to be on their best behavior at all times. This compliance training can have a tremendous effect on the ability to report or explain crimes without fear of consequences, shame, or guilt.

*Cognitive disability* is sometimes used as an umbrella term to refer to brain-related disabilities that occurs after the age of 18. Examples are traumatic brain injury, cerebrovascular injury, or degenerative disorder (i.e., stroke, dementia, Alzheimer's disease). Cognitive disabilities can occur at any time across a person's life span and may be the result of ongoing trauma or violence (i.e., choking, shaking, blows to the head). The severity of the disability is gauged on the person's adaptive functioning and can range from mild to profound.

### **Physical Disabilities**

Physical disabilities occur as a result of muscular skeletal or neuromotor system dysfunction. Physical disability pertains to total or partial loss of a person's bodily functions (e.g., walking, gross motor skills, and bowel/bladder control) and total or partial loss of a part of the body (e.g., a person with an amputation). A physical disability can be developmental (e.g., cerebral palsy, muscular dystrophy, Parkinson's disease) or acquired (e.g., spinal cord injury,

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<sup>12</sup> The Developmental Disabilities Assistance and Bill of Rights (DD Act of 2000 & American Association on Intellectual and Developmental Disabilities. (2016). Retrieved March 21, 2016, from <https://aaidd.org/intellectual-disability/definition/faqs-on-intellectual-disability#.VvAijmD2aM8>

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

<sup>15</sup> The Arc. (2016). *Intellectual disability*. Retrieved March 21, 2016, from [www.thearc.org/learn-about/intellectual-disability](http://www.thearc.org/learn-about/intellectual-disability)

amputation). Some individuals may use cane crutches, wheelchairs, prostheses, etc. Others may not require mobility aids.

### **Mental Illness**

A mental disorder, or mental illness, is characterized by significant difficulties that occur in an individual's emotional and behavioral life. Mental health and well-being can be defined as a person's feeling that they are coping, are fairly in control of their lives, and can manage challenges and responsibilities. A person who is mentally healthy has productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope (World Federation for Mental Health, 2006).

People diagnosed with mental illness or mental disorders may have significant difficulty with thinking clearly or cognition, self-regulation, and with managing their emotions, behaviors, impulses, responsibilities, and relationships.<sup>16</sup> Mental health disabilities can be related to traumatic stress from childhood and/or adulthood and the accompanying neurobiological effects of trauma, or difficulties in a person's social life, job, and other critical areas of daily living. For many people, symptoms related to mental health needs can be treated with medication, therapy, and/or support services-including non-traditional therapies (i.e., yoga, mindfulness training, acupuncture, art, etc.).

The most commonly diagnosed types of mental illness are anxiety disorders (e.g., Post-Traumatic Stress Disorder, obsessive-compulsive disorder, panic disorder), mood disorders (e.g., major depressive disorder, bipolar disorder), psychotic disorders (e.g., schizophrenia), and eating disorders (anorexia and bulimia). Most persons with mental illness are not violent, but are actually at higher risk of being victims of crime than people without mental illness. The formal classification system of various symptoms used by medical, psychiatric and psychology professionals for the purpose of diagnosing mental health disorders are contained in the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5)*.<sup>17</sup>

### **Sensory Disabilities**

Sensory disabilities are related to vision (blindness/low vision) and hearing (deafness/hard of hearing). Total blindness refers to people with very little or no functional use of vision (no light perception or only bare light perception). A person who is considered legally blind may be able to indistinctly see light, shapes, colors, and objects. Even with some functional vision and corrective lenses, the person may have difficulty with visual tasks. The ability to function visually can be increased through compensatory strategies, low vision devices, and modifications. People with visual disabilities may also use adaptive devices including canes, magnifiers, computerized voice technology/reading machines, or may read Braille. However, with the easy availability of voice technology, only about 10% of the population of children and adults who are blind read Braille.<sup>18</sup> Some individuals may rely on other people to guide them or read information to them.

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<sup>16</sup> American Psychiatric Association. (2013).

<sup>17</sup> Ibid, p. 20

<sup>18</sup> National Public Radio. (2012, February 13). *Braille under siege as blind turn to smartphones*. Retrieved March 7, 2016 from [www.npr.org/sections/alltechconsidered/2012/02/13/146812288/braille-under-siege-as-blind-turn-to-smartphones](http://www.npr.org/sections/alltechconsidered/2012/02/13/146812288/braille-under-siege-as-blind-turn-to-smartphones)

The medical definition of Deafness and hearing loss is partial or complete loss of hearing. This loss can be slight, mild, moderate, severe, or profound, depending upon how well a person can hear the loudness (intensities) and/ or pitch (frequencies) of sound. It may exist in only one ear or in both ears. Hard of hearing indicates that a person has some level of hearing loss, but is still able to rely on his/her ability to hear to communicate. People who are Deaf do not hear well enough to rely on their hearing to process speech and language. In the U.S., most Deaf people use American Sign Language (ASL) as a first and preferred language. ASL has its own grammar, syntax, semantics, and idioms, and is conveyed with signs made with the hands, facial expressions, and body language.

Many Deaf adults do not consider themselves to have a disability. People who identify themselves as Big D (capital D), identify with Deaf culture and community, a minority group with its own language, history, traditions, clubs, churches, values, and cultural norms. Little “d” often refers to people who do not identify with the Deaf culture and community; for example, a person who loses their hearing later in life.

### **Hidden Disabilities**

Examples of conditions which may not be readily apparent include diabetes, HIV/AIDS, cancer, seizure disorder, dyslexia, attention-deficit hyperactivity/disorder, etc. An individual in recovery from alcoholism or drug addiction may also be considered as having a disability if they experience limitations in daily activities.

### **Overview Adults in Later Life**

Aging is a complex process involving changes across the lifespan and that occurs at different rates for different people. Some changes do not pose significant health risks (i.e., gray hair) where others increase the risks for disabilities that seriously impact physical and/or mental health and longevity (i.e., age-related macular degeneration, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, hypertension, etc.).

Law enforcement officers need to remain alert to clues that many adults in later life do not hear or see well, although they may have a tendency to mask these changes in vision and hearing. This can disrupt the communication process and require different investigative techniques.<sup>19</sup> Common age-related physical and cognitive changes that can impact increase risks of harm and the ability of victims in later life to relay crime details are described below.

### **Physical Changes**

- Loss of bone and muscle mass can result in more easily broken bones, weakened muscles, and loss of strength.
- Possible vision loss as a result of cataracts, glaucoma, and macular degeneration.
- High pitch and lower frequency hearing abilities are reduced.
- Skin becomes thin and loses elasticity and may tear or bruise easily. Bruising can increase with certain medications.

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<sup>19</sup> Jordon, L. (May, 2002). *Law enforcement and the elderly: A concern for the 21<sup>st</sup> century*.

- The number of taste buds in adults in later life may decline, along with the sense of smell. A loss of smell also lessens sensitivity to odors related to poor care or a substandard environment.
- Changes in the digestive system include slower digestion, slower metabolizing of medications and alcohol, and a decrease in absorption of some nutrients.
- Adults in later life are more susceptible to drug toxicity. Drug reactions can result in depression, fatigue, incontinence, or inability to walk.

More than a third of people over the age of 70 have some form of memory loss, according to a national study. While an estimated 3.4 million Americans have dementia, defined as a loss of the ability to function independently, researchers estimate that another 5.4 million over age 70 have memory loss that disrupts their regular routine but is not severe enough to affect their ability to complete daily activities.<sup>20</sup>

With age, incidences of actual dementia increase substantially. One in 20 people over the age of 65 have dementia, and the number jumps to one in five over the age of 80. According to the National Institute of Aging, between 2.4 and 4.5 million people in the United States have Alzheimer's disease, the leading cause of dementia.<sup>21</sup>

Illnesses unrelated to the brain also cause significant changes in thinking and behavior. An adult in later life who appears to be seriously confused or seems to have severe dementia may actually have an untreated medical disorder. Treating the disorder may erase the confusion and memory loss, and the adult in later life can return to usual functioning. Approximately 100 medical conditions that mimic serious disorders are actually reversible. For example, almost any infection can cause an older person to become severely confused. Another common cause of temporary difficulties with thinking and behavior is fluctuations in glucose levels in adults with diabetes.

### **Cognitive Changes**

Some slowing of thought, memory, and thinking is a normal part of aging, but a high level of mental activity can be maintained until very old age. Some short-term memory loss with age is normal, but delirium, dementia, and severe memory loss are not a normal process of aging.

The following conditions will impact how law enforcement works with later life crime victims:

**Confusion** is the inability to think with usual speed or clarity. When confused, a person has difficulty focusing attention and may feel disoriented. Confusion interferes with a person's ability to make decisions. Confusion may come on suddenly or gradually, depending on the cause. Some confused people may behave aggressively.

A confused person at a scene may not be able to accurately answer questions about date, time of day, their location, or what they did that day. A physical problem may be the cause of sudden confusion, particularly if the person has a headache, dizziness, slow or

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<sup>20</sup> Duke Medicine. (2008). *One in three people over seventy have memory impairment*. Retrieved March 8, 2016, from [http://corporate.dukemedicine.org/news\\_and\\_publications/news\\_office/news/10261](http://corporate.dukemedicine.org/news_and_publications/news_office/news/10261)

<sup>21</sup> Health communities. (2008, December). *Memory loss*. Retrieved March 8, 2016 from [www.healthcommunities.com/memory-problems/overview-of-memory-loss.shtml](http://www.healthcommunities.com/memory-problems/overview-of-memory-loss.shtml)

rapid breathing, clammy or cold skin, shivering, or fever. If a physical cause for the confusion is suspected, seek medical assistance. A confused person should be moved to a calm, quiet place and should not be left alone.

**Delirium** is a condition of severe confusion and rapid changes in brain function. Delirium involves rapid changes between mental states (for example, from lethargy to agitation and back to lethargy), with attention disruption, disorganized thinking, disorientation, changes in sensation and perception, and other symptoms. It is usually caused by a treatable physical or mental illness. A more subtle cause of delirium, particularly in patients in later life, is reduced sensory input, caused by such things as prolonged hospital stays without glasses, hearing aid, or teeth.

A person with delirium will be unable to pay attention, will have disorganized thoughts, and will switch from subject to subject. Law enforcement will need to be prepared to take additional time and possibly repeat questions. The person's thoughts will be disorganized, and they will switch from subject to subject. This person will require a medical assessment. Recovery from delirium for an adult in later life can take up to two months.

People in later life who are victimized and who shows signs of confusion may have dementia or may have a recent and rapid onset of delirium (confusion) related to abuse or care provider neglect. Symptoms of both are similar. Asking questions about medical diagnosis and medications may help determine the cause of the confusion. For example, confusion may result if a care provider is failing to give adequate doses of medications or is giving too much medication. Asking when the last doses of medications were administered and checking against the bottle label can help determine missed or excessive dosages. Checking pre-filled pillboxes can also help determine the existence of mismanaged medications.

Other disorders that contribute to confusion or delirium include congestive heart failure, decreased oxygen, excessive carbon dioxide levels, thyroid disorders, anemia, nutritional disorders, infections, kidney failure, liver failure, psychiatric conditions and degenerative brain disorders like Alzheimer's disease. Stopping or reducing certain medications may decrease the confusion. Correction of co-existing medical and psychiatric disorders often greatly improves mental functioning.<sup>22</sup>

**Dementia** is a loss of mental function caused by a group of conditions that gradually destroy brain cells, leading to progressive decline in language, judgment, and other modes of functioning. Dementia or memory loss can be present due to Alzheimer's in 60-80% of the cases. Other leading causes are blood clots that block blood flow to the brain (cerebrovascular disease/vascular dementia); Lewy Body disease, caused from deposits of proteins inside nerve cells in the brain; and other diseases and conditions.<sup>23</sup> Alzheimer's disease progresses slowly and begins well before symptoms appear. The

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<sup>22</sup> Medline Plus. (April, 2004). *Delirium*. U.S. National Library of Medicine and National Institutes of Health.

<sup>23</sup> Alzheimer's Association. (n.d.). *Aging, memory loss and dementia: What's the difference?* [www.alz.org/mnnd](http://www.alz.org/mnnd)



number of Americans with Alzheimer's disease and other dementias will grow each year as the number of Americans 65 and older increases.<sup>24</sup>

Before assuming that the crime victim has dementia, make sure they receive food, water, proper medication and sleep.<sup>25</sup>

Signs of dementia include:

- short-term memory loss;
- inability to think problems through;
- inability to complete complex tasks without step-by-step instructions;
- confusion;
- difficulty concentrating;
- paranoid, inappropriate, or bizarre behavior; or
- clinical depression.<sup>26</sup>

Short-term memory loss is not an indicator of serious cognitive impairment. However, dementia is likely (particularly Alzheimer's) if the following signs are observed:

- use of nonsensical words in speaking;
- disoriented sense of time and place;
- wandering or becoming lost and not knowing where one lives;
- blank facial expression;
- poor judgment (e.g., wearing winter clothes in summer or a nightgown to go shopping);
- rapid mood swings for no apparent reason; and
- walking with slow, sliding movements without lifting the feet.

### **Dynamics of Sexual Assault/Family Violence in the Lives of People with Disabilities, Deaf Individuals and/or Adults in Later Life**

Family members and peers with disabilities perpetrate more than half of the cases of abuse of people with disabilities. Disability professionals (e.g., paid or unpaid care providers, physical and speech therapists, doctors, nurses, etc.) are generally believed to be responsible for the remaining 50%.<sup>27</sup>

In a telephone survey of almost 6,000 adults in later life, victims of abuse reported that 57% of perpetrators of physical abuse were a partner or a spouse.<sup>28</sup> Other common offenders are family members or care providers. However, sexual assault and stalking in later life may also be

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<sup>24</sup> Alzheimer's Association. (n.d.). *Types of dementia*. Retrieved March 8, 2016 from [www.alz.org/dementia/types-of-dementia.asp](http://www.alz.org/dementia/types-of-dementia.asp); & Alzheimer's Association. (n.d.) *Quick facts*. Retrieved March, 8, 2016 from [www.alz.org/facts/](http://www.alz.org/facts/)

<sup>25</sup> Brandl, B. (2002). *From a web of fear and isolation to a community safety net: Cross-training on abuse in later life*. National Clearinghouse on Abuse in Later Life, Wisconsin Coalition Against Domestic Violence. Published by Pennsylvania Coalition Against Domestic Violence.

<sup>26</sup> Family Caregiver Alliance (1999). *Dementia*. National Center on Caregiving.

<sup>27</sup> Sobsey, D. and Doe, T. (1991). Patterns of sexual abuse and assault. *Journal of Sexuality and Disability*, 9(3).

<sup>28</sup> National Institute of Justice. (2008). *Perpetrators of elder abuse*. [www.nij.gov/topics/crime/elder-abuse/pages/perpetrators.aspx](http://www.nij.gov/topics/crime/elder-abuse/pages/perpetrators.aspx)

committed by strangers. Adults in later life are also frequent victims of scams.<sup>29</sup> Understanding the controlling tactics that an abuser may use against a person with a disability, Deaf individual, and/or adult in later life may assist law enforcement with responding, investigating, and gathering evidence.

There are commonalities in the dynamics of family violence in the lives of people with and without disabilities, Deaf individuals, and adults in later life. The abuser may use a pattern of physical, emotional, sexual, and/or financial tactics to gain control over the victim (women and men). Abuse tends to begin in subtle ways and escalate over time. In the process, the relationship develops an unequal balance of power. Officers are encouraged to look at violence in the lives of people with disabilities, Deaf individuals and adults in later life from a framework of power and control; the abuser uses violence, threats, and other tactics, including intimidation and isolation, to maintain control over the victim's life.

People with disabilities may experience the following unique domestic/care provider violence:

- use the disability as an excuse for their abuse;
- hurt the victim through rough handling while performing required daily tasks (i.e., bathing or transferring from wheelchair to bed);
- leave the victim unattended for long periods of time;
- withhold, misuse, or delay needed supports like using medication to sedate the person, breaking equipment, or withdrawing equipment to immobilize the person;
- threaten institutionalization;
- force the individual to have an abortion or to be sterilized; and
- use seclusion and/or restraint as methods for gaining compliance or control over the victim in ways that could lead to injury, torture, or death.

Unique abusive tactics that perpetrators may use against Deaf individuals include:<sup>30</sup>

- Signing very close to victim's face when angry
- Using body language intimidation with American Sign Language
- Making fun of victim's speech or English skills
- Saying victim is too sensitive, too "hearing"
- Taking the person's Social Security check
- Checking email or text messages
- Checking videophone or Video Relay Service conversations
- Controlling which Deaf friends victim can talk to
- Moving away from Deaf community to isolate victim
- Hearing abusers may leave the victim out of social situations with hearing people, putting down the Deaf victim, and keeping the children from communicating with victim in ASL.

Unique abusive tactics that the perpetrator may use on adults in later life include:

- financial exploitation;
- gaining trust of family members, which can help perpetuate the abuse;
- taking advantage of the victim's confusion or possible symptoms of dementia;

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<sup>29</sup> National Clearinghouse on Abuse in Later Life. (n.d.). *Frequently asked questions*. Retrieved March 10, 2016 from <http://www.ncall.us/content/frequently-asked-questions>

<sup>30</sup> DeafHope. (2006). *Deaf power and control wheel*. Retrieved March 16, 2016 from [www.vawnet.org/assoc\\_files\\_vawnet/deafhopewheel.pdf](http://www.vawnet.org/assoc_files_vawnet/deafhopewheel.pdf)

- using silence, threats, intimidation, guilt, and blame;
- denying access to faith related activities;
- forcing the victim to perform sex acts against their consent or that they find offensive;
- using unwarranted procedures in caring for the victim’s genital or rectal areas; and
- killing the victim followed by killer’s suicide.<sup>31</sup>

Officers not yet trained regarding abuse in later life may not recognize these incidents as *criminal*.<sup>32</sup> They may mistakenly deem cases of abuse of adults in later life as *a civil matter* (e.g., financial abuse), *self-neglect* (claimed by a suspected care provider as self-inflicted), or death by a *natural cause* when neglect or abuse could be the cause.

People with disabilities and adults in later life are at increased risk to be abused by a care provider. A care provider helps with daily living activities the person would typically do for themselves, like bathing, eating, using the toilet, dressing, managing finances, and other tasks. Care providers may be a professional working for a residential facility or home healthcare provider, intimate partners, family members, friends, or anyone who is responsible for all or part of the individual’s care provider needs.

Crime victims with disabilities and adults in later life frequently do not report abuse or seek services related to abuse due to lack of familiarity with the system, embarrassment, fear, stigma, and concern about functioning without the daily assistance of the abuser. Deaf individuals often do not report abuse or seek services because the Deaf community is close knit, which can compromise confidentiality and the victim’s safety; shelters, victim services and law enforcement lack adequate resources for Deaf victims; and victims can be very isolated in the hearing world.<sup>33</sup>

These dynamics are further detailed in the power and control wheels on the following pages.

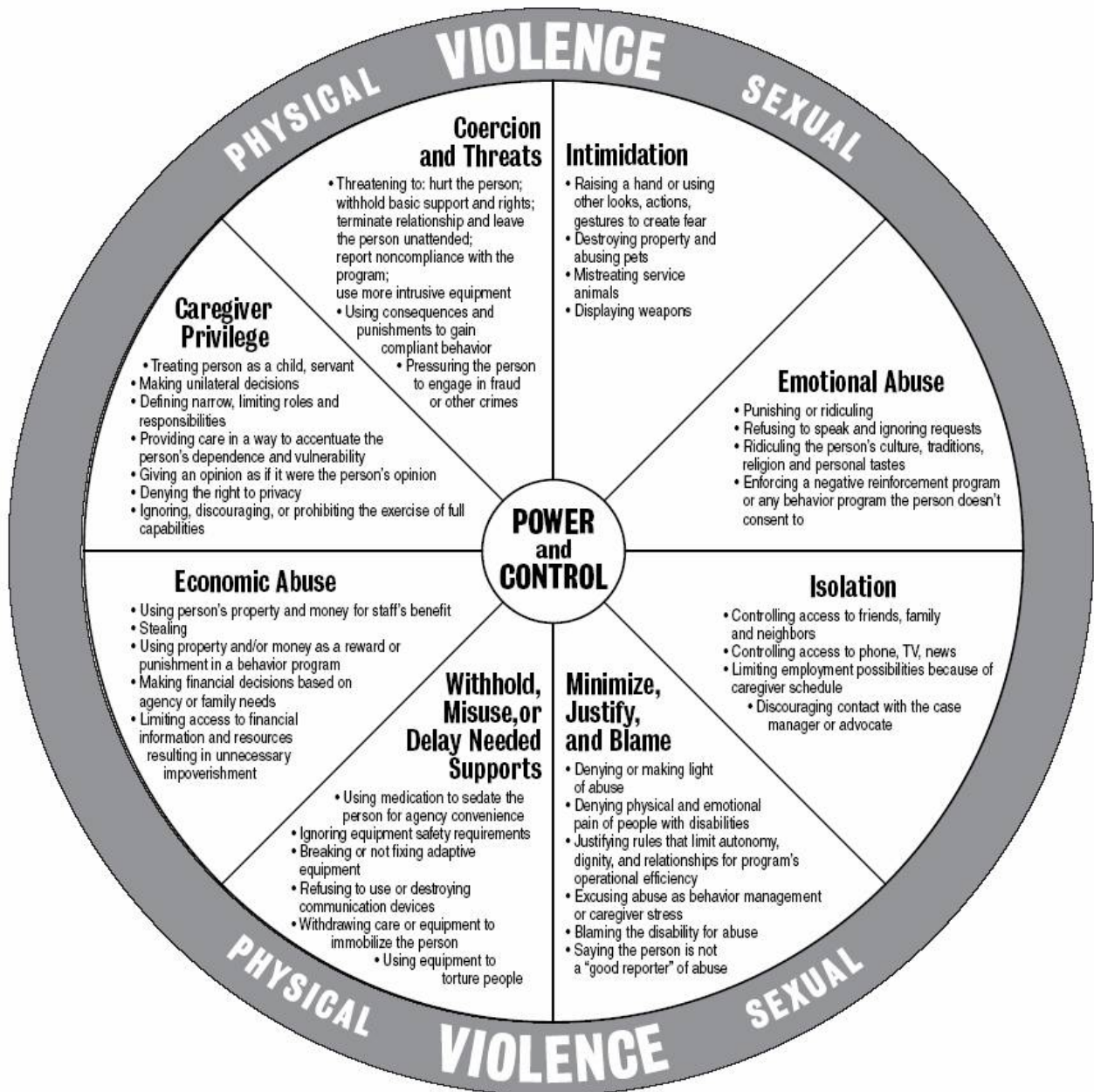
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<sup>31</sup> B. Brandl. (2002).

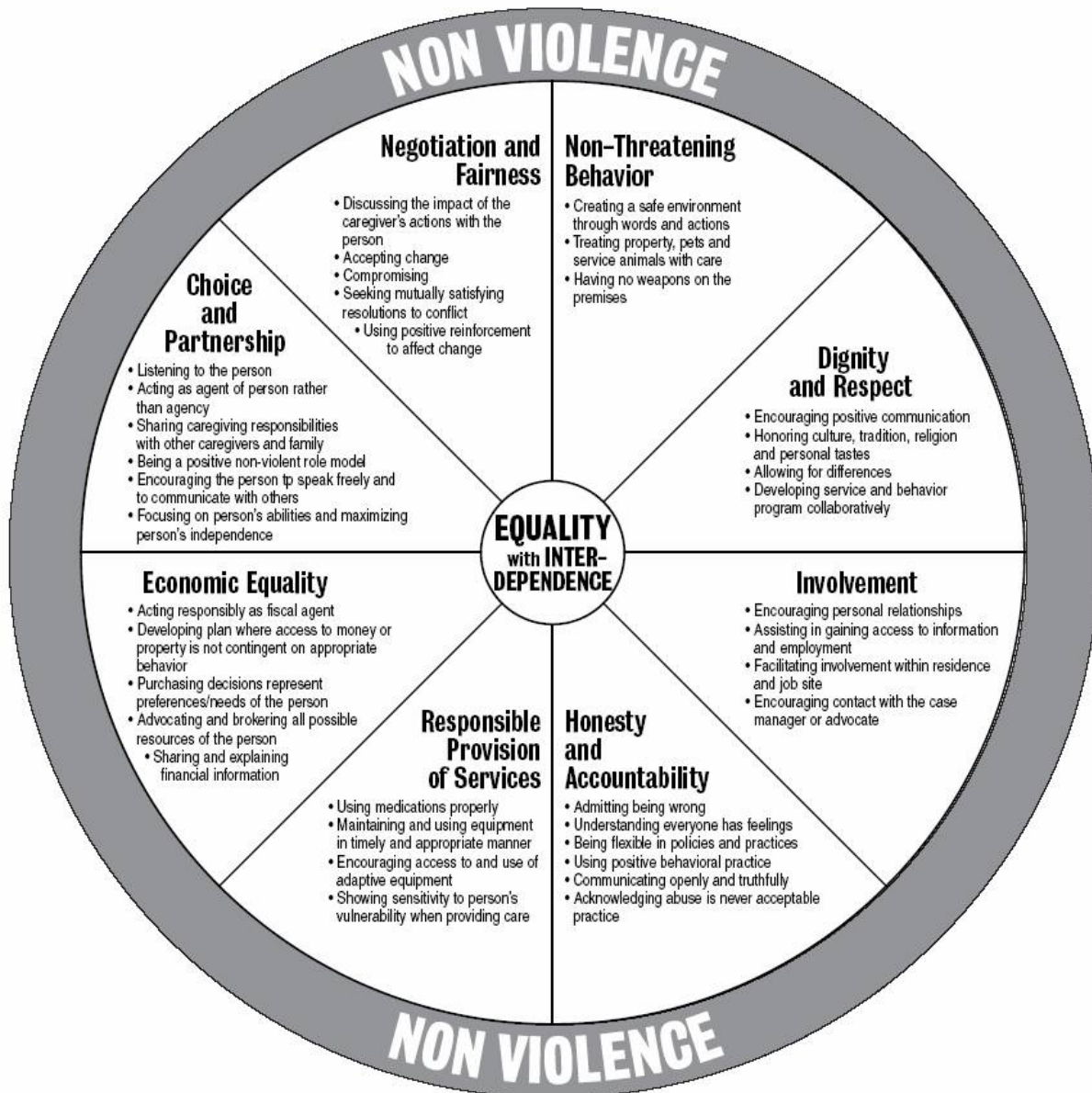
<sup>32</sup> Rohn, A. (1999). *A Multi-disciplinary approach to elder abuse prosecution*. Prosecutor’s Brief – The California District Attorney’s Association’s Quarterly Journal. XXI, (2), 7.

<sup>33</sup> NoMore Staff. (2015). *Gallaudet University students say NO MORE silencing Deaf voices*. NO MORE – Together We Can End Domestic Violence and Sexual Assault. Retrieved March 16, 2016, from <http://nomore.org/gallaudet-university-students-say-no-more-silencing-deaf-voices/>

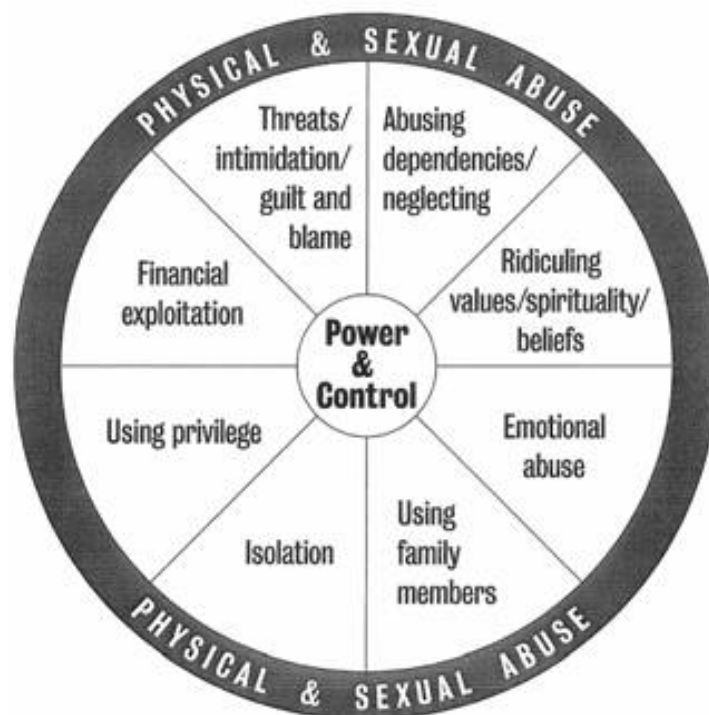
# Abuse of People with Developmental Disabilities by a Caregiver



# Abuse of People with Developmental Disabilities by Caregivers



## Family Violence in Later Life



*{These diagrams are based on the Power and Control/Equality wheels developed by the Domestic Abuse Intervention Project, Duluth, MN.}*

Often, older victims of combined sexual assault and robbery crimes may choose to report just the robbery. With this in mind, be aware of sexual assault indicators when the victim is an adult in later life (e.g., hints or coded disclosure of sexual abuse, self-destructive activity, suicidal ideation, or attempts).<sup>34</sup> Resources on crime victims in later late for law enforcement include:

- The National Committee for Prevention of Elder Abuse – Includes links to training and other resources for law enforcement. [www.preventelderabuse.org/professionals/law.html](http://www.preventelderabuse.org/professionals/law.html)
- National Center on Elder Abuse – A resource for policy makers, social service and health care practitioners, the justice system, researchers, advocates, and families. [www.ncea.aoa.gov/index.aspx](http://www.ncea.aoa.gov/index.aspx)
- National Clearinghouse on Abuse in Later Life (NCALL) – Includes information, resources, and trainings on working with adults in later life who have been abused or exploited. [www.ncall.us/](http://www.ncall.us/)

<sup>34</sup> Lonsway, K.A. (2001, May). *Successfully investigating acquaintance sexual assault: A national training manual for law enforcement*. National Center for Women and Policing.

Domestic abuse in later life may occur due to the following dynamics:<sup>35</sup>

- *domestic violence grown old*, abuse between partners lasting decades;
- a new partnership that begins later in life;
- a late onset of abuse due to violent behaviors from health conditions such as Alzheimer's; or reverse domestic violence (batterer is considered weaker than the victim); and
- adult child or other family member may become abusive (physically, sexually, emotionally or financially).

Women and men are both victims and perpetrators of abuse against adults in later life. Abuse is most often perpetrated by a person the crime victim knows. In fact, nationally, in almost 90% of abuse in later life and neglect incidents, the perpetrator is a family member. Two thirds of perpetrators are adult children or spouses.<sup>36</sup> Victims of murder over the age 64 were two times more likely than crime victims between ages 12 and 64 to have been killed by relatives or intimates.<sup>37</sup> In Texas, adult children are perpetrators in 38% of confirmed in-home adult protective services cases (including abuse in later life and individuals with disabilities). The second most frequent perpetrator is the spouse (16%) followed by the grandchild (11%), service provider (9%) and a combination of other relatives, including siblings and parents (17%).<sup>38</sup> A stereotype often held about adults in later life is that they are not targeted for sexual assault due to their age. However, one in six women aged 50-59 and one in 15 women aged 60 and older reported being raped, according to the National Violence Against Women Survey (2006).

U.S. representative Henry Waxman (2001) requested an investigation on the incidence of physical, sexual, and verbal abuse in the approximately 17,000 nursing homes in the United States from 1999 through 2001.<sup>39</sup> All of these violations had at least the potential to harm nursing home residents. In over 1,600 of these nursing homes, the abuse violations were serious enough to cause actual harm to residents or to place the residents in immediate jeopardy of death or serious injury. Overall, more than 40% of all abuse violations were discovered during complaint investigations. Three of the most common violations were the failure to: 1) properly investigate and report allegations of resident abuse, neglect, or mistreatment or to ensure that the nursing home staff do not have a documented history of abusing, neglecting, or mistreating residents; 2) develop and implement written policies that prohibit abuse, mistreatment, and neglect of residents and the misappropriation of residents' property; and 3) protect residents from sexual, physical, or verbal abuse, corporal punishment, or involuntary seclusion. Nursing homes are required to report abuse to the Texas Department of Aging and Disability Services (DADS) and local law enforcement.

A popular notion that abuse against people with disabilities and against adults in later life is primarily caused by stressed care providers has not been supported by research. However, research suggests that caregiver stress is not a primary or sole cause of abuse against older

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<sup>35</sup> B. Brandl. (2002).

<sup>36</sup> National Council on Aging. (n.d.). *What is elder abuse?* Retrieved March 8, 2016 from [www.ncoa.org/public-policy-action/elder-justice/elder-abuse-facts/#intraPageNav2](http://www.ncoa.org/public-policy-action/elder-justice/elder-abuse-facts/#intraPageNav2)

<sup>37</sup> Bureau of Justice Statistics. (2000).

<sup>38</sup> Texas Department of Family and Protective Services (2016). *2015 Data Book*.

<sup>39</sup> Waxman, H.A. (2001). *Abuse of residents is a major problem in U.S. nursing homes*.

adults.<sup>40</sup> The role of law enforcement is to determine whether a crime has been committed and make an arrest if necessary. Crime victims with disabilities and adults in later life frequently do not report abuse or seek services related to abuse due to lack of familiarity with the system, embarrassment, fear, stigma, and concern about functioning without the daily assistance of the abuser. Deaf individuals often do not report abuse or seek services because the Deaf community is close knit, which can compromise confidentiality and the victim's safety; shelters, victim services and law enforcement lack adequate resources for Deaf victims; and victims can be very isolated in the hearing world.<sup>41</sup>

### **Indicators of Abuse**

Whether your contact with an individual with a disability, Deaf individual, or adults in later life occurs because of a crime against them, or because they are a witness of crime against another person, look for indicators of possible abuse as you would in any other case.

Later life victims are twice as likely to suffer serious physical injury and require hospitalization over any other age group. Furthermore, the physiological process of aging brings with it a decreasing ability to heal after injury – both physically and mentally. Also, the trauma that older victims suffer can be worsened by their financial situation.<sup>42</sup>

The following list includes additional possible indicators of abuse. Some situations may include indicators of abuse that are not listed below.

#### *Possible Physical Indicators of Abuse:*<sup>43</sup>

- Bruises in places hidden by clothing
- Abrasions from rope or other restraints on the arms, legs, or torso
- Pressure or bed sores
- Cuts, scratches, bite marks, or bald spots from hair pulling
- Sprains, dislocations, fractures, broken bones
- Vaginal or rectal pain, bleeding, itching, stained or bloody underclothing
- Untreated medical (e.g., bedsores) or mental conditions
- Overmedicated or medications not given as prescribed by physician
- Lack of necessary adaptive aids (i.e., communication or mobility devices)
- Mismanagement of finances by care provider or relative

#### *Possible Behavioral Indicators or Reactions to Abuse:*

It may not be possible for you to notice changes in behavior if your contact with an individual is for a short period of time. However, possible behavioral indicators of abuse include:

- Has repeated “accidental injuries”

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<sup>40</sup> Brandl, B., & Ramond, J.A. (2012, Fall). Policy implications of recognizing that caregiver stress is *not* the primary cause of elder abuse. *Journal of the American Society on Aging*. Retrieved March 21, 2016 from [www.ncall.us/sites/ncall.us/files/resources/32\\_39\\_Gene\\_36\\_3\\_Brandl\\_Raymond.pdf](http://www.ncall.us/sites/ncall.us/files/resources/32_39_Gene_36_3_Brandl_Raymond.pdf)

<sup>41</sup> NoMore Staff. (2015). *Gallaudet University students say NO MORE silencing Deaf voices*. NO MORE – Together We Can End Domestic Violence and Sexual Assault. Retrieved March 16, 2016, from <http://nomore.org/gallaudet-university-students-say-no-more-silencing-deaf-voices/>

<sup>42</sup> Office for Victims of Crime. (2001). *First response to victims of crime: A handbook for law enforcement officers*.

<sup>43</sup> N.J. Robbi and C.S. Mastroleo. (2005).



- Asks to be separated from the care provider
- Says or hints at being angry, overwhelmed, numb, or cries for no apparent reason; experiences mood swings and/or emotional outbursts
- Unusual or inappropriate expression of affection
- Hyper alert, vigilant in watching actions of care provider/abuser
- Obsesses, worries or is anxious about his/her own performance; overly compliant; anxious to please care provider/abuser
- Constant criticism of the care provider—cursing, hitting, or scratching the care provider
- Unexplained withdrawal from normal activities, a sudden change in alertness, and unusual depression

### **Disclosure of Abuse**

A perpetrator of violence against a person with a disability, Deaf individual or an adult in later life may accompany the victim on any medical or other appointments or errands where the individual might have some opportunity to make an outcry. Disclosures of abuse can occur at any time. For example, an officer who responds to a call regarding an allegation of abuse at an institution may be approached by another resident who makes a disclosure that is unrelated to the current call. For many individuals with disabilities, this may be one of their first interactions with law enforcement, as well as their first safe opportunity to disclose abuse. People may not have known help was available through the criminal justice system until asked to testify for someone else.

### **Responding to Victims' Disclosures of Abuse**

- Make every effort to respond in ways that are consistent with the trauma-informed values of safety, trustworthiness, choice, collaboration, and empowerment.<sup>44</sup>
- Let the person know that you believe them, and that whatever they are feeling is okay.
- Explain your role and what you will do with the information.
- Make referrals to appropriate medical care, domestic violence/sexual assault crisis centers, etc. Respect the individual's choice whether or not to follow through on referrals.
- Explore strategies to increase personal safety.
- Explore community options for immediate safety. Do not take the person to an institution (e.g., nursing home, state school) simply because they have a disability or because they have periodically lived or been temporarily in an institution.
- Inform the victim that you are obligated by law to make a report to the agency that investigates allegations of abuse (Child/Adult Protective Services).
- Follow your agency's procedures to document the scene, photograph injuries, etc.

### **Working Collaboratively with Other Investigative Agencies when Investigating Reports of Suspected Abuse, Neglect or Exploitation of People with Disabilities, Deaf Individuals, or Persons over Age 65**

Most law enforcement agencies have standard operating procedures for responding to domestic and sexual violence, financial exploitation and other crimes. However, many departments lack

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<sup>44</sup> Fallot, R.D. and Harris, M. (2009, July). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol*. Community Connections, Washington, DC.

comprehensive policies and procedures for responding to and investigating crimes against persons with disabilities, Deaf individuals and adults in later life. Such protocols could cover: a) procedures to follow in specific cases based on which agency is the first responder; b) assessment of safety needs, inter-agency cooperation, and coordination; c) mandated reporting requirements; and d) ensuring accessibility (e.g., sign language interpreters). Information in this chapter may be useful in beginning to develop such protocols.

Often, few links exist between community groups and law enforcement on victimization and disability or aging issues. As police and sheriff's departments (particularly urban) revert back to some of the more effective tools of community policing, all officers will be more effective if they have information and collaborative relationships with community agencies serving people with disabilities and adults in later life.

Paramount to building any case is the multi-disciplinary coordination among all stakeholders. These stakeholders include dispatchers, emergency medical technicians and paramedics, responding law enforcement officers, social service providers, Texas Department of Family and Protective Services (TDFPS) or Texas Department of Aging and Disability Services (DADS) case workers, prosecutors, advocates, the victim(s), and any witnesses.

### **Reporting Abuse**

Texas statutes require mandatory reporting of suspected abuse, neglect, or exploitation of adults with disabilities or persons aged 65 and over. To make a report of suspected abuse to Texas Department of Family and Protective Services (DFPS), call its 24-hour hotline at (800) 252-5400 or report online at [www.txabusehotline.org](http://www.txabusehotline.org). For more information on investigation and protective services, please refer to the Human Resources Code, Chapter 48, § 48.051. A hotline reserved strictly for *law enforcement* to report both child and adult abuse is (800) 877-5300.

Adult Protective Services (APS) has two program branches. The APS In-home Program investigates allegations of abuse, neglect and exploitation of adults with disabilities or persons aged 65 and above who are residing in the community.

The Provider Investigation Program of APS investigates allegations of abuse, neglect, and exploitation of individuals receiving services in state operating and/or contracted settings that serve adults and children with mental illness or intellectual disabilities, including state supported living centers; state hospitals; local authorities serving people with intellectual and mental health disabilities; facilities and community-based contracts, including home and community-based (HCS) and Texas Home Living Waiver programs; Intermediate Care Facilities for people with intellectual disabilities; as well as individuals receiving services through the Medicaid Home and Community-Based Services programs.

APS policy requires the APS specialists immediately involve law enforcement if at any time during the investigation or service delivery the APS specialist suspects allegations of abuse, neglect, or financial exploitation that constitute a criminal offense. The APS Specialist is required to cooperate with law enforcement officials, including county or district attorneys and other investigative entities during a criminal investigation, including providing case information,

if requested. Upon completion of the investigation, the APS Specialist should submit a copy of the report to the appropriate law enforcement entity.

The Texas Department of Aging and Disability Services (DADS) investigates abuse reports in nursing homes, assisted living centers, private intermediate care facilities, home health and hospice, and day activity and health services. Again, these sites are still part of a law enforcement agency's jurisdiction. To make a report of suspected abuse to DADS, call their 24-hour hotline at (800) 458-9858. For more information, visit its Consumer Rights and Services webpage at [www.dads.state.tx.us/services/crs/index.html](http://www.dads.state.tx.us/services/crs/index.html)

Reports to both TDFPS and DADS agencies are made to statewide toll-free numbers, which are then assigned to the appropriate local office. The system is structured so that initial reporting of abuse against people with disabilities and adults aged 65 and over will most likely be made to Adult Protective Services or DADS, not local law enforcement. Often, an Adult Protective Services or DADS caseworker serves as first responder and investigator. Conversely, local law enforcement officers acting as first responders will report suspected abuse to APS or DADS, and may allow the investigative work to be conducted by these caseworkers. This structure creates a need for collaborative systems to exist between APS, DADS, and local law enforcement that ensure effective communication, cooperation, case building, and intervention for crime victims.

### **First Responders**

The first responders' role is critical, and law enforcement needs to have information and awareness of issues of importance to people with disabilities, Deaf individuals, and adults in later life. Areas for consideration include:

- the possibility that a paid or unpaid personal care provider or the person living with the crime victim may be the abuser;
- knowledge that intervention increases risks for additional harm, if the abuser remains in the residence;
- medical and/or behavioral emergencies related to some disabilities or age;
- the differences between indicators of abuse, common characteristics of certain disabilities, and medication side effects; and
- physical and/or cognitive changes due to the aging process.

Officers may not yet have training to recognize or respond to some of the following hidden disabilities: autism spectrum disorder, dementia, traumatic brain injury, mental illness and intellectual disabilities. The symptoms of some hidden disabilities can make people seem intoxicated or resistant to officer commands, angry without cause, unable to make eye contact, and many other behaviors. When uncertain about the cause of a person's conduct, find out as much as you can from others at the scene whenever possible, and approach the person in a calm and nonthreatening manner.

Before leaving the scene, ensure that the victim is safe from further violence, has received or is receiving proper medical care, has been referred to appropriate services, etc.

## **Interviewing, Investigating, Collecting Evidence, and Report Writing**

Unfortunately, people with disabilities have traditionally not been perceived as credible witnesses to their own abuse. However, officers can do much to dispel that misconception and build the case by believing the victim, assessing the situation, conducting a solid investigation, and by corroborating the victim's story with other people who are in the victim's daily life.

Victims of traumatic crimes may remember slowly, and need more time to process information. Be aware of the possibility of memory loss or memory fragmentation. Research over the past few decades has provided some evidence that distortions in human memory do occur and there is potential for inaccuracy in eyewitness testimony. It should not be surprising if the victim makes errors or inconsistencies in remembering. Memories can become more distorted over time and with retelling, particularly as people age.<sup>45</sup> In cases of sexual assault and/or for victims of other severe trauma, research also provides evidence that the victim's memory of events is likely to improve after several days, rather than deteriorate; particularly after the person sleeps and gets support.<sup>46</sup> Recording a formal interview can help reduce the chance that the crime victim will have talked to other people before the statement, reducing the argument that he or she was unduly influenced.<sup>47</sup>

In addition to disability-related difficulties with memory, it's also helpful to understand how the brain, the nervous system, memory, and behavior are interrelated for crime victims during the traumatic event. When victimized, a person's natural neurobiological protective response to danger is activated and releases powerful neurotransmitters (chemicals and hormones) that prepare and support the person to defend against danger. This traumatic stress response occurs when danger is perceived and the body prepares itself to fight, flee or freeze in order to defend itself against the perceived danger.

When the stress response is overused through repeated victimization as in domestic violence or repeated sexual abuse/assault cases, the neurochemicals intended to help defend against danger can damage memory and rational thought; cause memory to become fragmented, which makes remembering slow and difficult; increase hypervigilance; and make it difficult for the person to distinguish typical danger signals. This natural defensive human reaction to danger is important to understand, specifically in cases of sexual assault where neurobiological responses can impair the victim's rational thought for up to four days following an assault. As result, during this time decisions are compromised, and the survivor simply cannot think well.

If interviewed too soon after a sexual assault, the survivor is not likely to be able to produce all of the details related to the event(s). This stress-induced memory lapse can damage the victim's credibility. In addition, Opioids are released during the traumatic stress response. Although helpful in preventing or reducing pain, Opioids also inhibit memory and can cause flat affect. The impact of an assault cannot be judged by a victim's facial expressions or emotional

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<sup>45</sup> Lacy, J.W., & Stark, C.E.L. (n.d.) *The neuroscience of memory: Implications for the courtroom*. National Center for Biotechnology Information. Retrieved March 11, 2016, from [www.ncbi.nlm.nih.gov/pmc/articles/PMC4183265/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4183265/)

<sup>46</sup> End Violence Against Women International. (2013, June). Training Bulletin: When to Conduct an Exam or Interview. *Why are we prodding victims to keep them awake?* Retrieved March 15, 2016 from [www.evawintl.org/Library/DocumentLibraryHandler.aspx?id=77](http://www.evawintl.org/Library/DocumentLibraryHandler.aspx?id=77)

<sup>47</sup> D. Sobsey. (1994).

reactions. The neurochemicals that impact affect are also likely to stay elevated for about 96 hours after a sexual assault. During that period of time, victims may exhibit:

- flat affect
- strange emotions and emotional swings
- irritability, argumentativeness
- difficulty concentrating
- headaches and body pain
- stomach and GI distress
- increased alcohol/drug use (self-medication)
- compromised decision making, especially in relationships and sexuality

One important exception is when the assault is *drug and/or alcohol facilitated*. In those cases, the context of the assault is not encoded into memory and so sensory details are more likely to be available to the victim. When a victim had been under the influence of drugs or alcohol, it can be helpful to begin the interview or investigation by asking about sensory memories.

### **General Interviewing Tips**

During the interview, provide options for simple choices to the victim. *Would you like to tell me what happened in your own words? Would you prefer that I ask you questions now?* Let the victim know you may have questions they do not know the answers to, and that is okay.<sup>48</sup>

- Interview the crime victim and alleged perpetrator separately, so the abuser cannot hear or see the interview with the crime victim.
- When approaching the scene and identifying yourself, remember that the victim may be slower in processing information and may have difficulty hearing and seeing your identification. Give them a little extra time to view your identification.
- Get the person's attention before you speak.
- Make eye contact. Speak directly to the individual in your typical tone of voice.
- If you think the individual might need assistance, ask first. Wait for and follow the person's direction before lending aid. If your offer is refused, do not insist.
- Build rapport and trust; address the person by their first name.
- Ensure the victim understands what crime is being alleged and why.
- Take the opportunity to reiterate that the crime was not the victim's fault.
- Frequently summarize the most important points of the conversation.
- Stick to one topic. Ask one question at a time, waiting for a response before proceeding to the next question. Avoid interrupting the crime victim.
- Treat adults as adults – able to make their own decisions.
- Give frequent breaks.
- Pressuring the victim to remember more details is not likely to be successful. Instead ask the person to contact you if he/she remembers anything else, and provide them with your contact information.
- Victims of traumatic crimes may remember slowly, and need more time to process information. Be aware of the possibility of memory loss or memory fragmentation. Do not be surprised if the crime victim makes errors or inconsistencies in remembering, or has an emotional reaction.

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<sup>48</sup> Bard, M. and Sangrey, D. (1986). *The crime victim's book*, 2<sup>nd</sup> ed. Citadel Press: New York, NY.

- The victim may be embarrassed to discuss certain aspects of the crime. Ask if it would be easier to talk to a professional of the same gender.
- While it may be tempting to finish the person's sentences when the person struggles with words, avoid doing so. Likewise, do not correct the person.
- Keep the person's confidentiality by not providing information to family members, friends, or care providers unless the person (or their guardian) gives written consent.
- Refer to the disability only as necessary. Focus on the individual and the crime. Put the person before the disability. When speaking or writing a report, use respectful language (i.e., person who has an intellectual disability, person who uses a wheelchair, individual who is blind, or person who has a mental illness). Avoid using pitying or disempowering words like handicapped, cripple, crazy, wheelchair bound, etc.
- Inquire about any individualized needs in compliance with the Americans with Disabilities Act, regardless of whether or not the victim appears to have a disability. This will allow someone to disclose a hidden disability or address a visible disability to the extent that they feel comfortable.
- Be aware that the victim may not be part of the investigation by choice. Be prepared for fear, trepidation, and even hostility from the victim, as many people with disabilities who have been victimized fear being moved from their community to an institution.<sup>49</sup>
- When all else fails, start the interview over. If necessary, postpone the discussion for another time or use a multiple session interview protocol.
- People who are Deaf, people with intellectual disabilities or people have active mental illness may not use the same syntax or sequence as others. Document all facts, observations, and the victim's statement exactly. Be careful not to document your conclusions or assumptions.
- High or low frequency hearing loss may impact communication. Check to make sure he/she can hear and understand you. Maintain eye contact and keep your mouth visible.
- Provide written information that summarizes the important points you communicated verbally. If you are investigating a domestic violence case, ask if the person has a safe place to hide the information from the suspected abuser.

### **Cognitive Interviewing Techniques**

If the victim is having trouble remembering, consider using four of the following cognitive interviewing techniques.<sup>50</sup> Be cautious using these tools because they can also create unnecessary trauma with victims. If you plan to use these techniques, have victim, crisis services or other resources available in case the victim needs support.

- Ask the victim to reconstruct the circumstances (e.g., to describe the furniture and where it was placed, people, lighting, objects, weather, smells). Ask them to put themselves back at the scene. Reconstruct how they felt at the time and describe their reaction. This tool can be powerful in assisting memory.
- Ask the person to talk about every detail they can remember, even if it does not seem important. Do not interrupt.

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<sup>49</sup> Center for Child and Family Studies. (2003). *Voices ignored: Sexual assault of people with developmental disabilities*. College of Social Work, University of South Carolina.

<sup>50</sup> Lonsway, K.A. (May, 2001). *Successfully investigating acquaintance sexual assault: A national training manual for law enforcement*. National Center for Women and Policing.

- Ask the person to recall everything that happened in backward order. This technique can help people examine actual memory. People with intellectual, developmental and/or cognitive disabilities may not be able to remember events backward.
- Ask the person to describe what the crime would have looked like for somebody looking through a window.

### **Collecting Evidence**

The evidence collection process for crimes against people with disabilities, Deaf individuals, and adults in later life includes assessing the crime scene for physical evidence, including broken, missing/stolen, or withheld communication or mobility devices like cane crutches, computers, walkers, wheelchairs, telephones, or any other device that aids in independent functioning. Check your agency procedures about securing adaptive equipment if you need to temporarily keep a device as evidence.

Determine the extent of the abuser's obligation to care for the victim. Ask for any legal documents that would authorize the abuser to have control over financial and personal matters. When assessing for injuries, ask about the victim's medical diagnosis, obtain a list of their recent medications, find out the last time they saw the doctor, etc. Medications with bruising as a common side effect include aspirin; Ibuprofen; Naproxen; Coumadin (Warfarin, a blood thinner); Plavix (Clopidogrel, which prevents clots and blockages); and Prednisone (a steroid for inflammation). Skin changes as a person ages, and some medications can make adults in later life more prone to bruising and skin tears. Photograph injuries, and return two or three days later to photograph injuries again, because bruising worsens over time.

### **Report Writing**

Reports provide the official record of what happened on the day of the crime, down to every fact and finding. If something is missing in the report, it means there is not documentation on the full extent of facts related to the crime. In court, defense attorneys most often win cases by attacking the credibility of the investigation because of incomplete reports.<sup>51</sup>

In domestic violence reports, describe how the suspect used the victim's disability and/or advanced age to play into the events that happened. Did the perpetrator remove the Deaf victim's computer or phone so they could not access help or hide any mobility devices? Did the perpetrator overmedicate the victim? Did they put barriers in the way of someone who used a wheelchair so they could not access parts of the home or get help?

When writing the report, anticipate the potential defense strategies to discredit the testimony of a victim with a disability or a Deaf or adult in later life victim. Also keep in mind that the very disability or age-related conditions that increased the person's risks for abuse are often later used to discredit the victim's outcry. Document the person's disability and age in your report and make note of any necessary accommodations for communication, transportation, medication, interaction, and any other needs you identify. Corroborate as much as possible from other witnesses. Write exactly what the person said, did and reported. Gather all possible evidence, including photographs, videotapes, and body maps, which can substantiate the abuse. This is especially important in case of abuse against immigrants, since they could use such

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<sup>51</sup> Ibid.

documentation to obtain Violence Against Women Act legal remedies or a “U” Visa. A U Visa is a form of relief for immigrants who are victims of certain qualifying criminal activities; for example, domestic violence, sexual assault, rape, trafficking, incest, abusive sexual contact, prostitution, and female genital mutilation, among others. The U visa is part of a law passed by the United States Congress in 2000 in an effort to protect immigrant victims who have suffered substantial mental or physical harm due to the crime and to encourage them to report crimes to law enforcement. This legislation also created the T visa specifically for victims of human trafficking to again protect these victims and assist in the investigation or prosecution of human trafficking.

How a person conducting an interview or investigation thinks about a victim could be reflected in their report, which in turn, will be reflected at the trial. Be cautious about what you include and do not include in the report and *how* you write the report. Your report can either help or hinder the person’s credibility. Describe specific behaviors for instance *the victim was crying, breathing heavily, had difficulty remembering* rather than *the victim was acting crazy*.

If the person is Deaf and there was no interpreter at the initial response contact, confirm and correct what was said and what happened at a follow-up meeting that includes an American Sign Language (ASL) interpreter. Make sure that any reports or statements that were made with no ASL interpreter are reviewed later when an interpreter is present with the victim. ASL interpreters have different levels of certification, and at least a level IV certification is recommended for law enforcement domestic violence or abuse calls and investigations.<sup>52</sup>

Some law enforcement agencies provide follow-up response to victims through their officers, deputies, or victim services counselors. This role allows officers to stay in contact with the victim and provide updates about case status; assist with safety planning, taking in consideration their individualized needs; and provide referrals for services including support groups, individual counseling, housing/emergency shelter, or home health services.

### **Sexual Assault Investigation and Capacity to Consent**

Aspects of sexual assault can differ among people with disabilities, Deaf individuals, adults in later life and people with medical conditions. Examples include people with spinal cord injuries, who may have limited sensations in the genital or anal regions, but are still quite capable of knowing every detail of sexual assault or abuse. People with intellectual and other developmental disabilities may not have been taught about sex and sexuality, and may not realize that what happened was a crime or against the law. People with intellectual disabilities may also be uncomfortable talking about anything related to their bodies, may not know the terms for body parts, may not want the perpetrator to get in trouble, and may feel responsible for what happened.

Some adults in later life were of a generation taught never to speak of sex. Allow them to use words they are comfortable with. They may also have generational values like not talking about “private matters” with strangers. In the latter case, you may want to start with the following

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<sup>52</sup> Department of Assistive and Rehabilitative Services. (n.d.). *Situations and recommended interpreter certification levels*. Retrieved March 16, 2016 from <http://www.dars.state.tx.us/dhhs/beilvls.shtml>



questions: “Who makes decisions at your house?” “Has anyone you live with made you uncomfortable?”

If the victim seems uncomfortable talking about the sexual details of the crime, explain the purpose of the interview and why such detailed information is necessary; for example, *sexual assault with penetration is a different crime than sexual assault without penetration.*

When interviewing a sexual assault survivor with intellectual or cognitive disabilities and/or mental illness at a hospital, be prepared to take more time, since it may take a little longer to process feelings/information. Explain what is happening step by step. It is okay to repeat information using plain, concrete language if you are not certain the person understands. For example, if you have explained the person is going to go to the hospital to get an examination from the Sexual Assault Nurse Examiner, and you are not sure he/she understood why or what is going to happen, try to rephrase. “We are going to the hospital now. A nurse is going to visit with you, and if it is okay with you, she will examine your body. She will keep your underwear and give you a clean pair. She will ask you to pee in a cup. She will tell you everything she is going to do first.” Let hospital staff members know if disability-related accommodations will be needed (e.g., ASL interpreter).

Sexual assault investigations generally consist of one or more elements:<sup>[2]</sup>

- The victim was unable to give consent because he/she was or is “unconscious or physically unable to resist” [Texas Penal Code Sec. 22.011 (b) (3)]. This could mean that the victim was unconscious, asleep, comatose, intoxicated, drugged, etc. In these cases, the investigation will focus on information that corroborates the victim’s level of intoxication or drugged state, which could lead you to ask: “Was she throwing up? Was she carried out of the bar?”
- The victim is “incapable either of appraising the nature of the act or of resisting it... as a result of mental disease or defect” [Texas Penal Code Sec. 22.011 (b) (4)]. In other words, the victim is incapable of giving consent because of a developmental, intellectual or cognitive disability or mental illness, and this is known or reasonably should have been known to the suspect. To investigate using this line of reasoning:
  - find out if another person or agency has guardianship over the victim;
  - find out the type of guardianship;
  - identify if the victim is known as having an intellectual or cognitive disability or an active mental illness, and if that fact is either widely known or readily discernable? The investigation must support the fact that the offender knew that the victim was incapable of giving effective consent at the time of the assault.
  - Determine if there was forcible assault, meaning the victim did not give consent even if he/she submitted out of fear.

People with cognitive or intellectual disabilities can be forcibly assaulted and/or coerced or tricked into agreeing to sex. Even if the elements of force are not present, the officer must

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<sup>[2]</sup> Adapted from J. Archambault. (n.d.). *The preliminary sexual assault investigation*. Sexual Assault Training and Investigations (SATI).

establish whether the victim has the mental capacity to understand the sexual act and its consequences. Investigations resulting in a consent defense versus a question of the assailant's identity are different, requiring a totally different response from law enforcement officers.<sup>53</sup>

If the victim was forcibly assaulted and you anticipate a consent defense, focus on identifying evidence to corroborate the use of force, including an overturned table, suspect's history of preying on people with disabilities or adults in later life, victim's injuries; etc.

At times, a law enforcement officer must focus on whether or not an individual was able to consent under the law. There are no easy answers to this question. The book *A Guide to Consent* lists topics to consider in making an informed determination of capacity to consent. Some examples are:<sup>54</sup>

- Is the individual an adult as defined by law?
- Has the individual received sexuality education appropriate for their chronological age and learning ability?
- Does the individual have a basic understanding of sexual activities; birth control; pregnancy or sexually transmitted infections?
- Does the person recognize when someone is exploiting them or their disability?
- Can the individual differentiate truth from fantasy and lies? Are they capable of reasoning skills and thought processes that would enable them to engage safely in consensual sexual activities?

In Texas, physicians and psychologists certify whether or not a person has capacity to consent using standardized testing. If a victim with a disability or an adult in later life is in jeopardy of harm and should not remain in their current living environment, they may consent to go to a safe alternative living arrangement (temporary or permanent). However, an incapacitated victim (with a disability or in later life) may refuse to leave an unsafe living environment. If there is no legal guardian to provide consent (the authority of the guardian is sometimes limited in this area), the situation will require potential removal through Adult Protective Services intervention, mental health commitment, or order of protective custody.

Capacity to consent is a complex issue that requires careful, thoughtful consideration. An individual's capacity to consent is not static; it may change with education, life experience, health, and other factors.

## **Guardianship**

Some people with intellectual disabilities or adults in later life may have a guardian with full or limited guardianship. Less restrictive alternatives to guardianship include accessing community supports, having a Medical Power of Attorney, and engaging trusted others to assist with *supported decision making*. Disability or age alone is not a valid reason to declare an individual as incapacitated and in need of a guardian. Guardianship is a legal relationship between the following individuals: guardian—a competent adult, and ward—a minor or a person over the age of 18 who has a mental or physical disability that causes him/her to be considered

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<sup>53</sup> Ibid.

<sup>54</sup> Stavis, P.F. & Walker-Hirsch, L.W. (1998). Consent to Sexual Activity, R.D. Dinerstein, S.S. Herr & J.L. O'Sullivan (Eds.). *A Guide to Consent*. Washington, D.C. pp 57-67.

incapacitated as determined by a court of law. A judge makes a final decision based upon the arguments of an attorney, medical evidence, and other relevant information. A guardian is usually only given the right to make specific legal decisions limited to the areas where the ward is determined to be “incapacitated,” for example to give or deny informed consent for medical treatment; deciding where the ward will live; financial management; voting; etc. In Texas, guardianship is reviewed annually by the court.<sup>55</sup>

If the person has a guardian or Medical Power of Attorney, find out if they can consent to medical treatment and a forensic exam. If the individual is unable to tell you if they have a guardian or Medical Power of Attorney, ask the person who accompanied them or residential staff about the victim’s guardianship status. If the victim has a guardian, require written proof and review the legal documents detailing their guardianship status.

### **Investigations in Residential Settings**

In large and small institutional residences, power is firmly in the hands of the people running the facility at both administrative and direct care levels. Often policies developed under the guise of safety significantly limit people’s ability to make choices, have personal freedoms, and be their own advocate. As a result, residents may not know how to make choices or decisions for themselves, what their rights are, or how to advocate for themselves.

People living in residential settings may also have been denied education about personal safety and sexuality. The dynamics of institutional living can be very similar to those of family violence. For example, perpetrators may:

- say no one will believe the resident because they have a mental health disability or have been found unreliable in past reporting.
- threaten to or actually take away benefits and privileges if the person does not comply with behavioral expectations or if they make an outcry about abuses.

Abusive care providers are likely to be aware of the placement of security/safety cameras and where other staff works at any given time. An abusive staff member can also isolate the person in their bedroom or a bathroom. Institutional abuse also happens behind closed doors.

Victim services staff may help the person develop a safety plan. A safety plan is traditionally developed by a person who is at risk for or has experienced sexual abuse, caregiver abuse, or domestic violence and wants to have a concrete plan in place to increase safety or to avoid a violent confrontation. However, there are no guarantees that a person will be safe as result of safety planning.

### **Ensuring Accessible Services**

Two major laws impact the civil and legal rights of people with disabilities and adults in later life in the United States: The Americans with Disabilities Act (ADA) and The Older Americans Act (OAA).

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<sup>55</sup> N.J. Robbi and C.S. Mastroleo. (2005).

## **The Americans with Disabilities Act (ADA)**

The Americans with Disabilities Act (ADA) of 1990 prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications. . According to the ADA:

An individual is considered to have a "disability" if he or she 1) has a physical or mental impairment that substantially limits one or more major life activities, 2) has a record of such an impairment, or 3) is regarded as having such an impairment.

Major life activities include caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. To be substantially limited means that such activities are restricted in the manner, condition, or duration in which they are performed in comparison with most people. The ADA also protects people who are discriminated against because of their association with a person with a disability.<sup>56</sup>

Of the five ADA titles, Title II – Public Services and Public Transportation is the section that relates to law enforcement agencies, prosecutor's offices and other criminal justice system agencies. State and local governments cannot deny access to people with disabilities or deny participation in programs or activities that are available to people without disabilities. For more information about the ADA, visit [www.usdoj.gov/crt/ada/adahom1.htm](http://www.usdoj.gov/crt/ada/adahom1.htm).

People with disabilities and their service animals are also protected under the ADA. The ADA defines a service animal as “any animal that has been individually trained to provide assistance or perform tasks for the benefit of a person with a physical or mental disability which substantially limits one or more major life functions.” Abuse of service animals has been recognized as a violent tactic used by domestic violence perpetrators, and in Texas that abuse can be prosecuted.

For more information on “Commonly Asked Questions About the Americans with Disabilities Act and Law Enforcement,” visit [www.usdoj.gov/crt/ada/q%26a\\_law.htm](http://www.usdoj.gov/crt/ada/q%26a_law.htm).

## **Older Americans Act: Title VII Vulnerable Elder Rights Protection**

For nearly forty years, the *Older Americans Act* has expressed the nation's commitment to protecting older Americans. When the Act was reauthorized in 1992, Congress created and funded a new Title VII, Chapter 3 for prevention of abuse, neglect and exploitation. Title VII Vulnerable Elder Rights Protection also includes provisions for long term care ombudsman programs and state legal assistance development. In the most recent amendments of 2000, Congress called on states to foster greater coordination with law enforcement and the courts. As the years have gone by, Title VII Vulnerable Elder Rights Protection has proven instrumental in promoting public education and interagency coordination to address elder abuse. Title VII is designed to serve as an advocacy tool. In 2001, ombudsmen investigated 264,269 complaints against nursing homes and other adult care facilities. In the area of legal rights, Title VII includes

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<sup>56</sup> U.S. Department of Justice. (n.d.) *Commonly asked questions about the Americans with Disabilities Act and law enforcement*. Retrieved March 11, 2016, from [www.usdoj.gov/crt/ada/q%26a\\_law.htm](http://www.usdoj.gov/crt/ada/q%26a_law.htm)

a provision for a legal assistance developer in each state to serve as a focal point at the highest state level for all aspects relating to legal services for the elderly. For more information, visit [www.ncea.aoa.gov/](http://www.ncea.aoa.gov/)

More recently, the Elder Justice Act was signed into law in 2010. It provides authority for:

1. highlighting critical issues through citizen participatory advisory councils;
2. enhancing Adult Protective Services programs and data; and
3. improving quality of care in nursing facilities through enhancements to the Long-Term Care Ombudsman Program, establishing a system to report crimes in nursing homes, and assisting States to implement criminal background check programs for employees with direct access to patients.<sup>57</sup>

### **Ensuring Accessible Response to Crime Victims with Disabilities**

Effective communication is essential to responding, investigating, building a case, safety planning and ensuring that all domestic/sexual violence victims have equal access to the justice system. The following suggestions are for working with crime victims with specific disabilities. These are general suggestions only. Individuals will have different preferences regarding how they wish to be treated. When in doubt, ask the person what they need.

#### **Accessible Responses to Victims with Intellectual-Developmental-Cognitive Disabilities**

Do not assume that the individual understands your role, why they are there, or what the “problem” is, especially if the perpetrator is someone they have known and trusted over time. You may have to explain which law was broken, why that law exists, and why you (and others) are now involved.

The victim may fear that they made a mistake. You may need to let them know that they did nothing wrong and will not go to jail. Individuals with intellectual or cognitive disabilities often have very structured routines. Having this routine broken can be upsetting, especially when the person has experienced a potentially traumatic crime and is answering the questions of strangers. Watch for signs that the person’s ability to pay attention and cooperate are lessening. These signs can include shifting eyes, repetitive movements or comments, lack of attention and/or shifting position. It may be helpful to suggest a break.

- Use short sentences with plain and concrete language.
- Break questions or instructions into smaller parts. Ask only one question at a time.
- Ask for concrete details. Instead of, “What did he look like?” ask, “What color was his hair?” Instead of, “When did this happen?” ask, “Did this happen before or after you ate dinner?” Or ask questions like: “What did you see when you were in the car going to the lake?” “What kind of food did you have?”
- Perpetrators may use “code words” for illegal behavior. Typical code words are words for games, daily activities, or sometimes activities in which the victim most likely does not have the opportunity to participate, can include: *exercising; swimming; playing doctor*. Ask the victim to explain or show how they did the activity.

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<sup>57</sup> Greenly, K. (2011). *Statements on elder rights and the Older Americans Act*. U.S. Department of Health and Human Services. Retrieved March 11, 2016 from [www.hhs.gov/asl/testify/2011/08/t20110823a.html#](http://www.hhs.gov/asl/testify/2011/08/t20110823a.html#)

- Use of visual aids including anatomical dolls or communication boards, may be helpful.
- People who do not use speech likely have other methods of communicating.
- Allow the person time to understand and answer your questions.
- Have written materials available in “basic” reading levels.

### **Accessible Responses to Crime Victims with Physical Disabilities**

- The individual with the disability is the expert about what he/she can or cannot do.
- Be respectful of personal space, which includes wheelchairs, other mobility aids or assistive devices. Do not lean on, touch or move any of these items without permission.
- Sit when speaking to someone who uses a wheelchair so you are at their eye level.
- If you call the individual at home, remember that it may take longer for him/her to get to and answer the phone.
- Ask the person if they have reliable transportation. Some people may drive their own accessible vehicles; rely on public transportation or accessible transit services; or volunteers may drive them. Offer transportation vouchers if possible.
- If the victim’s mobility aid (e.g., wheelchair, walker, scooter, cane) needs to be kept as part of evidence collection, consider how you will help the individual obtain a suitable, alternate mobility aid. Avoid keeping their mobility aid if at all possible.
- If the crime involves a personal care assistant, the victim may need referrals to home health services or to alternate accessible housing.

### **Accessible Response to Crime Victims with Mental Illness**

- Your level of comfort is important when communicating with a victim who may be in mental health crisis. Be aware of your posture, eye contact and personal space. Remain calm and ask the person how you can help. Listen to their responses and suggestions.<sup>58</sup>
- Structure meetings. Before each appointment, let the individual know the agenda—what you will talk about, do, and for how long. As much as possible, keep to that agenda. Keeping your word will help establish trust.
- Be direct and clear about who you are, your role, and how you fit into the process.
- Create a safe environment. Respect the individual’s personal space by refraining from touching or crowding him/her.
- If the crime victim is agitated or angry, do not crowd. Closing in on personal space can be experienced as threatening and result in defensive traumatic stress responses (fight, flight and freeze).
- Provide seating options that allows the person to face the door. Keep a path to door open.
- Keep your language simple. Ask open-ended questions and be prepared to repeat yourself if necessary.
- Make eye contact in a friendly manner, but be aware that eye contact may be difficult for some people with mental health disabilities.
- Take cues from the individual, and be flexible in adapting your communication style. If the victim is having trouble processing information or sounds, use clear, simple and direct communication.<sup>59</sup>
- Be honest. People with mental illness may be suspicious of strangers. A small lie that you think might be in the person’s best interest may be detrimental to establishing trust.

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<sup>58</sup>SafePlace. (2000). *Strategies for working domestic violence survivors with mental illness*. Austin, Texas.

<sup>59</sup> Ibid.

- Some persons with schizophrenia or depression may be fearful when doors are closed or conversations are held away from their full range of hearing. If you must take a phone call or have a conversation with another person, explain the context.
- A hallucination is seeing, hearing, smelling, touching or even tasting something that is not real. Most hallucinations are auditory. If a person is having a hallucination, do not confirm or deny the reality of the hallucinations. Try to gently shift the focus back to the task at hand. If the hallucination is obviously upsetting, let the person know that you can understand that they are scared. Sometimes a brief change in activity or shift in focus can help the individual to overcome or ignore the hallucination.
- A delusion is a firm belief in something, despite strong evidence against it. An example is a person believing they are the president. As with hallucinations, do not argue with delusions or try to talk a person out of them. Continue to shift the focus back to your questions.
- Know medications to treat mental illness. If you need more information about the person's treatment plan or possible medication side effects, consult with the individual or ask for their consent to contact their doctor or mental health worker/therapist.
- Medications can cause observable symptoms often associated with a mental illness. Whether prescribed for a diagnosed mental illness or another condition, some drugs can produce symptoms similar to those exhibited by a person with mental illness (e.g., tremors, dry mouth, excess salivation, or shuffling gait).
- Know who to contact for additional assistance. Obtain the numbers for your local mental health related resources, always keeping confidentiality when contacting any outside agency.

### **Accessible Response to Crime Victims with Visual Disabilities**

- Identify yourself when you enter the room and let the person know when you leave. Also, identify others by name as they speak, come and go.
- Speak directly to the person and use their name. When addressing others who are present, use their names and ask them to speak so that the person will be able to recognize voices, follow the conversation, and know when they are being addressed.
- If the person requests assistance, ask how you can help. Some people who are blind use canes to aid mobility, and some walk holding the outside elbow of a companion. Let the person instruct you on what to do.
- When guiding the person, provide him/her with details as to any obstacles on the floor, walls, or hanging from ceiling.
- Have written materials available, or know how to readily obtain or produce materials, in the following alternate formats: large print, rich text, Braille, CD.
- Offer to read materials aloud. This is especially important for posted information that is intended to be read and understood by all victims.
- Do not touch service animals without permission. Service animals are not to be petted when they are working. Do offer to get water or to help find an area for relief area for the dog, if needed.

## **Accessible Response to Crime Victims who are Deaf**

- Ask the person's preferred method of communication. If they prefer a sign language interpreter, ask which language – most likely American Sign Language (ASL) – and follow your agency protocol for obtaining an interpreter.
- Do not use family members (especially children), or a professional who is present in another capacity (i.e., using a classroom teacher to assist with communication). Use of a non-certified interpreter may make information inadmissible in court, and asking a child to interpret their parent's abuse is unethical. If you must use a non-professional to assess safety, restrict questions to asking if the offender is on the premises, if the offender has a weapon, and if the victim needs medical attention. Wait for a professional interpreter to ask questions about the crime.
- Use only a certified interpreter, bound by the interpreters' Code of Ethics, who has at least Level IV Certification.
- When using an interpreter, make eye contact with and speak to the Deaf individual directly, not to the interpreter. Speaking directly to or asking the interpreter questions is considered rude. The interpreter's task is to be the communication liaison between you and the person who is Deaf. They will interpret everything that is said in the room, even side conversations.
- To attract the person's attention, move to a location so that you can be seen, then lightly tap him/her on the shoulder, flick the lights, or wave.
- Unless the individual has indicated speech-reading and/or writing as his/her preferred means of communication, do not rely on these methods.
- If the person indicates speech-reading as a preferred means of communication, speak as you would typically, make sure you are in a well-lit place, and keep your mouth free of distractions. Speech reading is an imprecise method of communication, and much of what you say will be inferred, not directly understood.
- If the person indicates writing as preferred communication, keep your messages short and to the point. Although most Deaf people can write and read English, ASL is usually their first and primary language, and the grammar/syntax for English and ASL is different. For example, in English, a sentence might read "What was the perpetrator wearing?" In American Sign Language (ASL), the best word-for-word written translation might be: "Ask—That man hurt you—his clothes what color what look like clothes?" As another example, in English: "How long have you and your husband lived together?" In ASL: "You with husband same house live—how many months years?"
- People who are Deaf may nod during conversation to indicate that they are paying attention. If you are unsure whether the individual understands you, ask.
- When responding to a domestic violence call, be sure to communicate with the individuals separately before determining what happened or who should be arrested. The abuser may try to take advantage if they have better communication skills. A Deaf victim who has just experienced a traumatic event may sign assertively, use strong gestures, or vocalize. An abuser who can hear may try to convince the officer that this behavior is indicative of aggression.
- Ensure that the victim and the alleged abuser are sufficiently separated so that one cannot see the other. Remember, sign language is visual. If the abuser is fluent in sign language and can see the victim's or the interpreter's hands, they can also understand what is being communicated. Alternatively, the abuser may use signs or facial expressions to threaten



the victim in a way that law enforcement personnel may not understand. When separating the parties, make sure that they cannot see each other.

### **Accessible Response to Crime Victims with Communication Related Disabilities<sup>60</sup>**

- Prior to the appointment, find out how the victim most effectively communicates.
- Methods for communication include computers or communication devices with voice synthesis, as well as “word boards” and “picture boards.” Use of these devices may be time consuming, but can provide an investigator with accurate information. However, sometimes these devices may not contain all relevant vocabulary for reporting abuse.
- Do not try to finish the individual’s sentences or thoughts. If the person’s speech does not reflect their affect or feelings, ask them “How did you feel about that?”
- If you do not understand the individual, say so. Ask the person to repeat or rephrase. Try repeating back what you heard for confirmation. If this is not effective, ask how best to communicate. Ask the person if there is someone who might assist. Carefully consider whether this other party may have an involvement in the crime, or whether their own opinion may influence their “interpretations.”
- Use “yes” or “no” questions when other methods do not work.
- Adapt to the individual’s vocabulary.
- Some individuals use non-verbal communication like eye or head movements to indicate “yes” or “no.”
- If you have difficulty understanding the person over the phone, ask if you can use Speech-to-Speech Relay Services (877-826-6607) for phone conversations.
- Know what options exist for accommodating a person with a communication disability so that interviews will meet admissibility guidelines for court.

### **Accessible Response to Crime Victims Who Have Alzheimer's Disease<sup>61</sup>**

- Approach crime victims from the front, and establish and maintain eye contact. Introduce yourself as a law enforcement officer and explain the reason for your encounter.
- Ask for identification (e.g., driver’s license). Check for a *Safe Return* bracelet, necklace, etc. *Safe Return* identification provides the first name of a person bearing this ID, indicates that he or she has a memory impairment, and gives the 24-hour toll-free number for the Alzheimer's Association's *Safe Return Program*. The program includes a nationwide participant registry that contains the full name of the registrant, a photograph, identifying characteristics, medical information, and emergency contact information. When you call the program's crisis number at 1 (800) 625-3780, a *Safe Return* clinician will contact the registrant's care providers.
- If the individual was found wandering and is not registered with the *Safe Return Program*, encourage their care provider to register the individual.
- Remove the person from crowds and other noisy environments, as this can cause restlessness, pacing, agitation, and panic. Also, turn off your car's flashing lights and lower the volume on your radio.
- Establish one-on-one conversation. Talk in a low-pitched tone of voice. Speak clearly, using short, simple sentences with familiar words. Repeat yourself. Accompany your words with gestures when this can aid in communication, but avoid sudden movements.

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<sup>60</sup> N.J. Robbi & C.S. Mastroleo. (2005).

<sup>61</sup> Office for Victims of Crime (2001). *First response to victims of crime: A handbook for law enforcement officers*.

- Alzheimer's shortens attention span and increases suspicion. Your calm demeanor and including the crime victim in the conversation can make them less agitated and panicked.
- The crime victim may not understand you, answer your questions and comply with your instructions. Give simple, step-by-step single instructions. For example, "Please sit here." You can also substitute nonverbal communication by sitting down if you want the person to sit down.
- Ask one question at a time. "Yes" and "No" questions are better than questions that require the crime victim to think abstractive or recall event sequences. Be prepared for answers that are confusing and keep changing. If the person's words are unintelligible, ask them to point, gesture, or otherwise physically communicate their answer.
- Never argue with the crime victim or challenge his/her reasoning.
- If you identify possible triggers to distressed or confrontational behaviors, document them so other professionals will know to try to avoid such triggers.
- Do not leave the crime victim alone. They may wander away.

### **Safety Planning**

Safety planning is the process of helping victims reduce the risk of future incidences of violence and maximize safety. Safety planning involves identifying risks, the person's routines, their resources and strategies to increase safety. Begin by discussing the victim's overall safety at home, work, school, during explosive incidents, when preparing to leave the abusive relationship, when there is a protective order, etc. This strategizing can be in addition to providing extra patrol coverage where the victim lives or offering wellness checks. If the abuser is in jail, request an additional hold period if possible so the victim has time to relocate to a safe place. If the abuser is arrested, let the victim know how to request an Emergency Protective Order. Notify the victim if the abuser has been arrested or is going to be released from jail.

Safety planning is individualized and revolves around the victim's own choices and decisions. The ideas below are example topics to discuss during safety planning. Avoid strategies that might alert the perpetrator and put the victim in more danger.

#### **General safety planning strategies:**

- Listen and validate that the abuse is not the crime victim's fault. Allow for a safe space for the person to process feelings.
- Assist the victim in assessing their level of potential danger.
- Respect the individual's decision to stay in or leave an abusive relationship.
- Protect the dignity of all crime victims by including them in decision-making conversations in their presence.
- If the individual needs to be transported to the hospital, shelter or other safe location, check that he/she has identification and all necessary medication, medical equipment, insurance papers, etc.
- An adult in later life may not feel comfortable in a domestic violence and/or rape crisis center shelter because of the chaotic and noisy environment. Ask if there is a friend or family member who can provide safe shelter. Check if they have any other support network (e.g., church, mosque, synagogue volunteers).
- If the person uses a home health care agency or requires personal attendant, plan for continuity of services.

- Suggest that the person obtain a lifeline pendant/ medical alert alarm button if they don't already have one. This personal emergency response service calls for help at the touch of a button. It is often used to help people continue to live independently, but also to help support people in situations where they need assistance.
- Victimization is not a sign that the person cannot live independently and needs to be moved to an institution. Provide resource information for social services and other resources.
- Provide the person with accurate information, offer alternative options, refer to local resources, work with aging experts, and support victims to make their own choices and decisions.
- Referrals may be appropriate. If the person needs round-the-clock care or other services, call:
  - Texas Department of Aging and Disability Services/Primary Home Care Program at 1-855-937-2372 or online at [www.dads.state.tx.us/providers/phc/](http://www.dads.state.tx.us/providers/phc/)
  - Adult Protective Services at 1-800-252-5400 or [www.txabusehotline.org](http://www.txabusehotline.org) or [www.dfps.state.tx.us/adult\\_protection/](http://www.dfps.state.tx.us/adult_protection/)
  - Locating the name(s) of the local APS supervisors may expedite APS services.
  - The Eldercare Locator can be contacted at 1-800-677-1116 or through [www.eldercare.gov](http://www.eldercare.gov). They will assist in finding services for adults in later life and their families in your area, including the local Area Agency on Aging. The Area Agency on Aging offers a variety of services to adults in later life, including information and referral and home support services. It also has a category for Aging & Disability Resource Center.

**Safety planning with crime victims who are thinking about leaving an abusive situation:**

- Plan for assistance with personal care tasks. If the person receives Medicaid/Medicare and is low income, they may qualify to receive personal care services from the Texas Department of Aging and Disability Services/Primary Home Care Program.
- Keep any vehicle in good condition and the tank half full of gas, in case the person needs to leave quickly. If they don't drive, they may want to apply for special or para-transit services, if available, so they have transportation options.
- If the abuser is the payee on their Social Security Income/Social Security Disability Income benefits, the abuse victim may wish to change the payee to themselves or someone they trust. Explore how to do this without alerting the abuser, as this could pose further danger.
- Suggest that they plan to have access to needed equipment, medications, and identification if they decide to leave.
- Provide contact information for a domestic violence program or shelter. If the person has a disability, suggest that they share what their needs are and inquire about accessibility for themselves and their care provider or service animal (if relevant). If a crisis agency refuses access to the individual with a disability or their service animal, they can call:
  - Disability Rights Texas at (800) 252-9108 or submit an online request at [www.disabilityrightstx.org/](http://www.disabilityrightstx.org/)

- Americans with Disabilities Act information line at 1- (800) 514-0301 (voice) or 1-(800) 514-0383 (TTY). See [www.ada.gov/infoline.htm](http://www.ada.gov/infoline.htm) for more information.
- Inquire if they have a plan to take supplies and documents.
- The individual knows their abuser best. Remind them to use the steps that make sense for their personal situation. If something does not feel safe to the individual and might put them or their children in further danger, encourage the crime victim to trust their own instincts.

In the event your law enforcement agency is unable to provide comprehensive safety planning, know where to refer a victim so that he/she can receive this potentially life-saving information. The National Domestic Violence Hotline (NDVH) can refer individuals to local crisis centers that provide comprehensive safety planning. The hotline is 1-(800) 799-SAFE (7233) (voice) or 1-(800) 787-3224 (TTY). NDVH also provides an online chatroom at [www.thehotline.org](http://www.thehotline.org)

The Rape, Abuse and Incest National Network (RAINN) can be contacted at 1-(800) 656-HOPE (4673) to link individuals to the nearest rape crisis center. RAINN also provides an online service at <https://ohl.rainn.org/online>

### **Texas Laws**

Law enforcement personnel shall be familiar with the following laws as it relates to crime victims with disabilities. Please consult the relevant codebook for the most complete information.

Hate Crime Statistics Act P.L. 101-275, 104 Stat. 140, 1994  
People with disabilities were added to the list of hate crime victims.

#### Texas Penal Code

Title 5. Offenses Against the Person

Chapter 22. Assaultive Offenses

P.C. §22.04. Injury to a Child, Elderly Individual, Or Disabled Individual

Title 9. Offenses Against Public Order and Decency

Chapter 42. Disorderly Conduct and Related Offenses

P.C. §42.091. Attack on Assistance Animal

#### Texas Human Resources Code

Chapter 48. Investigations and Protective Services for Elderly Persons and Persons with Disabilities

#### Texas Health and Safety Code

Chapter 242. Convalescent and Nursing Facilities and Related Institutions

This chapter was revised in 2016 by Dianne King and Michelle Schwartz of SafePlace, a partner agency of SAFE, located in Austin, Texas. The original chapter was prepared by Cema Mastroleo, Wendie Abramson, and Dianne King of SafePlace. For additional information on this topic or to obtain information on the “Responding to Violent Crimes Against Persons with Disabilities” resource, contact SAFE at (512) 267-7233 or visit their website at [www.safeaustin.org](http://www.safeaustin.org).