

Disability Justice Initiative
Technical Report #1: Review of the Literature

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Abstract

There is a growing number of crimes against people with disabilities, however, these crimes are mostly unreported. This review of the literature highlights the type of crimes most often committed against people with disabilities, in particular mental retardation and mental illness. This report spotlights the common perpetrators, and outlines factors that make people with disabilities more vulnerable than the general population. Also examined is the role of people with disabilities as perpetrators of crime and the factors that make them more susceptible to arrest and incarceration. Specific types of programs that promote positive interaction between police and people with disabilities are also discussed.

There is a growing number of crimes against people with disabilities in our society (Petersilia, n.d.). According to research, most people with disabilities will experience some form of sexual assault or abuse during their lifetime (Sobsey & Varnhagen, 1989). People with significant disabilities experience serious crime at a rate four to ten times higher than the general population (Pease, 2000). The 1990 census data estimate 6.2 to 7.5 million people (2.5 to 3 percent of the general population) in the United States have mental retardation (The Arc, 1982). The rate of sexual assault is 10.7 times higher for people with mental retardation than for the general population and 12.7 times higher for robbery. Studies have found that over 80% of women and 30% of men with intellectual disabilities have been sexually assaulted. Even more alarming is that 80% of those women who have been sexually assaulted have been assaulted more than once and 50% have been assaulted more than 10 times (Sobsey & Doe, 1991; Sorenson, 2000). Despite the high rate of crime against this group, there is limited information, expertise, and services available to women with developmental disabilities (Johnson, 2000).

What is just as disturbing is that so few of these crimes are reported. A study by Wilson and Brewer (1992) found that 40% of the crimes against people with mild mental retardation went unreported to the police, and 71% of those against people with severe mental retardation went unreported. Action cannot be taken by police, prosecutors, or the courts, if they are not informed. There is a widespread notion among people with disabilities, their families, and advocates, that reporting crimes may be useless (Sorenson, 2000). Sometimes when the crimes are reported, they are not believed. There is also a

widespread belief among prosecutors, jurors, and judges that the testimony of victims or witnesses with disabilities will not be deemed reliable in court (Johnson, 2000; Petersilia, n.d.; Sorenson, 2000). This belief is more of a continual stereotype than an actual reality. A study completed by Nitza Perlman (as cited in Sorenson, 2000) compared the testimony of adults with intellectual disabilities to university students. The study found that the testimony of both groups was equal in accuracy. Other research suggests people with autism and mental retardation often have very good memories. After viewing videotapes or live staged events depicting crimes, persons with developmental disabilities were as competent as people without disabilities when it came to remembering details of the crimes (Henry, L.A. & Gudjonsson, G.H., 1999). These studies support the notion that cases involving victims or witnesses with intellectual disabilities can be successfully prosecuted with the right skills, attitudes, and accommodations. Unfortunately, many times when criminal convictions do occur, sentences for crimes committed against people with disabilities are lighter, particularly for sexual assault (Petersilia, n.d.).

Certain characteristics have been identified that create vulnerability to victimization in people with disabilities (Petersilia, n.d.). Severe level of functioning and four maladaptive behaviors (categorized as violent, disruptive, rebellious, and hyperactive), were found to be significantly related to abuse status (Zirpoli, Snell, & Loyd, 1987). The desire to please others and be accepted often leads to behavior they may not otherwise engage in. A feeling of powerlessness also plays a role when the perpetrator is a caregiver. When a person is dependent on the abuser for food and other essential needs, that dependency deters him or her from resisting or reporting the abuse. Most people with developmental disabilities do not have reliable access to transportation,

few have received sex education, and many lack the communication skills to report the abuse. According to the literature on domestic violence, a key predictor of victimization is social isolation and lack of social support, both of which are factors for people with developmental disabilities (Johnson, 2000).

Most workers in the criminal justice system do not know what mental retardation is or how to recognize it; therefore they do not have the skills to communicate and interact effectively with people who have mental retardation (Davis, 2000; Petersilia, 2000; Reynolds, 1995). Without being identified as having mental retardation, victims do not receive the support they need to navigate through the complex justice system and an offender's disability is not taken into account if and when it comes to sentencing.

Some responses that are common among people with mental retardation may effect their ability to protect their own rights during encounters with police or other criminal justice personnel (Reynolds, 1995):

- The person may not want their disability to be recognized and may try to cover it up.
- The person may not understand rights, but pretend to understand.
- The person may not understand directions.
- The person may be overwhelmed by police presence.
- The person may act upset at being detained and/or try to run away.
- The person may say what he or she thinks others want to hear.
- The person may have difficulty describing facts or details of the crime.
- The person may be the last to leave the scene of the crime and the first to get caught.

- The person may be confused about who is responsible for the crime and “confess” even though innocent.

Although the 911 emergency service falls within the governmental regulations for the Americans with Disabilities Act, this service is inadequate to some people with disabilities who have limited communication skills. Specific situations involving 911 operators and responding officers who have not recognized seizure activity and autism associated with mental retardation have resulted in significant harm and even death to people with disabilities (Ransom & Madrid, 2000).

Lack of awareness of autism resulted in the death of a man in Nashville when police responded to an incident. Circumstances which involved poor judgment on the part of the man’s personal care worker resulted in the man becoming agitated in a public place. Police used pepper spray and restrained the man using handcuffs and a cloth strap around his ankles. He was placed face down on the ground where he continued to struggle and then vomited (Debbaudt, 2000). If the service agency and the police officers had been properly trained they may have been able to use less invasive techniques to calm the man.

With proper training, these situations could have likely been avoided or safely de-escalated. Even for medical emergencies, police officers are often the first to arrive at the scene when a call to 911 is made, making training for officers in the field a necessity.

Perpetrators

Most perpetrators of crimes against people with disabilities are caregivers (Sobsey, 1994). They are in a position of power over the people whom they provide services to. This is also one of the reasons for the high number of repeated sexual assaults

again women with developmental disabilities. The caregivers are in a position to pressure the women to remain silent and then continue to victimize the women under their care. One study found that an alarming 44% of all offenders against people with disabilities made initial contact with their victims through the network of services provided to people with disabilities (Sobsey, D. & Doe, T., 1991)

Offenders with Disabilities

Research has also examined the role of people with mental retardation as offenders. Beginning with the desinstitutionalization movement in the 1980's, people with mental retardation have had an increasing number of opportunities to become involved with the criminal justice system. People with developmental disabilities comprise 2%-3% of the general population, but represent 4%-10% of the prison population (Petersilia, 2000). Although there is no link between mental retardation and criminal behavior, there is a greater likelihood that someone with mental retardation will be caught if involved in criminal activity. People with mental retardation can easily be persuaded to participate in illegal activity or to take the blame for something they may not have been responsible for. After entry into the criminal justice system, they are more likely than people without disabilities to be convicted, sentenced, and then victimized within the prison (Petersilia, 2000; Santamour, 1986).

Petersilia (2000) identifies several variables that make people with mental retardation more susceptible to arrest and incarceration. Offenders with MR generally come from low income groups where police presence is more prevalent, they are unlikely to meet the criterion for bail which includes employment and having an intact support system. They often do not fully understand their rights and are likely to waive them, they

are likely to give answers they believe the police want to hear rather than an accurate account of what really happened, and they are less able to help prepare their own defense. As with victims who have mental retardation, offenders are often not identified as having a disability, and therefore not provided effective support to negotiate through the criminal justice system. McAfee and Gural (1988) found that 75% of offenders with mental retardation were not identified as having a disability at arrest, and more than 10% were not identified until they were in prison.

There are numerous examples in the literature of people with mental retardation confessing to crimes they did not commit. A Missouri man confessed to murdering an elderly woman even though he was seen with his mother at the grocery store at the time of the crime. He is serving a life sentence without parole (Perske, 1994). In the state of New York a man confessed to killing his brother, even though trial evidence showed that the brother died in his sleep (Perske, 1991).

There are also many cases in which people with mental retardation did commit the crimes to which they confessed. However, even in these cases, the confessions came faster and easier than those from the average suspect. Perske (1994) has followed numerous cases involving suspects who have mental retardation, he offers the following explanations for the types of responses often made by people with mental retardation.

- Relying on authority figures for solutions to everyday problems.
- The desire to please people in authority.
- The inability to abstract from concrete thoughts.
- Watching for clues from the interrogator.
- Longing for friends.

- Relating best with children or older persons.
- Plea bargaining of accomplices.
- Bluffing greater competence than one possesses.
- An all-too-pleasant façade (smiling to get approval might be mistaken for lack of remorse)
- Dislike of the term mental retardation.
- Real memory gaps.
- A quickness to take blame.
- Impaired judgment.
- Inability to understand court proceedings, assist in one's own defense, and understand the punishment.
- Problems with receptive and expressive language.
- Short attention span.
- Uncontrolled impulses.
- Unsteady gait and struggling speech.
- Seeing people with disabilities as less than human.
- Exhaustion and the surrender of all defenses.

Mental Illness

The literature also raises concern regarding the treatment of people with mental illness during interaction with the criminal justice system. Several factors have increased the likelihood of police encounter with people with mental illness, including deinstitutionalization, cutbacks in federal mental health funding, and changes in the legal

code governing patient rights and affirming the rights of mentally ill people to live in the community without psychiatric treatment (Teplin, L., 2000).

Many officers have difficulty intervening in mental health crises (Borum, R., et al., 1998). There are many situations where inappropriate intervention has resulted in serious injury or death of people with mental illness. In one situation, the tragic shooting of a person with mental illness in Tennessee led to the formation of a crisis intervention team within the police department (Cochran, Deane, & Borum, 2000).

Mental health crisis systems often have criteria for admission that results in barriers to care (Dupont, R. & Cochran, S., 2000). In some systems, a person cannot be intoxicated and cannot have significant impairments, other medical conditions, mental retardation, or dementia. As a result, officers may have to seek out a treatment facility that will admit the person before a disability can be established. Limited options often lead to arrest, even when mental health services would be more appropriate (Borum, R., Deane, M.W., Steadman, H.J., & Morrissey, J., 1998). An exception to the challenge of these examples is in Memphis, TN, where there is a crisis drop-off center for persons with mental illness with a no-refusal policy for police cases.

A survey conducted in 1996 describes three models of intervention to mental illness; most police departments conform to one of these models (Deane, M.W., Steadman, J.J., Borum, R., Veysey, B.M., & Morrissey, J.P, 1999).

Police-based specialized police response model. This model involves police officers who have special mental health training and serve as the first responders to mental health crisis calls, they also act as liaisons to the community mental health system.

Police-based specialized mental health response model. This model employs

mental health professionals within the police department to provide on-site and telephone consultations to officers in the field.

Mental-health-based specialized mental health response model. This model involves a partnership between police and mobile mental health crisis teams. The teams are part of the community mental health services system and independent of the police department.

Data suggest that collaborations between the criminal justice system, the mental health system, and the advocacy community, along with essential services, reduce the inappropriate use of jail time for people with mental illness (Steadman, H.J., Deane, M.W., Borum, R., & Morrissey, J.P., 2000)

Police Perspective

The manner in which human service workers provide advocacy for people with disabilities is sometimes considered questionable by those in the criminal justice system. The disability service system can be confusing to those trying to investigate from the outside. The acronyms can be confusing, the paperwork overwhelming, and concepts like age appropriateness and normalization are misunderstood by those who have not had training or experience in the disability field. In some situations, by the time an incident is reported to the police, an individual has usually been interviewed numerous times by various agency personnel. In some circumstances, human service personnel have influenced the people they support with their own feelings of mistrust about the police.

One study done in 69 communities across the U.S. found that the relationship between the community and the police was generally positive. However, when responding to calls involving people with mental illness, officers were frustrated by

having to wait for crisis staff, and crisis staff felt that they often had to wait excessively for police response. Crisis staff also believed that mental health calls received a lower response priority (Borum R., et al., 1998).

Training/Treatment

Memphis, Tennessee has developed a program that utilizes a Crisis Intervention Team (CIT) to train officers on how to respond in situations involving people with mental illness. The program is a collaborative effort between law enforcement personnel, mental health professionals, consumers, and advocates. Police officers volunteer for the training and, if chosen, receive specialized training to learn about mental illness, substance abuse, psychotropic medication, treatment modalities, patient rights, civil commitment law, and crisis intervention techniques. Training is provided by mental health providers, family advocates, and mental health consumer groups at no cost. The teams provide 24-hour coverage throughout the city. When dispatchers are aware of an incident that may involve a person with mental illness, they assign that call to a crisis intervention team officer. The CIT program has been effective in diverting people with mental illness from jail, lowering the arrest rate of people in crisis, and having officers on the scene more often and more quickly (Cochran, Deane, & Borum, 2000). The program has also made a positive impression on officers. CIT and non-CIT officers from Memphis rated their program significantly higher than the ratings given by officers from two other intervention programs in other cities (Dupont, R. & Cochran, S., 2000). The results of the same study further indicate that CIT training appears to increase officer comfort and confidence in responding to mental health emergencies.

Programs such as these are essential to ensure proper intervention and support is provided for people with disabilities who enter the criminal justice system.

Summary

Vulnerability of victims with disabilities stems from dependency on caregivers, a devalued position in society, desire to please and be accepted, and lack of education about sexuality and abuse issues. Victims with disabilities are often unable to advocate on their own behalf for services and equal justice. Raising awareness of these issues among people with disabilities, service providers, and the criminal justice system is critical for system changes. Education must be threefold; people with disabilities must be taught to avoid, recognize, and report crimes when they occur. Secondly, those who support people with disabilities through advocacy or service provision must be able to recognize the symptoms of abuse and be compelled to report it. Finally, criminal justice system personnel need to be taught how to effectively interact with people who have disabilities throughout all aspects of the system.

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