

MEETING THE NEEDS OF CRIME VICTIMS WITH DISABILITIES

1. INTRODUCTION

According to the U.S. Department of Justice, there are approximately 43 million individuals with disabilities in the United States (Rubin, 1993). There are many issues facing crime victims who are disabled. For those who are not disabled before a crime, trauma is exacerbated when they become disabled as a result of their victimization. The Crime Victims with Disabilities Awareness Act (1998) states that individuals with disabilities are at greater risk of being victims of violence.

The risk of being physically or sexually assaulted for adults with developmental disabilities is estimated 4 to 10 times higher than it is for other adults (Sobsey, 1994). Increased vulnerability can be partially attributed to communication difficulties, mobility limitations, or dependence on caregivers.

In many situations with both disabled and non-disabled persons, the victim's family or caregiver may be the perpetrator of the assaults, abuse or neglect. Persons with severe disabilities are particularly at risk to such victimization. Victims who are dependent on their abuser are even more reluctant than others to repeat victimization when compared to non-disabled victims of crime.

Non-institutionalized Americans with disabilities often lack assistance in the aftermath of criminal victimization, and most will not seek assistance from either legal or treatment services. Thus, they may experience increased physical or social isolation as a result of their victimization.

Developmentally, disabled persons often have a strong, involved network of service providers and caregivers e.g., family, physical and occupational therapists, and case managers. It is important for clinicians to collaborate and consult with existing providers, to obtain an understanding of the client's disability and needs and any existing treatment that is occurring, as it might be relevant to the mental health treatment being provided. Additionally, these individuals can take an active role in the treatment process, e.g., helping to implement treatment goals. When necessary, clinicians should refer clients for a full assessment of cognitive and physical functioning. This can often be coordinated with existing caregivers.

2. UNDERSTANDING DISABILITY DOMAINS

When working with a disabled person it is helpful to develop an understanding about the client's specific disability. treatment should be oriented to the client's cognitive and physical abilities.

Baladerian (1998) describes disabilities as occurring in six major domains:

1. **INTELLIGENCE** disabilities related to intelligence include amnesia, mental retardation, learning disabilities, organic brain syndrome, other brain damage or developmental impairment.
2. **COMMUNICATION** disabilities include aphasia, autism, cleft palate, speech production impairment and language processing impairment.
3. **SENSORY** disabilities include deafness, hearing impairment, blindness, visual impairment, deaf and blind, mute and absent pain awareness.
4. **MOTOR** disabilities include Cerebral Palsy, Muscular Dystrophy, and other central Nervous System impairments.
5. **SOCIAL** disabilities include Autism, Schizophrenia, and Personality Disorders.
6. **PSYCHIATRIC** disabilities include personality disorders, thinking disorders such as psychosis, clinical problems include depression, anxiety, and dissociative disorders.

3. **INSTITUTIONAL BARRIERS TO OBTAINING ASSISTANCE**

Persons with disabilities have historically been perceived as “suffering” and as the deserving recipients of “charity.” Until the Americans with Disabilities Act (ADA, 1990), paternalization and charity were often the substitute for civil rights protection for persons with disabilities. People with disabilities continue to be perceived as lacking the ability to make competent choices in all spheres of their lives. Many citizens avoid persons with disabilities for fear that the stigma of a disability will be contagious. Deviations from the physical and sensory norms of self-sufficiency in all spheres and mobility frighten many in the “able-bodied majority” who provide the definition of “normal.” Baladerian (1998) explains that until the recent inclusion movement, the life experience of persons with disabilities has consisted of segregation from not only the general community, but also generic programs including schools, transportation, health/mental health centers, abuse-response agencies and rape treatment centers. General information about the community, in which they live, is not learned through “osmosis” as it is with the non-disabled population. As a result, information about the services around them is unavailable.

Few victim assistance programs are designed to meet the needs of individuals with disabilities (National Institute of Justice, 1998). Services for victims with disabilities were largely overlooked on the national level until the 1990 passage of the Americans with Disabilities Act (ADA). The ADA required states and organizations receiving public funding to make their services accessible to all persons. Since then there have been several efforts to provide information to state and local criminal justice agencies and victim assistance programs on achieving ADA compliance (National Institute of Justice, 1998). However, mental health treatment programs with staff whom are knowledgeable about disability issues are limited. This includes a lack of inpatient and residential treatment programs that are equipped to accommodate and understand the needs of persons with disabilities.

Some of the issues confronting crime victims with disabilities are similar to those affecting all crime victims. These include the following: under reporting of crimes, the perceived lack of credibility of the crime victim, corresponding lack of responsiveness by law enforcement and/or prosecutors. Additionally, people with disabilities and non-disabled victims may lack the strength, stamina, and resources to interact with the criminal justice system or available resources.

Issues of credibility are an area of concern, especially among persons with speech impairments and mental cognitive disabilities. As an example, a telephone intake worker may attribute slurred speech as someone on drugs or alcohol, and not consider the possibility of a speech impairment or cerebral palsy. Some slow learners or persons with emotional issues might not track a conversation on the phone very well and, therefore, tend to be dismissed by phone workers, law enforcement officials, court officials and emergency personnel. Consent can also be a difficult area as well. Individuals with cognitive disabilities are often agreeable by nature and may be quick to provide their consent. In addition, disabled persons have frequently been taught by service providers to be compliant. This could result in the provision of consent, without awareness of the implications. In sexual abuse cases, determining the victim's understanding of consent can be a complex and challenging process.

4. TREATMENT ISSUES

Crime victimization may significantly alter the lives of victims with and without disabilities. Appropriate support and treatment can help victims reconstruct their life. This section will make general treatment recommendations for serving victims with disabilities. The Violent Crimes Compensation Board (VCCB, 2000) guideline on initial response, assessment and documentation procedures and the guideline on advocacy services also provide useful information about providing assistance to crime victims, as do the other VCCB treatment guidelines dealing with clinical conditions known to affect crime victims.

Examples of Appropriate Terminology (Based on Baladerian, 1998)

Inappropriate Language

handicapped, the disabled, crippled
the wheelchair or wheelchair bound
mentally retarded

Preferred Language

person with a disability
wheelchair user
slow learner

Preparation for Working with an Individual with a Disability (Based on Baladerian, 1998)

A. When preparing for working with an individual with a disability:

1. Focus on how you are alike.
2. Consider the concept of TAB (we are all temporarily able bodied).
3. Employ therapeutic empathy.

B. Psychological Aspects of Treatment:

1. Prepare the client for the interview.
2. Focus upon knowledge as power for the client.
3. Maintain awareness of the client's possible limited reading ability.
4. Be aware of the client's need to be accompanied, or pressure on the victim to be accompanied.
5. Treat the client with dignity and respect, irrespective of their cognitive or physical impairment.

C. Identify Practical Aspects of treatment:

1. Assess the need for an interpreter (due to speech production differences, use of assistive technology, facilitated communication, sign language, language processing impairments).
2. Become familiar with the ethics of practice while using an interpreter, for example, know how to access and hire an interpreter (**please refer to the VCCB guideline on utilization of interpreters, 2000**).
3. If appropriate with deaf clients, utilize a note pad and pen to communicate. Also inquire about whether the client uses any assistive hearing devices.
4. If the client takes medication, make sure it has been administered prior to the interview if necessary.
5. Prior to the session know if the client has a conservator who makes decisions regarding care and removes or affects your legal authority to conduct the interview. if your client is determined to be incompetent, or is a dependent adult (e.g., has a protective payee or guardian), make sure you are familiar with the laws regarding these issues.
6. Consider the applicability of:
 - a. Evaluating the potential physical barriers associated with accessing the building, e.g., entering the building, getting to the office, using the bathroom, public telephone and drinking fountain.
 - b. The accessibility and sensitivity of the interview setting. Ensure sufficient room to maneuver for those using wheelchairs, scooters and other assistive devices, and adequate space for all persons present.
 - c. Reducing if not eliminating noise and visual stimuli that could be distracting.
 - d. The accessibility of literature:

- i. Are materials easy to read e.g., large print, simple language (third grade reading level is recommended), and in the language of the client?
- ii. Are brochures free of staples?
- iii. Do brochures may flat when open?
- iv. Can literature be translated into Braille or put on tape if necessary?
- v. Are consents available on tape as well as in written form(s)?

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