

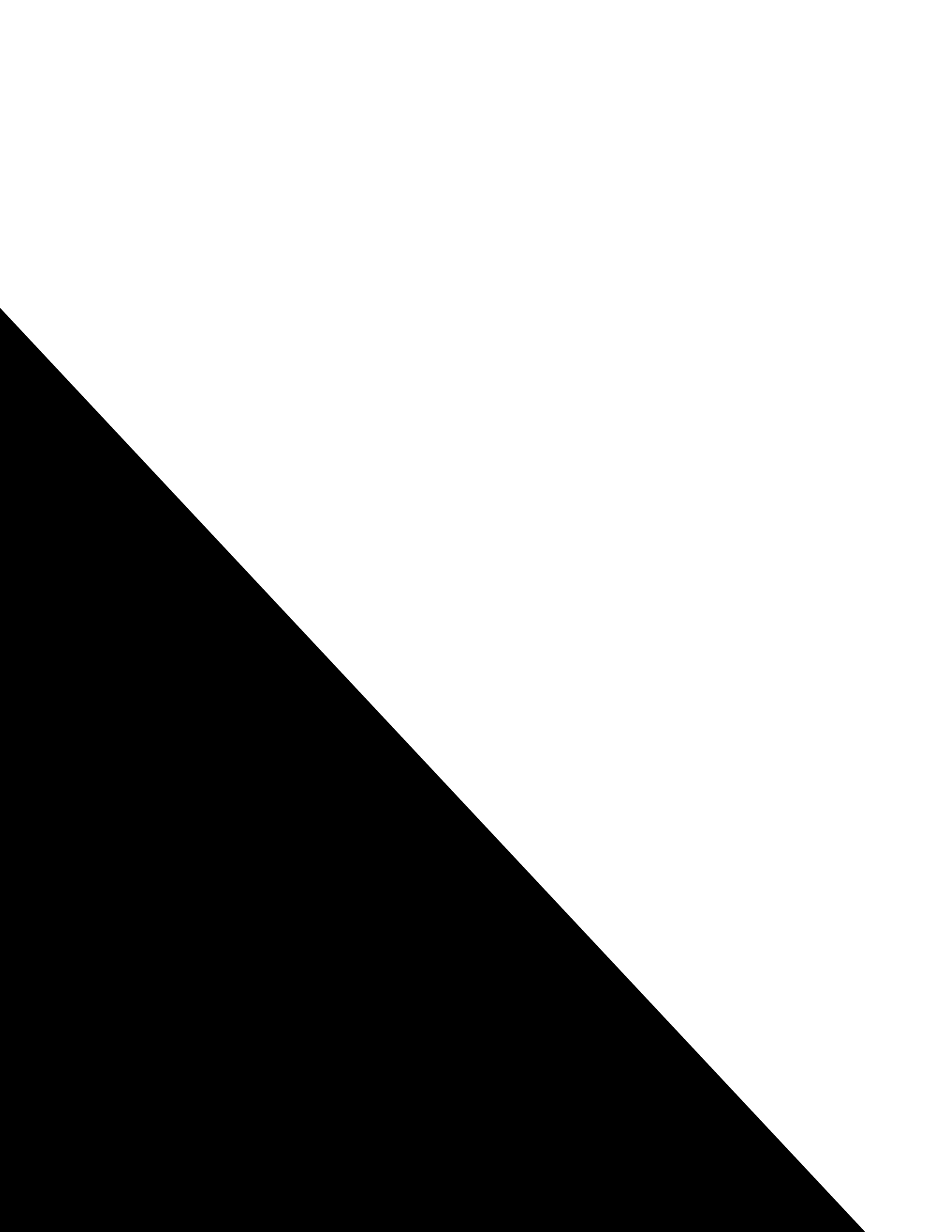


VICTIMS WITH DISABILITIES:

Collaborative, Multidisciplinary First Response

Techniques for First Responders Called To
Help Crime Victims Who Have Disabilities







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TRAINER'S GUIDE

A training DVD and trainer's guide designed to demonstrate effective techniques for first responders called to help crime victims who have disabilities that affect the victim's intellectual and communication abilities.

Office for Victims of Crime
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Message From the Director

Children and adults with disabilities who become victims of abuse and other crimes need to have equal access to and protection of their rights as crime victims by the criminal justice system. Unfortunately, this access is oftentimes obstructed or made more difficult for victims with disabilities due to a lack of specific training on the part of the professionals who are responsible for providing first response services to them.

To provide services in a safe and successful manner to a person with a disability, the service provider must have information about how a specific disability may affect an individual, and how trauma and stress may bring out or exacerbate certain characteristics. Professionals must be able to adjust their normal interaction procedures accordingly, in order to ensure that victims with cognitive or communication disabilities have the opportunity to provide input into their own care, express their needs, share what happened to them in their own way, and participate in the criminal justice process to the same extent as victims without such disabilities.

The goal of this DVD and training guide is to present this knowledge to professionals who may need to provide first response services to crime victims who have cognitive or communicative disabilities.

Sincerely,

Joye E. Frost

Acting Director

Office for Victims of Crime





SECTION I

INTRODUCTION

PURPOSE OF THE DVD

This training DVD provides a specific set of guidelines for first responders (e.g., law enforcement officers, paramedics, victim advocates, forensic interviewers) who have been called to the scene of a crime in which the victim has a disability. It is designed to help these professionals hone their ability to work with individuals who present specific challenges to a successful first response.

Developed under the guidance of a national advisory board, this DVD provides guidelines for interacting with both adults and children, and places special emphasis on crime victims who have communication and/or intellectual disabilities. Intellectual disabilities, which involve the mental process of knowing, include disabilities such as mental retardation and autism. [Note: Despite the fact that the term *retardation* is considered pejorative by many in the disability community, this term remains current in diagnostic nomenclature and is therefore used in this guide.] Communication disabilities, which have to do with physical involvements that interfere with a person's ability to convey information and ideas, include disabilities associated with speech production (e.g., cerebral palsy, stroke).

Crime rates that involve crimes against children and adults with disabilities far exceed rates of crime against individuals who do not have disabilities. Research published in 2001 found that crimes against children with disabilities occur at 3.4 times the rate of children who do not have disabilities (Sullivan, P.M., and Knutson, J.F. *Maltreatment and Disabilities: A Population-Based Epidemiological Study. Child Abuse and Neglect 2000. 24(10):1257—1273*). Estimates of maltreatment of adults with disabilities range from 4 to 10 times the rate for adults without disabilities (Garbarino, J., Brookhouser, P.E., and Authier, K.J. (1987). "Special Children, Special Risks: The Maltreatment of Children with Disabilities.").

Although research on the crime victimization of individuals with disabilities is sparse, the findings are consistent that crime rates are much higher within this population. Additionally, individuals who acquire disabilities as a result of crime victimization represent a significant number each year, but public recognition of both of these populations continues to be all but absent.

PROCESS OF CREATING THE DVD

While maintaining a primary focus on victims of crime with communication and/or intellectual disabilities, this DVD concentrates on certain essential aspects of a first response. These essentials or basic principles should be applied to any response to a person with a disability. If these guidelines are followed, they will facilitate a successful interaction between responder and victim. The foundation for this DVD is the *First Responders Curriculum: Responding to Child Abuse Calls Involving Children with Disabilities*, published in 2005, which was produced under a grant from the California Children's Justice Act to Arc Riverside.

This DVD was created with use of the expertise of a national advisory board and a production team; both groups brought years of experience to the project. Writer and director Greg Byers has many years of personal experience working with individuals who have a variety of disabilities. The same is true of co-producer Jennifer Ballinger, who is the mother of a teenager with disabilities, as well as a special education teacher for children with autism and other disabilities. Members of the advisory board include individuals with many years of professional experience relating to crime victims with disabilities throughout various life stages. These members include law enforcement officers, current and former prosecutors, disability specialists, professionals from child protective services, elder and dependent adult protective services, and victim service advocates. [Note: The terms *dependent adult* and *dependent person* are used in several states to identify individuals between ages 18 and 65 who may qualify for adult protective services. Other states use *vulnerable adult*, *endangered adult*, *impaired adult*, and other terms. Although some in the disability community find these terms controversial and pejorative, they are the legal terms used in this context, and are therefore used in this guide.]

The goal of this DVD is not only to help law enforcement personnel acquire additional skills, but also to help them acquire a deeper understanding of the lives, personal attributes, and abilities of individuals with developmental and other disabilities. To accomplish this latter goal, the DVD provides vignettes featuring each of the interviewees, both on their own and in the company of others, thereby giving practitioners a privileged insight into the lives of people with disabilities. Increased knowledge about people with disabilities helps bridge the gap between myth and fact and helps erode stereotypical perceptions that could interfere with the first response process. Bridging this gap, you will notice, is a major theme throughout the DVD.

After introducing individuals with various disabilities, the DVD then describes and demonstrates the basic protocols for effective and productive interactions. In order to show how these protocols are applied in real situations, the DVD includes first responses being conducted on-screen by a variety of law enforcement and medical professionals. These first responders include police, paramedics, protective services workers, chaplains, and Sexual Assault Response Team (SART) professionals. [Note: If desired, the DVD can be stopped at the end of each topic to allow for further discussion. See *How To View This DVD* for more information.]

In addition, this DVD also describes and demonstrates the basic steps followed during both first responses and subsequent interventions, such as the following:

- ▶ Understanding a disability before meeting a victim.
- ▶ Addressing a victim directly during the initial contact.
- ▶ Transporting a victim according to protocol.
- ▶ Applying first responder techniques to all professional interventions.

Because some of the individuals who appear in this DVD are somewhat difficult to understand, a complete written transcript of the audio portion has been provided. In actual interactions, however, first responders have to rely on their own listening skills. Although captioning is available for deaf and hard-of-hearing viewers, others are encouraged to listen carefully to each person's speech pattern and attempt to discern what is being said.

Furthermore, even though this DVD does come with open- and closed-caption versions and enhanced audio (see page 5), the inclusion of a written transcript that can be modified for those with vision impairments further expands access to the entire audio portion.

DIFFICULT CHOICES (A MILE-HIGH WISH LIST)

Advisory board members have had many wonderful suggestions for the development of this training DVD. Because these suggestions could not be accommodated within a single DVD, they will be addressed in later proposals for video training projects. Ideas for future DVDs include an additional focus on the following:

- ▶ Individuals who reside in congregate living situations such as group homes.
- ▶ People who experience mental illness.
- ▶ People who have recently acquired a disability due to a crime.
- ▶ Individuals who are medically fragile and whose transport, if needed, requires special skills.
- ▶ People who have dual diagnoses of both an intellectual disability and a psychiatric condition.
- ▶ Specific issues for those who are deaf or hard-of-hearing.
- ▶ Specific issues for those who are blind or have low vision.

Board members also discussed the need to create training for judges, prosecutors, victim advocates, protective services workers, and other specialized groups. Each concept suggested has merit and deserves special attention. However, if we tried to include all of these important ideas within one DVD designed to serve all concerned, we would no longer be providing professionals with the specialized, in-depth training that is our goal.

THE IMPORTANCE OF LANGUAGE

The words that first responders use with and about individuals with disabilities influence the outcome of interactions between responders and crime victims who have disabilities. Language reflects our attitudes about, knowledge of, and, particularly, the respect we have for individuals of any population group or designation. To encourage respect and optimize interaction, the language preferences regarding a certain group should emerge from that particular community—which means that language preferences regarding people with disabilities should emerge from the disability community. Inevitably, these preferences will change over time. The preferred terminology and phrases that are used on these pages today may no longer be preferred a few years from now. To avoid language that may be offensive to people with disabilities, it is important to keep up with these changes.

Throughout this DVD and Trainer's Guide, the terms *individuals with disabilities* and *person who has a disability* are used. This is consistent with the language preferences originally promulgated by the People First organization. This Oregon-based self-advocacy group declared that "we are people first, then we are people who have disabilities." Their approach emphasized the perception of a disability as only one part of an individual's identity, rather than as the person's entire identity. It also marked a milestone in moving away from what many refer to as the *medical model* of disability, in which the individual was primarily perceived as a medical patient. The concept of *having* rather than *being* a disability is important because it allows many other aspects of an individual's life to be included in their identity (e.g., a person with a disability may also be a professional in a particular field, a wife and mother, or an active community leader). In other words, one may "have cerebral palsy," not "be a cerebral palsy."

It is not acceptable to use an adjective to include information about an individual's disability. For example, it is not acceptable to say, "the retarded boy." Instead, one may say "the boy who has an intellectual disability." In the past, the phrase *mental retardation* was common; recently, the term *intellectual disability* has become the preferred way to describe this condition. Despite this change, the term *retardation* remains current in diagnostic nomenclature. This usage is distressing for many individuals who have strongly

negative feelings about any permutation of the word *retarded*. The phrase *being slow* is among the descriptions currently preferred by these individuals.

It is also unacceptable to refer to someone's assistive device without referring to the person. An example of this inappropriate language might be, "Let's go talk to the wheelchair." Individuals are not, nor are they part of, their assistive devices. Therefore, one should not say, "the wheelchair" or "the wheelchair person," but rather, "the woman who uses a wheelchair."

Grouping people by disability is also unacceptable. Phrases such as "the disabled" or "the mentally ill" disrespect people with disabilities by taking away their individuality. This disrespect extends to hospitals as well, where one might hear, "How about the appendix in room 346?" It is currently more acceptable to say "individuals who have an intellectual disability" or "the patient with appendicitis."

The term *consumer* is also considered disrespectful by some. This term was developed several years ago in an attempt to find a word other than *client* or *patient* that could refer to individuals with developmental disabilities. Originally, individuals with disabilities were to be referred to as "consumers of case management services." Unfortunately, the term *consumer* then became so commonly used that individuals with disabilities are now universally referred to as "consumers," regardless of whether or not they use the services of a case management program. Many dislike this term because it contradicts the "whole person" concept and promotes the negative concept of people with disabilities as individuals who use up community resources. Some leaders in the disability community prefer to use the word *consumer* only when the person is actually engaged in case management activities. In other situations, they prefer to use a different descriptive noun, ideally a term that might describe a person who did not have a developmental disability. For example, when people are not engaged in case management activities, they could be called pedestrians, shoppers, tenants, workers, and customers.

Many guides are available on the Internet regarding the preferred language to use with and about individuals with disabilities. Because language is constantly changing, it is wise to check these guides periodically.



SECTION 2

DVD USE

HOW TO VIEW THIS DVD

This training DVD is designed with several optional viewing opportunities. The DVD is easy to view in one sitting, with sections flowing seamlessly from one to the next; however, there are also a number of good reasons to break up the DVD viewing into smaller sections. One reason might be a simple time consideration such as roll call, during which only 5 minutes or so of the DVD would be viewed in one sitting. Another reason might be the desire to explore various topics during group discussions and exercises. When using this enhanced learning option, a number of longer training sessions would be scheduled; during each session, a particular section of the DVD would be viewed and discussed. Or, finally, these topical training sessions could take place sequentially during a one-day training seminar, where the entire DVD would be viewed and discussed, one section at a time.

Because this particular DVD-plus-training guide has been designed specifically for first responders (e.g., law enforcement professionals, firefighters, paramedics), it is our belief that most viewers will want to watch the entire DVD during one uninterrupted training session, starting and stopping the DVD to discuss points along the way. With this in mind, instructors' cues have been provided within each section of this training guide to let them know when and where to stop the DVD for discussion. To facilitate this discussion, a topical outline of the DVD's contents has also been included. Each one of the guide's sections begins with an outline of that section's content, and then—after providing the appropriate cue for the instructor—lists a number of suggested “Discussion Points and Questions” before moving on to the next topic.

To facilitate alternate viewing plans, this DVD has a number of special features:

- ▶ *Play Video*: By selecting this choice on the main menu, viewers will be able to watch the DVD in its entirety.
- ▶ *Select Scene*: By selecting this choice on the main menu, viewers will be able to select and then watch an individual section of the overall program. At the end of each section, the player will stop automatically and return to the scene selection menu.
- ▶ *Play Enhanced Audio*: This choice will enable blind and low-vision users to hear an audio-only presentation comprised of the dialogue, narration, and expanded descriptions of visual elements for a more complete training experience. [Note: An audio navigation feature that begins automatically at the start of the video will guide blind and low-vision users to this setting.]
- ▶ *View Accessibility Options*: By selecting this choice on the main menu, users may proceed to activate open- and closed-captions, as well as a visually described feature that provides basic audio descriptions of visual elements.



SECTION 3

STOP/START DISCUSSION POINTS AND QUESTIONS

PART I: INTRODUCTION

Terms

This DVD training program focuses on victims of crime with intellectual and/or communication disabilities.

An *intellectual disability* refers to the mental process of knowing, including aspects such as awareness, perception, reasoning, judgment, and learning. A crime victim's conditions may include intellectual disabilities, such as autism (Autism Spectrum Disorder), Asperger's syndrome, or brain injury (e.g., traumatic brain injury), among others.

A *communication disability* refers to the physical involvement that impairs one's ability to convey information and ideas. A crime victim's conditions may include communication disabilities caused by cerebral palsy, stroke, deafness (deaf or hard-of-hearing), or autism, among others.

Facts and Concepts

- ▶ Many people who have intellectual disabilities have an excellent recall of traumatic or special events in their lives.
- ▶ The communication method of the victim may be new to a first responder, but it is an everyday, every moment method for the individual.
- ▶ Victims with disabilities may be thought of as a credibility risk for the case and are therefore not interviewed. Consultants for case-building advise first responders to treat each new crime victim as if their particular case will be viable for prosecution. This means that each victim should be subject to standard first response protocol, such as investigating the scene, interviewing the victim and witnesses, documenting the findings, and planning the next step. If the on-the-scene responder chooses not to interview a crime victim or witness who has a disability, this may lessen the strength of the case when it is forwarded through the system.
- ▶ Initially, in response to the severity of a crime victim's disability, a first responder may believe that the victim will be unable to contribute to the interview process; however, interaction should not end here. The first responder should consider the victim's initial impression as the beginning of a relationship: a first interaction that will serve as a bridge to "learning how" to interact further. In some cases, it may be necessary for the responder to seek additional guidance from supervisors or other community resources.
- ▶ Regardless of a crime victim's appearance—and regardless of a responder's first impression of a victim—it is essential for all first responders to address each crime victim directly. This initial contact is critical and will set the tone for all future contact with this particular victim.

- ▶ It is essential for all first responders to remember that they are part of a team: a group of professionals who share the responsibility for each case's outcome. This team responds to the crime during various aspects of the victim's "journey," from the actual crime scene to the hospital, police stations, and beyond. With this broader picture in mind, first responders will be better able to
 - ▷ create a seamless experience for the crime victim with a disability;
 - ▷ lay appropriate groundwork for all professionals involved;
 - ▷ encourage optimum communication between all parties; and
 - ▷ facilitate case building.
- ▶ By applying the information contained in this Trainer's Guide to standard approaches, first responders can be assured of achieving the best possible outcome for both the crime victim and the case.
- ▶ In many cases, the individual's disability may not be apparent. Among the hundreds of types of disabilities that exist, many are termed *hidden disabilities*, as they do not affect physical appearance or verbal fluency, yet have a significant impact on the individual's ability to function either physically, emotionally, or cognitively.



INSTRUCTOR: STOP DVD WHEN PART 2 BEGINS.

DISCUSSION POINTS & QUESTIONS

1. What general assumptions exist in today's society regarding people with obvious disabilities?
2. When you see a person with an obvious disability, what thoughts pop into your mind regarding this person's ability to communicate with you?
3. Do you think that a person with a speech disability probably has an intellectual disability as well?
4. What does the term *intellectual disability* mean to you?
5. Make a list of the types of intellectual disabilities with which you are familiar.
6. Make a list of the types of communication disabilities with which you are familiar.
7. Suggest ways to overcome the negative attitudes that are taught by our disability-negative society.

PART 2: EXPOSURE AND KNOWLEDGE

When thinking of people with disabilities, it is helpful to consider how different their life experiences have been from those without disabilities. In many cases, these differences may be equivalent to deeply ingrained cultural differences—differences that first responders need to understand before interacting with crime victims who have disabilities.

As with any culturally sensitive interaction, certain facts and concepts should be explored before an interaction begins:

- ▶ General information about various types of disabilities.
- ▶ Physical and behavioral factors.
- ▶ Potential methods of reasoning (concrete vs. abstract).
- ▶ Communication barriers and alternative options.
- ▶ Educational possibilities and limitations.
- ▶ Levels of interaction with the surrounding community.
- ▶ How all of the above might affect a particular crime victim.

Cultural differences can include physical/behavioral customs, the way information is shared, movement, spatial needs, responses to touch and/or eye contact, and exclusion of those who are not members of a particular culture.

For example, some who are deaf may choose to align themselves with the Deaf community where American Sign Language is the primary language. Others are welcome to interact with this community, of course, but members are members. There is a great deal of pride in being deaf. The word is written with an upper case “D” to distinguish members of the Deaf community from those who are deaf (with a lowercase “d”) or hard-of-hearing. This latter group does not use American Sign Language as a primary language, and chooses to align itself with the general population rather than with the Deaf community.

There are many such distinctions within the disability community. Unfortunately, due to societal prejudice, segregation, and lack of educational intervention, the general public remains largely unaware of these cultural differences. In fact, most people—including first responders—unconsciously subscribe to disability-negative attitudes.

For the public at large, the antidotes for disability-negative attitudes include

- ▶ information gathering;
- ▶ organized classroom activities;
- ▶ personal exploration; and
- ▶ social exposure and interaction.

For first responders in particular, agency supervisors can invite appropriate experts to participate in a series of in-service meetings, roll calls, training sessions, or seminars. Supervisors can also contact the Center for Independent Living, a national organization whose local chapters can provide both experts and information. It is essential to acknowledge that no one person can speak for individuals with every type of disability.

The goal is to equip first responders with both informational expertise and an attitudinal “clean slate” so that their response to calls involving individuals with disabilities can proceed in an optimal manner.



DISCUSSION POINTS & QUESTIONS

1. Identify ways in which individuals who are different or who have a disability are not valued in a “disability-negative” society.
2. Identify some myths and stereotypes that could interfere with a positive interaction between two individuals.
3. Discuss how belief in such myths or stereotypes could negatively affect a first response or the interpretation of a first response.
4. Discuss how a feeling of discomfort regarding another person can interfere with a positive interaction.
5. Discuss ways to overcome the discomfort caused by individuals whose appearance or behavior differs from the norm. Use individuals you have seen in the DVD or in your own life as examples.
6. Discuss the similarities and differences between the people with disabilities shown in the DVD and the viewers watching the DVD. Identify at least twice as many similarities as differences.
7. Discuss how these differences might affect a first responder’s perception of an individual’s ability to communicate.
8. Discuss cultural differences caused by different types of disabilities (e.g., intellectual or communication disabilities, deafness, autism, cerebral palsy), and how these differences might affect an interaction with a first responder.
9. Select five words usually used during a first responder’s interaction with a crime victim, then evaluate how easily these words might be understood by a concrete rather than an abstract thinker.
10. Discuss how the use of positive references to people who have disabilities can affect the outcome of an interaction or interview.

PART 3: PROFILES FOR PRACTICE

By consciously applying the techniques and protocols described in this training program, first responders can have a successful interaction with almost any person who has an intellectual and/or communication disability. From initial contact to closure, there are many steps to remember, but two key moments stand out as being crucial.

First Impression – How a first responder perceives the victim, how he or she responds to the victim, and how the victim feels as a result will set the stage for the rest of the investigation.

Last Impression – How a first responder leaves the victim will set the tone for both the next intervention and the rest of the investigation.



DISCUSSION POINTS & QUESTIONS

1. What should a responder do if he or she is really deeply affected by the disability of the child?
2. How can responders prepare for interaction with individuals with severe disabilities?
3. Which response strategies will help create a positive outcome?

PART 4: METHODS OF COMMUNICATION

The appropriate first response to calls involving individuals with disabilities is divided into four components. These will be discussed throughout this section:

- ▶ Pre-interview considerations.
- ▶ Initial contact skills.
- ▶ A successful interaction.
- ▶ Report writing.

Pre-Interview Considerations

Responder's Attitude: Before arriving at the scene of a crime, a first responder must have a clear mind: the "mind-set" required of a professional who moves from one call to the next. During this in-between period, a responder must prepare for all possibilities, leaving the last call behind, clearing the way for whatever might follow. In most cases, neither dispatcher nor responder will know whether or not the next crime victim will have disabilities. Unless a caller provides this information, the dispatcher has no way of knowing because asking about a disability would violate ADA regulations.

Nonverbal Crime Victim: During a first encounter with a crime victim, the victim may be described as *nonverbal*. This term can mean different things to different people, and it is essential to learn which meaning is being implied. Meanings can range from "this person does not have any form of meaningful communication," all the way to "this person has a limit of about 200 words in voiced communication." Specifically, this may mean that a victim uses other means of communication, such as sign language or typed communications. It may also mean that despite their disability, the victim is able to convey quite a bit of information, even though it may be delivered in a format that differs from conventional verbal exchange.

Family Members and Caregivers: A victim's family or caregiver may try to interpret for the victim or interfere with the responder's access. They may describe the victim as "nonverbal" (see above); they may even be unwilling to provide the technology or interpreter necessary for direct communication with the victim. Although these people may see themselves as the victim's best advocate, it is essential that a first responder be allowed to address a victim directly. The responder should make every attempt to persuade family members and caregivers that direct communication is in the victim's best interest—but if this proves impossible, the responder can delay interaction with the victim, even if this means waiting until the next stage of the response (e.g., at a police station or hospital).

Residential Staff: If a first responder is called to a group home, the home's residential staff may behave in a manner similar to the family members/caregivers described above, thereby hindering the responder's attempts to communicate directly with the victim. Again, the responder should make every attempt to persuade staff members that direct communication is in the victim's best interest—but if they continue to resist, the responder should ask to speak to the home's supervisor or owner, even when this person is off-site.

Communication: If a victim cannot communicate easily in a conventional format, their method of communication must be identified. If a victim uses a method that could involve a certified interpreter, the first responder should make every effort to get an interpreter to the scene. If necessary, the responder can delay the interview with the victim until an appropriate interpreter is available—even if this means waiting until the next stage of the response (e.g., at a police station or hospital).

Interpreters: It is essential for first responders to become familiar with the ethics and protocols for conversing with someone through a certified interpreter. Most of the rules are the same as those for working with a language interpreter, but for American Sign Language or other methods, additional considerations affect the protocol.

Hidden Disabilities: First responders must remember that a crime victim's disabilities may not be immediately apparent based on physical appearance. Hidden disabilities can include psychiatric disabilities, intellectual disabilities, speech and language disabilities, sensory disabilities, as well as other disabilities such as autism or Asperger's syndrome, all of which may affect the interaction between victim and responder. If necessary, a responder may ask for the assistance of a disability resource person.

PART 5: INITIAL CONTACT

As soon as a responder arrives, the first impressions formed by a crime victim with disabilities can make or break the case. These impressions are based on subtle cues:

- ▶ How long the responder spends with other adults before addressing the victim directly.
- ▶ The responder's facial expressions.
- ▶ The responder's tone of voice, choice of words, and conversational style.
- ▶ The responder's body language.
- ▶ The responder's position in relation to the victim.
- ▶ Eye contact.

Each one of these cues will help determine whether or not the victim will choose to interact with a first responder. As described above, direct communication between responder and victim is essential—but the style of this interaction is also important. In order to achieve the most positive results, a responder should consider the following:

Physical Position – A first responder's position while communicating with a crime victim affects the perceived balance of power. The ideal position for a responder is wherever he or she can best be observed by the crime victim: ideally, at the eye-level of the conversation partner, with appropriate lighting (see details regarding lighting below). This is especially important for children, whose communication needs demand a clear view of facial expressions.

Space – For individuals with different types of disabilities, space considerations differ. For example, a child with autism or Asperger’s syndrome may require quite a bit of space between him or herself and a first responder, whereas a child who is deaf or hard-of-hearing may benefit from a normal amount of space. Before approaching too close, the responder should ask either the victim or the victim’s care provider about particular space needs.

Touch – Because some disabilities create a sensitivity to touch, a first responder should avoid touching a crime victim who has disabilities. Although such sensitivities are usually found only in individuals with autism and Asperger’s syndrome, it is hard to know in advance whether a victim has these disabilities or other prior traumas that have created sensitivities that could inadvertently be triggered by touch. In some cases, a normal handshake will be welcome—but before initiating such contact, the responder should ask either the victim or the victim’s care provider whether this is acceptable. Also, because some children have been taught to hug everyone, it is also best to avoid possible compromise and offer a handshake instead.

Eye Contact – Although eye contact between conversation partners is usually considered a plus, this is a minus for victims with certain types of disabilities. For this reason, a first responder should not demand eye contact, particularly when interacting with children; instead, the responder should allow eye contact to be initiated by the victim. There are many reasons why a victim might resist eye contact, but in terms of disability, this may be a sensory activity that is unpleasant or even painful. It is essential to be aware that training regarding eye contact as regards suspects should not be similarly applied with individuals with disabilities, whose disability may cause body movements, postures, verbal hesitations, eye contact, and eye movements to differ from the norm. This is not indicative of suspicious conduct or lying, but normal aspects of the individual’s mannerisms.

Voice – A first responder should always speak in his or her regular voice, especially when addressing a child with disabilities. The responder’s tone should be consistently friendly, supportive, and inquiring, thereby reflecting a clear desire to help the victim. Volume should be normal. Even when the victim is deaf, a responder should use normal volume, tone, and enunciation.

Lighting – When a first responder is called to a home, it is important to ensure that proper lighting is present during the course of an investigation. This includes a variety of appropriate choices:

- ▶ Ample lighting for victims with hearing disabilities.
- ▶ Adequate lighting for those with vision disabilities.
- ▶ Reduced light directly behind both responder and victim.
- ▶ Nonfluorescent lights for those with sensitivities to toxins, such as individuals with autism and Asperger’s syndrome.

Distractions – A first responder should bring a minimum of distractions to the crime scene. A victim with disabilities may be easily distracted or even traumatized by equipment such as a radio, beeper, gun, phone, or other paraphernalia. In addition, the responder should remove any pre-existing distraction, such as a radio or a TV, by asking the victim or the victim’s care provider if it can be turned off.

Attempt to Record – A first responder should attempt to make an audio and/or video recording of his or her interaction with the victim and others interviewed at the scene. Local laws regarding such recordings may vary, but, in general, most professionals agree that recordings can help build a stronger case and reduce the need for re-interviews.

Along with consideration of these eight elements, a responder's first task is to communicate the following information:

- ▶ That the victim is not in trouble.
- ▶ That the responder is there to help.
- ▶ That what happens from that moment forward will be the responsibility of the perpetrator, not the victim.

There is a good reason for this three-fold assurance. In many cases, an individual with disabilities has been taught that getting others in trouble will violate a key social rule, and that to do so would be wrong, even when a crime has been committed.

A Successful Interaction

The flow of an interaction with a crime victim who has disabilities should follow the standard practices of first responders. In general, once the initial contact has been made, most encounters will proceed through the following stages:

Rapport Development – Using standard rapport building tactics, a first responder should address a victim who has disabilities—particularly when the victim is a child—as if he or she can understand all that is said. To assure optimal understanding, a responder should use the conversation technique called Plain English, and avoid “baby” or “kiddy” talk. Speak normally, as one would to any other person in the age group. In addition, a responder should continue to use the information covered in the previous section regarding position, space, touch, vocal tone, and body language. All of these choices will demonstrate the responder's respect for the victim and gradually build a rapport.

Communication Strategies – To encourage conversation, a first responder should try to engage the victim by discussing familiar people and places. At times, a victim may be reluctant to engage in direct conversation, in which case indirect communication may help. A responder can ask a victim to show a photograph or make a drawing instead of speaking. This might be an image of someone or something related to the child, if in the rapport development phase; it might be an image of someone or something related to the crime, if in the investigation phase. These photos or drawings may also prove useful later when conducting assessments: they might help identify something or someone, or help distinguish the truth from a lie. The responder should become comfortable with periods of silence after a question while the victim is processing the question and answer.

Open-Ended Questions – As in standard practice, a first responder should begin an investigation by asking open-ended questions. Such questions elicit the best information and allow the victim to tell what occurred in his or her own style. Whenever the victim is speaking, a responder should facilitate this by using techniques such as active listening. Even when the narrative is disjointed, without chronological order, the responder should not interrupt the flow. The spontaneous monologue is what matters; the chronology can be figured out later. If the victim is unable to respond to this open-ended approach, however, the responder should resort to directed questions.

Closure – At the end of an interaction, a first responder should always close on a positive note: by assuring the victim that the conversation went very well, by offering to answer any questions, and by explaining what is going to happen next. Just as first impressions are critical, so are final ones. These efforts will assure the victim that he or she has been heard and respected, and that whatever was said has been taken seriously.

Subsequent Interventions

As described above, the initial response to a crime involves first responders who go either to the scene of the crime or to the location of the crime victim. After this first interaction with the victim, subsequent interventions may take place either at a police station or at a hospital where, once again, the interaction and communication skills described in this training program will be key. Whenever a victim has a disability, it is essential that all first response professionals involved during these later stages—whether they be victim advocates, Sexual Assault Response Team members, chaplains, protective service professionals, or others—are as familiar with disability protocols as the first responders who precede them. As with any other victim, conversations with the care providers or other household members will be limited to acquiring essential information about the crime that occurred and considerations necessary for assuring appropriate accommodations for the crime victim with a disability.

Sexual Assault Response Team. If a victim may have been sexually assaulted, the next intervention will occur at a hospital. There, members of a Sexual Assault Response Team will interact with the victim. Their goal will be to conduct a forensic sexual assault exam of the victim—and, if this victim has a disability, they must follow certain protocols. First, they must gain consent for the exam from the victim (depending on the legalities in their jurisdiction) and/or the legal guardian. It is essential for those acquiring consent to know if the victim is 18 years of age or older. If the person has reached the age of majority, they are the only one who can consent, unless they have been deemed incompetent in a court of law and a legal guardian or conservator has been appointed. If another individual states that they are the legal guardian for the victim it is essential that they provide proof of a current guardianship court order. Fraud has been committed in this regard, either by benign manner (they are the parent or de facto caregiver and mistakenly believe that this gives them the legal authority to consent for another person) or attempt to control and defraud (by knowingly falsely asserting that they hold a valid guardianship court order). There must also be an opportunity for the victim to be interviewed outside of earshot and eye view of their family or care providers. If the victim's disability is physical, the Sexual Assault Response Team must be prepared for proper transfer to the exam table (a hydraulic lift table is one solution). If the victim's disability involves communication, the appropriate people or appliances must be in place, as well. This may include an interpreter's presence at all stages of the exam.

Chaplain. Spiritual comfort and support for both victim and witnesses is essential to a successful investigation, particularly when the crime victim has a disability. Chaplains can offer such support at all stages and locations of intervention. By being present from the outset, or as early as possible during the course of the response, a chaplain may be able to ease the psychological distress of the victim, which may in turn facilitate the investigation. After the initial encounter of victim and chaplain, the victim has the right to request the presence of the chaplain during the rest of the investigation proceedings.



DISCUSSION POINTS & QUESTIONS

1. How much interplay should there be between first responders and other professionals involved in the case? Is the presence of a disability resource person necessary?
2. How is the role of a chaplain affected when the crime victim has a disability?
3. When the crime victim is a child with a disability, what issues may arise regarding consent, and what impact might this have on a first responder?
4. When a child uses assistive technology for communication, how would the first responder accommodate this type of communication with the victim?

PART 6: TRANSPORTATION

The initial response to a crime involves first responders who go either to the scene of the crime or to the location of the crime victim. After this first interaction with the victim, the next stage may involve transportation of the victim, either to a police station or to a hospital—and here, too, whenever a victim has a disability, certain protocols will apply.

The following issues should be considered before initiating transportation of any victim who has disabilities:

Physical Fragility – Paramedics may be needed if a victim is medically fragile, has been injured, or becomes behaviorally distressed. Because this need may not be apparent, first responders should always inquire if there is a medical condition or fragility to be considered.

Behavior – Some victims with disabilities have behavioral patterns that escalate due to stress. These changes can range from involuntary movements to aggressive behavior, and may occur in individuals with disabilities such as Tourette’s syndrome, attention-deficit disorder/attention-deficit hyperactivity disorder, autism, and Asperger’s syndrome. In some cases, the assistance of paramedics may not suffice, and accompaniment by the parent/care provider may be necessary. In other cases, parental transport to the next stage of the investigation may be the best option.

Ambulation or Communication Equipment – A victim’s ambulation appliances (e.g., wheelchair, crutches) as well as any communication equipment (e.g., machines, communication boards) must always accompany the victim during transport.

Medical Support – A victim’s medical support (e.g., medications, oxygen equipment) must always accompany the victim during transport. Also essential are instructions regarding the method of administration of these items.

Service Animals – A victim’s service animal must also be allowed to accompany the victim during transport. Such animals could be a service dog, cat, pig, or some other trained animal.

Interpreter – Some victims communicate best with the services of a qualified interpreter. For example, they may not mean what they say, and what they mean may only be expressed with the assistance of an



DISCUSSION POINTS & QUESTIONS

1. If a victim becomes distressed and begins to behave in ways that appear out of control, this behavior may simply be an expression of agitation as a function of the victim's disability. How do you know whether you should attempt to intervene or let the victim "do his thing"?
2. What are the protocols of working with service animals? Should you pet a dog when it is working?
3. When a first responder is told that a victim does not mean what they say, should the responder believe this? What other communication options might be appropriate in this situation?

PART 7: REPORT WRITING

The writing of a first responder's report should also follow standard procedures. The protocols for report writing include the following steps:

- ▶ Document what was said, by whom, and who heard the statements.
- ▶ Document the demeanor of the declarant while making the statements.
- ▶ Document the context of the statements made.
- ▶ Include statements made by everyone present, regardless of whether or not you believe the person may later be declared incompetent to be a witness, since the statement may be later declared admissible under the spontaneous statements rule.
- ▶ Avoid characterizations; instead use the technique of objective description. Use person-first and respectful language about all persons at the scene.
- ▶ Avoid language that demeans or dehumanizes such as "suffers from" (as in, "the child suffers from cerebral palsy") or "she only can grunt." Instead, emphasize facts: "to communicate she uses grunting sounds."
- ▶ Describe behaviors and conduct that you observe, and avoid making interpretations or assessments.

When the case involves a victim with a disability, it is essential to avoid personal prejudice and maintain objectivity—a perspective that is often difficult to maintain in today's disability-negative society.



DISCUSSION POINTS & QUESTIONS

1. What are the various connotations of the term *nonverbal*?
2. What might motivate you or someone else to describe a victim as nonverbal?
3. What kinds of disabilities could be considered hidden? How might you learn that a victim has a disability, and how would knowledge of this disability improve your response?
4. What might happen when you touch a victim who has a disability? What about touching the victim's wheelchair? What are the appropriate options?
5. In terms of eye contact, what are the appropriate options, and why?
6. How might lighting affect your interaction with a victim who has a disability?
7. In developing a rapport with the victim, what steps should you follow?
8. How might drawings or photographs help, both during your investigation and later on?
9. What is the difference between recording an observation of behavior and characterizing a behavior?
10. Consider common words or phrases used to describe individuals with disabilities. Which descriptions belong/do not belong in a report? Are there other assessments or conclusions that belong/do not belong in a report?
11. What is the key factor when closing your interaction with the victim?



SECTION 4

REFERENCE AND BACKGROUND MATERIAL

The foundation material for this DVD project was the resource, “Interviewing Skills to Use with Abuse Victims Who Have Developmental Disabilities.”

Additional materials were used from the law enforcement training program of California’s Office of Criminal Justice Planning-Funded Child + Adult Abuse and Neglect Disability Outreach (CAN DO) Project.

DEFINITIONS OF DISABILITY

The definitions of disability used as a foundation for this DVD project are listed below:

According to the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101, the term *disability* means, with respect to an individual,

- ▶ a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- ▶ a record of such an impairment; or
- ▶ being regarded as having such an impairment.

According to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law 106-402 – October 30, 2000, the term *developmental disability* means a severe, chronic disability of an individual that

- ▶ is attributable to a mental or physical impairment or combination of mental and physical impairments;
- ▶ is manifested before the individual attains age 22;
- ▶ is likely to continue indefinitely; and
- ▶ results in substantial functional limitations in three or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency, and need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

WORKING WITH AN INTERPRETER

The following is an excerpt from the Standard Practice Papers available at the Registry of Interpreters for the Deaf (RID) Web site, <http://www.rid.org>. The excerpt covers the interpreter's professional conduct and the confidentiality expected of them. The practices RID suggests apply to working with interpreters of any kind and can help an interviewer develop skill in working with interpreters.

It is the interpreter's sole responsibility to enable deaf or hard-of-hearing individuals the opportunity to communicate freely with hearing individuals. In order to do this, they must be given enough information about a particular assignment to allow them to determine if it is a situation where they can perform professionally. Content may be shared so the interpreter may determine if she or he has sufficient knowledge or skill to adequately convey the information in both languages. Also, names of participants are shared to ensure that the interpreter is able to work without bias or partiality toward any of the parties involved.

Interpreters strive to remain unbiased toward the content of their work and not alter or modify the meaning or tone of what is conveyed. Interpreters may request materials prior to certain assignments to assist in their preparation. Confidentiality is crucial, and an interpreter is expected to refrain from discussing or disclosing the content of a situation in which he or she interpreted. Aside from court mandated testimony, an interpreter strictly maintains this confidentiality. RID and the National Association of the Deaf (NAD) have jointly developed the NAD-RID Code of Professional Conduct, which may be seen in its entirety on the RID Web site.

ACRONYMS

ADA – Americans with Disabilities Act

ALS – Amyotrophic lateral sclerosis

Arc – Arc previously stood for the Association for Retarded Citizens, but because language preferences have changed, the organization is now referred to as “the Arc.” Arc–U.S. is the national organization that advocates for individuals with developmental disabilities. See the Language section for an explanation of why it is no longer acceptable to refer to individuals with disabilities using adjectives.

CAN DO – Arc Riverside's Child + Adult Abuse and Neglect Disability Outreach

CREDO – A philosophical approach; the acronym stands for compassion, respect, empathy, dignity, and openness to the needs of others.

DMH – Department of Mental Health

DVD – Digital video disc

IDEA – Individuals with Disabilities Education Act

OCJP – The California Governor's Office of Criminal Justice Planning, closed in 2004, was merged into the California Governor's Office of Emergency Services (OES). All project information is available through OES.

TDD – Telecommunications Device for the Deaf

GLOSSARY OF TERMS

Attention-Deficit Disorder and Attention-Deficit Hyperactivity Disorder – Attention-deficit disorder (ADD) and attention-deficit hyperactivity disorder (ADHD) are phrases used to describe a child or adolescent who has difficulty focusing and maintaining attention in academic and social situations. Children are sometimes labeled attention-deficit disorder or attention-deficit hyperactivity

disorder if they are very energetic and tend to be disruptive in the classroom or, conversely, if they are very quiet children who sit at their desks staring out the window or doodling. A child who is chronically disorganized, has difficulty remembering, consistently loses things, or waits until the last minute to complete homework or projects also may have ADD.

Children and adults with attention-deficit hyperactivity disorder have symptoms in two main areas. The first is characterized by a poor attention span, which causes the individual to ignore details, make careless mistakes, and have difficulty following instructions, listening, and finishing tasks. They also may appear to be forgetful, distracted, and disorganized. The second area is hyperactivity or impulsivity that causes a person to fidget, have difficulty sitting still, talk excessively, interrupt others, be in constant motion, and display a general sense of physical restlessness. Although most of us exhibit some of these symptoms occasionally, a person with attention-deficit hyperactivity disorder probably displays them more consistently and has done so since early childhood. (Definitions are taken from OneADDplace.com, <http://www.oneaddplace.com/adhd-symptoms.php>.)

Amyotrophic Lateral Sclerosis – Amyotrophic lateral sclerosis (ALS) is a chronic, progressive disease marked by gradual degeneration of the nerve cells in the central nervous system that control voluntary muscle movement. The disorder causes muscle weakness and atrophy; symptoms commonly appear in middle to late adulthood, with death in 2 to 5 years. The cause is unknown, and there is no known cure. This disorder is also called Lou Gehrig's disease or motor neuron disease. Literally, amyotrophic lateral sclerosis means without muscle nourishment, side (of spinal cord) hardening.

Anxiety Disorders – The Anxiety Disorders of America offers the following definition for generalized anxiety disorder (GAD) on its Web site, <http://www.adaa.org/GettingHelp/AnxietyDisorders/GAD.asp>:

The essential characteristic of generalized anxiety disorder is excessive uncontrollable worry about everyday things. This constant worry affects daily functioning and can cause physical symptoms. GAD can occur with other anxiety disorders, depressive disorders, or substance abuse. GAD is often difficult to diagnose because it lacks some of the dramatic symptoms, such as unprovoked panic attacks, that are seen with other anxiety disorders; for a diagnosis to be made, worry must be present more days than not for at least 6 months. The focus of GAD worry can shift, usually focusing on issues like job, finances, or health of both self and family; but it can also include more mundane issues, such as chores, car repairs, and being late for appointments. The intensity, duration, and frequency of the worry are disproportionate to the issue and interfere with . . . performance of tasks and ability to concentrate. Physical symptoms include muscle tension; sweating; nausea; cold, clammy hands; difficulty swallowing; jumpiness; gastrointestinal discomfort or diarrhea; . . . individuals tend to be irritable and complain about feeling on edge, are easily tired, and have trouble sleeping.

Other types of anxiety disorders include panic disorder and agoraphobia, post-traumatic stress disorder, social and other specific phobias, and obsessive-compulsive disorder.

Autism – Autism is a complex disorder of unknown origin that can cause delays or difficulties with growth and development, primarily in the areas of communication and social interaction. In addition, anxiety issues and a need for routine or sameness in many aspects of life is typical. Physical appearance and development are not affected.

Autism Spectrum Disorders – These are disabilities that range from autistic disorder to Asperger's syndrome. The difference is in the severity and number of characteristics the individual has. Both may improve as the child ages into adulthood, but not always. Changes in function during the early years of development (before age 6) seem to predict later language and social skills. Children with autism spectrum disorders demonstrate deficits in (1) social interaction, (2) verbal and nonverbal communication, and (3) repetitive behaviors or interests. Also, they may have unique sensory responses, such as when they are touched, and they may appear quite sensitive to sound or light.

Blind – Legal blindness, according to the American Foundation for the Blind, is “a level of visual impairment that has been defined by law to determine eligibility for benefits. It refers to central visual acuity of 20/200 or less in the better eye with the best possible correction, as measured on a Snellen vision chart, or a visual field of 20 degrees or less.”

Braille – Braille is a system for writing down language that uses raised dots on the page that blind people read by touch. It is based on a logical system in which dots in particular formations represent letters. It is estimated that approximately 10 percent of those who are blind use Braille.

Cerebral Palsy – According to the Web site of the Cerebral Palsy Program at the Alfred L. DuPont Institute in Wilmington, Delaware, “cerebral palsy is diagnosed when developmental milestones as well as physical findings that might include abnormal muscle tone, abnormal movements, abnormal reflexes, and persistent infantile reflexes are present. . . . Most children with cerebral palsy can be diagnosed by the age of 18 months.”

Cognitive Disability – People who have cognitive disabilities have difficulty in learning and thinking.

Communication Disability – Communication disabilities interfere with a person’s ability to understand and express speech or language.

Compulsions – People with obsessive-compulsive disorder typically try to make their obsessions go away by performing compulsions. Compulsions are acts the person performs over and over again, often according to certain “rules.” People with an obsession about contamination may wash their hands constantly to the point that their hands become raw and inflamed. A person may repeatedly check that she has turned off the stove or iron because of an obsessive fear of burning the house down. The individual may have to count certain objects over and over because of an obsession about losing them. Unlike compulsive drinking or gambling, obsessive-compulsive disorder compulsions do not give the person pleasure. Rather, the rituals are performed to obtain relief from the discomfort caused by the obsessions.

Deaf – These definitions of deaf and Deaf are taken from the National Association of the Deaf’s Web site, <http://www.nad.org>:

*When we define “deaf,” the parameters of the definition should be determined. The audiological definition can be used—that is, one that focuses on the cause and severity of the hearing loss and whether or not hearing can be used for communication purposes. Generally, the term “deaf” refers to those who are unable to hear well enough to rely on their hearing and use it as a means of processing information. Or a cultural definition may be used, as Carol Padden and Tom Humphries, *Deaf in America: Voices from a Culture* (1988) clarify:*

We use the lowercase deaf when referring to the audiological condition of not hearing, and the uppercase Deaf when referring to a particular group of deaf people who share a language—American Sign Language—and a culture. The members of this group have inherited their sign language, use it as a primary means of communication among themselves, and hold a set of beliefs about themselves and their connection to the larger society. We distinguish them from, for example, those who find themselves losing their hearing because of illness, trauma, or age; although these people share the condition of not hearing, they do not have access to the knowledge, beliefs, and practices that make up the culture of Deaf people.

People lose their hearing in various ways. The most common causes of hearing loss are

- ▶ *childhood illnesses (spinal meningitis and rubellalgerinan measles are the most common examples);*
- ▶ *pregnancy-related illnesses (such as rubellalgerinan measles or dependence on drugs or alcohol);*
- ▶ *injury (a severe blow to the head can damage the hearing);*

- ▶ excessive or prolonged exposure to noise;
- ▶ heredity (scientists involved with the mapping of the Human Genome Project have identified approximately 50 “deaf” genes to date, and they are working on identifying the remaining 350 “deaf” genes); and
- ▶ aging (progressive deterioration of hearing in older people, which is a natural part of the aging process).

Dual Diagnosis – This term refers to having both a condition of mental retardation and of mental illness. In mental health communities, this term also is used to refer to individuals who have both a mental illness and an addiction to drugs and alcohol.

Electronic Devices – Many computerized devices permit voiced communication at a variety of levels and are suited to the individual’s literacy skills and needs.

Epilepsy – Epilepsy is a neurological condition that makes people susceptible to seizures. A seizure is a change in sensation, awareness, or behavior brought about by a brief electrical disturbance in the brain. Seizures vary from a momentary disruption of the senses, to short periods of unconsciousness or staring spells, to convulsions. Some people have just one type of seizure. Others have more than one type. Although they look different, all seizures are caused by the same thing: a sudden change in how the cells of the brain send electrical signals to each other.” (Definition taken from the Epilepsy Foundation’s Web site, <http://www.epilepsyfoundation.org>.)

Facilitated Communication – This is a method of assisting an individual who uses a keyboard or a word or picture board by providing resistive support to the individual’s hand or arm. The facilitator holds or supports the person’s arm or hand so that the individual can touch the letter, word, or picture in sequence to form a phrase or sentence.

Hard-of-Hearing – The term *hard-of-hearing* refers to those who have some hearing, are able to use it for communication purposes, and who feel reasonably comfortable doing so. A hard-of-hearing person, in audiological terms, may have a mild to moderate hearing loss. The terms *deaf* and *Deaf* have been described above. . . . [The] Deaf Life article ‘For Hearing People Only’ (October 1997, page 8) defines hard-of-hearing in the following manner: ‘Hard-of-Hearing’ [HOH] can denote a person with a mild-to-moderate hearing loss. Or it can denote a deaf person who doesn’t have/want any cultural affiliation with the Deaf community.’ The terms *hearing impaired* and *deaf and dumb* are now considered unacceptable.

Learning Disabilities – The phrase *learning disabilities* refers to a disorder that affects people’s ability either to interpret what they see and hear or to link information from different parts of the brain. These limitations can show up as specific difficulties with spoken and written language, coordination, self-control, or attention. Such difficulties extend to schoolwork and can impede learning to read and write or to do math. (Definition taken from the LDOnLine Web site, <http://www.ldonline.org>.)

Loop Systems – Most hearing aids today have a switch marked M and T. Some even have M, MT, and T. The M (microphone) position is for normal listening, that is, receiving sound via the microphone built in to the hearing aid. The T position is for receiving sound via an induction coil in the hearing aid. For the induction coil to provide sound, a magnetic field is set up by a loop of wire around the area concerned and powered from a special loop driver amplifier. The MT position on some hearing aids allows a person to listen simultaneously to both airborne sound via the microphone and inductively transmitted sound via the induction loop system.

In recent years, induction loop systems have begun to be provided in public places such as churches, cinemas, theaters, offices, reception desks, lecture theaters, conference rooms, and even in the home, where the T facility is used to listen inductively. Induction loops are now becoming mandatory in many public buildings. Apart from being a means of communication, they also support a facility’s emergency evacuation protocol. (This information was taken from the Web site, www.hagger.co.uk.)

Medically Fragile – Children and adults who require constant medical care—for example, individuals who require tubes for breathing and eating and who require special handling for transferring from a chair to a bed—are considered to be medically fragile.

Mental Illness – Mental illness includes conditions such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention-deficit/hyperactivity disorder, borderline personality disorder, and other severe and persistent illnesses that affect the brain. These disorders can profoundly disrupt a person’s thinking, feelings, moods, ability to relate to others, and capacity for coping with the demands of life. Mental illnesses can affect persons of any age, race, religion, or income. Mental illnesses are not the result of personal weakness, lack of character, or poor upbringing. Mental illnesses are treatable. Most people with serious mental illness need medication to help control symptoms, but also rely on supportive counseling, self-help groups, assistance with housing, vocational rehabilitation, income assistance, and other community services to achieve their highest level of recovery. (Definition taken from the National Association on Mental Illness Web site, <http://www.nami.org>.)

Mental Retardation – *Mental retardation* is a term used to describe people who have certain limitations in mental functioning and in other areas of life, such as communicating with others, taking care of themselves, and social skills. These limitations will cause a child to learn and develop more slowly than a typical child. Children with mental retardation may take longer to learn to speak, walk, and take care of their personal needs such as dressing or eating. They are likely to have trouble learning in school. They will learn, but it will take them longer. There may be some things they cannot learn. (Definition taken from the National Dissemination Center for Children With Disabilities Web site, <http://www.nichcy.org>.)

Neurological Conditions – Neurological conditions are those that affect the nervous system (i.e., brain, spinal cord, nerves, and muscles), such as stroke (brain attack), Alzheimer’s disease, and back pain. (Definition taken from the Neurology Channel Web site, <http://www.neurologychannel.com>.)

Obsessions – Obsessions are thoughts, images, or impulses that occur over and over again and feel out of the person’s control. The person does not want to have these ideas, finds them disturbing and intrusive, and usually recognizes that they do not really make sense. People with obsessive-compulsive disorder may worry excessively about dirt and germs and be obsessed with the idea that they are contaminated or may contaminate others. Or they may have obsessive fears of having inadvertently harmed someone else (perhaps while pulling the car out of the driveway), even though they usually know this is not realistic. Obsessions are accompanied by uncomfortable feelings, such as fear, disgust, doubt, or a sensation that things have to be done in a way that is just so.

Obsessive-Compulsive Disorder – People who have this neurological disorder experience recurrent, unwelcome thoughts (obsessions) and repetitive behaviors (compulsions) that drive them to perform certain activities repetitively. (Definition paraphrased from Questions & Answers About Obsessive Compulsive Disorders on the Web site of the Obsessive Compulsive Disorder Foundation, <http://www.ocfoundation.org>.)

These symptoms cause distress, take up a lot of time, and significantly interfere with the person’s work, social life, and relationships. Most individuals diagnosed with obsessive-compulsive disorder recognize that their obsessions come from their own minds and are not about real problems, and that the activities they are compelled to perform are excessive or unreasonable. (Definition culled from the Web site of the Obsessive Compulsive Disorder Foundation, <http://www.ocfoundation.org>.)

Other Features of Obsessive-Compulsive Disorder – Obsessive-compulsive disorder symptoms cause distress, take up a lot of time (more than an hour a day), or significantly interfere with the person’s work, social life, or relationships. When someone with obsessive-compulsive disorder does not recognize that these beliefs and actions are unreasonable, it is called obsessive-compulsive disorder with poor

insight. Obsessive-compulsive disorder symptoms tend to wax and wane over time. Some may be little more than background noise; others may produce extremely severe distress.

Picture Boards – These are commercially or individually designed boards with pictures indicating the most typical things, actions, or ideas the individual may want to convey. Usually these boards include clear pictures of the basics, such as food and clothing, and more specific items the person may want, such as water, sandwich, sweater, bathroom, and TV. Many individuals customize their commercial boards. These boards are for individuals who cannot read.

Psychiatric Condition – See the Mental Illness section.

Response Set – This occurs when questions are asked that demand a set response pattern. For example, a response set occurs if all questions in a row are answered “yes” and the interviewee automatically says “yes” to the next question, or if one can identify a pattern for correct responses on a true/false test.

Sign Language – See the Deaf section. There are many different types of sign languages, including American Sign Language and finger spelling, and the sign languages of foreign countries. Signed English is one of several signing systems created to reproduce the grammar and word order of English. (Scott, Susanne and James H. Lee, “Serving Clients Who Use Sign Language,” American Speech-Language-Hearing Association Web site, <http://www.asha.org>.)

People who are both deaf and blind also use American Sign Language or an English signing system. However, they feel the signs by placing their hand over the signer’s hand and may use only finger spelling.

Spinal Cord Injury – Spinal cord injury is damage to the spinal cord that results in a loss of function, such as mobility or feeling. Frequent causes of damage are trauma (e.g., a car accident, gunshot, fall) or disease (e.g., polio, spina bifida, Friedreich’s ataxia). The spinal cord does not have to be severed for a loss of function to occur. In fact, in most people with spinal cord injury, the spinal cord is intact but the damage to it has resulted in loss of function. Spinal cord injury is very different from back injuries such as ruptured disks or pinched nerves, or degenerative conditions that may occur with aging, such as spinal stenosis.

People can “break their back or neck” yet not sustain a spinal cord injury if only the bones around the spinal cord (the vertebrae) are damaged, but the spinal cord is not affected. In these situations, the individual may not experience paralysis after the bones are stabilized. (Definition taken from the National Spinal Cord Injury Association, <http://www.spinalcord.org>.)

Stroke – A stroke or “brain attack” occurs when a blood clot blocks a blood vessel or artery, or when a blood vessel breaks, interrupting blood flow to an area of the brain. When a brain attack occurs, it kills brain cells in the immediate area. Doctors call this area of dead cells an infarct. These cells usually die within minutes to a few hours after the stroke starts. When brain cells die during a stroke, abilities controlled by that area of the brain are lost. This includes functions such as speech, movement, and memory. The specific abilities lost or affected depend on where in the brain the stroke occurs and the size of the stroke (i.e., the extent of brain cell death). For example, someone who has a small stroke may experience only minor effects such as weakness of an arm or leg. Someone who has a larger stroke may become paralyzed on one side or lose the ability to express and process language. Some people recover completely from less serious strokes, while other individuals lose their lives to very severe strokes. (This definition is found on the Web site of the National Stroke Association, <http://www.stroke.org>.)

Touch Toxic – This occurs when touch is painful or distressing for the individual. This is most common in individuals diagnosed with an autism spectrum disorder, but can also be present in individuals who have attention-deficit disorder or attention-deficit hyperactivity disorder, an obsessive-compulsive disorder, or an anxiety disorder.

Vision Impaired – Vision impairment refers to reduced or degraded vision due to conditions such as macular degeneration, cataracts, glaucoma, stroke, and retinal damage. (Definition taken from the Wrong Diagnosis Web site, <http://www.wrongdiagnosis.com>.)

Word Boards – Like picture boards, word boards contain frequently used words and give the individual the opportunity to communicate quickly.



SECTION 5

APPENDIX

RESOURCES

Preparation for working with crime victims and witnesses who have disabilities is a necessity. Finding a specialist or consultant in a hurry can be an added strain on the officer and others working the case.

The table below includes information that can be used when the need arises. It should be filled out with local and national resources.

Some national information is provided to give you a head start. This is illustrative only. Although we have included some of the major resources, the idea is to identify the types of organizations, agencies, and governmental departments that should be included on your list. Thus, following the first list is a form for you to complete and keep handy as you serve victims of crime who have a disability.

For those who are interested in acquiring a copy of the comprehensive curriculum upon which this DVD is based, the original documents can be downloaded at the following URL: <http://www.oes.ca.gov/Operational/OESHome.nsf/CJPDHome>, or Arc-Riverside (www.arcriversideca.org) can be contacted for an updated version.

RESOURCE	AGENCY	TELEPHONE	E-MAIL OR URL
Developmental Disabilities Experts & Resource (National)	Administration on Developmental Disabilities	202-690-6590	http://faq.acf.hhs.gov/cgi-bin/acfrightnow.cfg/php/enduser/std_alp.php?p_cat_lvl1=69
Local Developmental Disabilities Experts & Resource	State Councils on Dev. Disab. Nat'l Assn. of State Councils	703-739-4400	info@nacdd.org
Deaf Child/Adult Blind Child/Adult	OSERS –Office of Special ED & Rehab Svcs.		http://www.ed.gov/about/offices/list/osers/ntid.html
Sign Language Interpreters	Check Internet and your state licensing board of certified interpreters		
Mental Illness Experts & Resource (National)	NAMI – Nat'l Assoc. on Mental Illness; and NMHA – Nat'l Mental Health Association		
Mental Illness Experts & Resource (Local)	NAMI – local DMH – local NAMH – local		
Facilitated Communication (FC) Experts & Resource	Syracuse University, Cultural Fdn/Educ. 376 Huntington Hall, Syracuse, NY 13244	Phone: 315-443-2699 Fax: 315-443-2274	dpbiklen@syr.edu
Facilitated Communication (FC) Interpreters	Syracuse Univ.		
Forensic Interviewers	Child Advocacy Ctr.		

RESOURCE	AGENCY	TELEPHONE	E-MAIL OR URL
Disability Experts & Resource	Independent Living Center		
Service Animals	Service Animals of America		http://www.affluent.net/sara
Special Education Division	School District		
Organizations that advocate for and provide services to children and adults with developmental disabilities	Arc of the U.S.	800-433-5255	www.thearc.org/
Agencies specializing in responding to the nexus of abuse and disability plus online resource library and listserv.	Arc Riverside, CAN DO! Project (Child + Adult Abuse and Neglect Disability Outreach)	951-688-5141	ArcriverCa@aol.com www.disability-abuse.com
Cerebral Palsy	United Cerebral Palsy	800-872-5827	www.ucp.org
Online information resource on abuse and individuals with disabilities	Wyoming Institute for Individuals with Disabilities		http://wind.uwyo.edu/resourceguide
Onsite resource and outreach program	SafePlace Austin	512-267-SAFE	www.austin-safeplace.org
Victims services	National Center for Victims of Crime	202-467-8700	www.ncvc.org
Victims services	National Domestic Violence Hotline	800-799-7233	www.ndvh.org
Victims services	Rape Abuse Incest National Network	800-656-HOPE	www.rainn.org
Victims services	National Domestic Violence Hotline	800-799-7233	www.ndvh.org
Individuals with Disabilities	University of Minnesota		http://www.mincava.umn.edu/

RESOURCES FOR CRIME VICTIMS WITH DISABILITIES

This is a form for you to complete and keep handy as you serve victims of crime who have a disability.

RESOURCE	NAME	AGENCY	TELEPHONE	E-MAIL OR URL
Developmental Disabilities Experts & Resource (National)				
Local Developmental Disabilities Experts & Resources				
Deaf Child/Adult				
Blind Child/Adult				
Sign Language Interpreters				
Mental Illness Experts & Resource (National)				
Mental Illness Experts & Resource (Local)				
Facilitated Communication				
Experts & Resource				
Facilitated Communication				
Interpreters				
Forensic Interviewers				
Disability Experts & Resource				
Special Education District/Directors				

ADVISORY BOARD MEMBERS

The following professionals were members of our national advisory board:

PROFESSIONAL IDENTIFICATION	NAME AND TITLE	STATE
Law Enforcement	<i>Carolyn Gammiccia</i> Police Officer	MI
Law Enforcement	<i>Tony Miano</i> Chaplain, Los Angeles County Sheriff's Department	CA
Prosecution	<i>Elizabeth Schiebel</i> District Attorney, Northeast County	MA
Protective Services – Adult	<i>Eva Kutas</i> Director, Office of Investigations and Training, Dept. of Human Services	OR
Protective Services – Children	<i>George Stone</i> Supervisor, Riverside County Medical Center	CA
People with Disabilities	<i>Angela Kaufman</i> , Project Assistant, L.A. City Dept. on Disability	CA
Victims Services	<i>Wendy Abramson</i> Director, SafePlace	TX
Victims Services	<i>Sharon D'Eusanio</i> Attorney General's Office	FL
SART Services	<i>Diana Faugno</i> SART Trainer	CA
SART Services	<i>Michael Weaver</i> Emergency Room Physician	MO

DVD STAFF PRODUCTION TEAM

The following professionals were members of our DVD Staff Production Team:

NAME AND TITLE	STATE
<i>Nora J. Baladerian, Ph.D.</i> Executive Producer	CA
<i>Jim Stream</i> Executive Producer for Arc Riverside	CA
<i>Jennifer Ballinger</i> Co-Producer	CA
<i>Greg Byers</i> Producer, Director, and Writer	CA

EVALUATION AND OBSERVATIONS

The following evaluation form was used in our pilot tests of this DVD training product to assess its value and effectiveness through observations by members of our national advisory board.

Please use this format to inform OVC about your experience in using this training DVD. Positive comments provide validation that this product is meeting the needs of those responding to crime victims. Negative comments help guide future efforts and help to avoid repetition of undesired outcomes. Many comments let OVC know that this information is important to those in the field serving crime victims with disabilities, as well as those preparing to serve them.

DVD Evaluation Form

Please answer the following questions in order to inform OVC about your experience in using this training DVD.

#	QUESTION	YES	NO	COMMENT
1.	Did you learn something new while watching this training DVD?			
2.	Did you learn something new about people with disabilities?			What did you learn?
3.	Did you learn a new attitude or fact about people with disabilities that will help in your job?			Please describe:
4.	Did you learn first response contact skills or techniques that you will be able to apply in your job?			Please describe:
5.	Did you enjoy watching the DVD?			
6.	Was the length of the DVD about right for your learning needs?			
7.	What was the most important factor you gained from watching this DVD?			
8.	What did you like best?			
9.	What did you like least?			
10.	Was anything missing?			
11.	Would you recommend this DVD as an appropriate training tool for other law enforcement or first response agencies?			

Name _____ Phone _____

Position _____ Agency _____

E-mail _____

WRITTEN TRANSCRIPT OF THE DVD

A complete transcript of the training DVD, *Victims with Disabilities: Collaborative, Multidisciplinary First Response*, is provided below.

OVC – VICTIMS WITH DISABILITIES: COLLABORATIVE, MULTIDISCIPLINARY FIRST RESPONSE

>> Every day someone becomes a victim and every day a first responder is in some way working to help a victim of crime. Some of these crime victims are more vulnerable than others. People with physical disabilities may have difficulties protecting themselves or escaping harm. Some victims may not be able to readily communicate the vital information to a first responder that is needed to further their case. Conversely, the first responder may not be able to access the crime victim's information due to being unfamiliar with various methods of communication. This training video will focus on improving those very first contacts with crime victims and their families.

>> Part I, Introduction. The first response is not limited to law enforcement, but is a multidisciplinary team effort, which can include paramedics, firefighters, emergency medical technicians, both child and adult protective personnel, and interpreters. Further steps in the first response could also include forensic medical examiners, SART and SANE professionals, chaplains, victim advocates, and other healthcare and law enforcement professionals. We want to assure that all those who may or should be included reflect the multidisciplinary collaboration that is best for the victims and best for the case.

>> This initial contact is important and will have a permanent effect on the victim and their family. This contact will gain their trust and allow you to help victims cope with the trauma of the crime and begin to restore a sense of security and control back into their lives. This training information is for you as a first responder to use in addition to your current skills and practices in the field. Although there are many types and combinations of disabilities, this training video focuses primarily on individuals with cognitive and communication disabilities.

>> Cognitive differences are found in people who have mental retardation or conditions like mental retardation, such as those resulting from acquired brain injuries and learning disabilities that affect information processing.

>> Communication differences include speech production difficulties of individuals who have cerebral palsy, who are deaf or hard-of-hearing, deaf blind, and others whose communication may be difficult to understand. They may communicate best with the use of assistive communication technologies or use of certified or qualified interpreters.

>> When the first responder has information about how a disability may affect an individual and how trauma and stress bring out or intensify certain characteristics, the responder is more likely to understand that some behaviors that may seem odd or aggressive are, in fact, behaviors intended to communicate or simply demonstrate the victim's trauma or stress. Their behaviors may include rocking, pacing, loud verbal outbursts, and self-hitting, among others. These are not behaviors to be managed or stopped by the responder, but understood as part of the individual's normal behavior or exaggerated due to the stress of the event or moment.

>> By yourself.

>> They said that.

>> Yeah.

>> What a bunch of baloney. That's stupid.

>> Get this. He made my sister get off the ride.

>> We live in a society that maintains a disability negative attitude, which is based on a history of myth and misconception supported by a lack of understanding, awareness, and communication in all facets of disabilities.

>> If we want me angry and upset and I'm frustrated and it's wrong.

>> Yes, it was wrong. And just being angry it's no excuse to get physically aggressive.

>> What he did, _____ pull my hair and punch my arm. It's black and bluish and _____ the truth.

>> This Saturday I'm leaving. I'm going to the _____ with my family.

>> Where are you going?

>> Huh?

>> Where are you going?

>> This Saturday.

>> No where?

>> Um Oklahoma.

>> Oklahoma.

>> Yes. With my family.

>> Sometimes even if it's not an issue of them being understood, a lot of times you know communication deficits can be in putting thoughts together logically. And sometimes you know really seemingly articulate people or guys that are fairly articulate and the disability is kind of hidden when you're looking at them. You're saying oh what's wrong with this guy. You know he looks, he looks totally normal, you know. And it would then be when you get into a prolonged conversation you can see that the disability may be very involved with regard to their communication skills.

>> I have one thing to say. For the residents who live in Inglewood, be on alert. There was a kidnapping last night around 8:30 p.m. A 13-year-old was kidnapped at gunpoint after he got out of his uncle's truck. They sped off on the area around 104th and Dody _____. Just to let you guys know.

>> Ryan.

>> Okay. Once again like every Wednesday I'm going out to see the No Doubt cover band called No Duh, and I'm going to give them a copy of my CD.

>> Fantastic. All right. Good for you.

>> Three weeks from Friday, I'll be 37 years old and I'm going to be singing a Journey song, "I'll Be All Right Without You."

>> Two things to look forward to.

>> Officers and other first responders have identified specific issues that affect their work with individuals with disabilities. They find that, at times, it's hard to understand what the person is saying. They're uncertain that the victim understands what they are asking. They are concerned that the person with disabilities may have limited or different vocabulary. They are aware that the victim may love or have a close relationship to the abuser. They recognize that the victim may be dependent on the abuser. They do not know alternative resources if the caregiver or abuser is removed from the victim's home. They have an initial uncertainty of the person's credibility or reliability. They have a heightened concern about the viability of the case.

>> These common reactions may make these cases more difficult and also make the first responder less effective in their duties.

>> Exposure and interaction is the key to understanding people who have disabilities and eliminating the fear of the unknown. Although this video cannot address all situations or all disabilities, the understanding and use of the basic principles provided in this training program will assist any first responder in having a more successful personal experience and create a positive experience for the victim.

>> Part 2: Exposure and Knowledge.

>> Hey yeah _____ mailroom. Background, that's your cue to start moving, okay. That's okay.

>> Personal familiarity with individuals who have a disability creates an understanding and awareness to one's uniqueness. But for those who are not as familiar, they may feel uncomfortable, awkward, and uncertain in responding to any individual with a disability.

>> Going back like go back to the beginning. I'm a woman who has cerebral palsy. I'm also a daughter, a sister, a sister-in-law; hopefully, soon, one day I'll be an auntie. I mean it's just a part of who I am. It definitely has an affect on who I am. It affects certain areas of my life more than others. You know I don't drive. I take the bus everywhere. That certainly, cerebral palsy has that effect on how I live my life in certain areas, but I didn't want it to define who I am. You know I'm a woman who has cerebral palsy. I'm a woman who's black. I'm a woman who's no longer 25. You know it doesn't, it's just not the sole definition of who I am. It's part of who I am.

>> Pass me the ball.

>> When meeting an adult or child with a disability, it is helpful to consider what they have been taught socially in order to fully understand and document their information accurately.

>> Nick had never spent the night by himself before and really when he lived with my mom, he didn't have a lot of responsibilities. He was really taken care of.

>> I'll tell them.

>> Oh, he loves this one.

>> I'm going to stand by myself. No. I go to the hospital. No, I call mom's cell phone first. My mom didn't answer the cell phone. I called the hospital. Let me read more. I grabbed the phone book and looked down _____, called my mom's cell phone. First, I called my mom's cell phone. Then she didn't answer. I grabbed her phone book and looked down _____, found it, called.

>> So he was smart enough on his own with nobody telling him to do this to open up the phone book and he found the M's and looked up for Middletown Regional Hospital and called and went through the nurse's station and got them to get him through the room so that he could get a hold of us, which I was pretty impressed by.

>> The only reason I called because somebody needed to pack my lunch.

>> It wasn't really an emergency.

>> People with developmental disabilities often are taught values and beliefs that affect their behavior and social etiquette. These include, do not get others in trouble and do not cause trouble.

>> That's what they eat. Yeah.

>> Obey the rules and those in charge. Don't get angry. Agree with adults or authority figures. Do not be assertive. Don't express negative feelings or a desire for change. Knowing these values will help you understand why a person may have behaved in a particular way such as not resisting a sexual advance or not telling about an abuse or not wanting to get an abuser in trouble.

>> Sometimes I say a guy is coming, following you or something like that. I punch him and kick him, too. That's what I do. I just punch; I always punch him in the eye. I do like that. Sometimes I always tell a teacher, too. I always tell her that, too.

>> So where did you learn the self-defense?

>> Because I _____, so I says _____ the school because Carla told me that because I have to stay away from strangers as I am not allowed to open the door, I cannot do that. I just waited to tell my dad.

>> Okay. That's done.

>> Janine, before you leave can you do something for me? I need for you to do some acting.

>> I don't leave yet before 10.

>> Oh, I mean before you leave the bathroom, before you come out of the bathroom.

>> Yeah.

>> Can you do some acting for me?

>> I don't do acting.

>> Well here's what I want you to do. Can you take your badge off?

>> I can't take it off though. I have to leave it on, on my uniform.

>> Well what I mean is can you take it off now and then we'll get a shot of you putting it on.

>> I already did it before you guys just got here. I already did it.

>> I noticed that. But can you do it for the camera to pretend like you're just putting it on for the first time.

>> Maybe I can do this right now.

>> Yeah.

>> Okay.

>> And do it right there in front of the mirror like you're getting ready, like you do in the morning.

>> No, I'm getting out.

>> No, stay, can you stay in there and put it on in front of the mirror?

>> I'm going to be right here.

>> She's very strong willed and if you don't explain well to her then she puts the brakes on, you know. But once you explain she relaxes and everything's fine.

>> Okay.

>> And then adjust your hat when you're done with that on.

>> I got my hat on.

>> Okay. And making sure it looks nice. That's it. Now look at yourself. Can you wink at yourself real quick?

>> I'm not going to wink my eyes.

>> You can't?

>> Not in the camera.

>> Well do it in the mirror like you're winking at yourself.

>> There. Only one eye.

>> Since there are so many variations in individuals with disabilities' lifestyles, values, beliefs, and world experience, many people believe in the concept of culture of disability. And within this are subcultures that vary depending upon the disability.

>> A lot of people, you know, first think I'm just stupid you. And _____ wait a minute, I'm deaf. I don't understand. Say it again. I can hear you just I don't always understand you. So it's just a matter of reading your lips. And then I'm like oh okay and then make sure that they're more clear and their lip movements rather than it looks like they're mumbling. But they're not mumbling; it's just the way they talk. But to me, it's what I'm hearing is mumbling.

>> And to make sure that you tell them too, if you need to talk to me make sure you're looking at me instead of you know saying something or they may be writing something down first and you can't see. Or if they have a mustache or a beard or something like that it's harder to read lips.

>> And the police couldn't understand her, couldn't understand her. I don't understand them either.

>> This is why it is critical to have some background information on different types of disabilities and how these disabilities affect the individual.

>> _____.

>> And scary.

>> Scary. Crying a lot.

>> This book, the legal rights, I have it in my purse and I take it everywhere I go, we go. And we do come across _____ and you're not sure what to do there's always a toll free number that the EMT can call or the police department can call and find out exactly what the proper procedures are. Once you see the ID of that person or whatever, normally you're going to find an ID card that says I'm deaf, I need an interpreter, things like that.

>> Among many individuals with disabilities, their body has been the domain of others for hygiene, dressing, mobility, medical attention, feeding, and transport among other tasks.

>> The child or adult who requires such assistance is used to being touched by others without their permission and have not had the opportunity to develop or exercise a sense of personal body integrity. It is easier to understand that the individual may be confused when sexual contact happens by a caregiver. They always know however that the sexualizing of contact felt wrong or bad.

>> Now I'm going to butter it now. Okay that's how.

>> Sometimes a response set or desire to please may result in many affirmative answers to questions that may not accurately reflect the individual's experience.

>> Janine do you have waffles every day?

>> Yes, I do. Yes.

>> You never vary from it? You don't have like, what if you're out of waffles and there's only toast.

>> But then you know why because after this is cereal.

>> So, this is your first course, first-course meal.

>> Yeah.

>> What she means is she varies about every other day. You have waffles maybe what two or three times a week and then you have cereal the other days.

>> Yeah. Yes, I do.

>> So, you don't eat cereal right after this?

>> No.

>> By allowing them to tell what has happened in their own way and later by having a discussion with others who know the person will lead to a more productive result.

>> A training guide that accompanies this training DVD contains a section on a variety of major types of disability you're likely to encounter as a first responder. Although the differences in lifestyles appear vastly different, throughout this video you will see that there are more similarities than differences among those with and without disabilities.

>> Okay, here we go.

>> Part 3: Profiles for Practice.

>> The following sections are glimpses into the lives of some individuals with disabilities. Physical appearances will sometimes clue you in to a disability, but other times you will need to pay closer attention to find out that a disability may be something you can't see and that maybe there is something more capable beyond one's disability. Take the time to listen and observe. Notice the speech and thought patterns.

>> Pretty amazing, huh.

>> Notice the concern of family members and appreciation of employers. Notice any similarities to your own life.

>> Okay. My name is Danny Harris. I'm a writer from _____ School and I worked so hard today and I'm here with my good friends. This is my brother, Joey, and this is my dad, Steve Harris.

>> Hi, everybody.

>> We, we had a good time from Wes of last week until Saturday and Sunday and Monday, Tuesday, Wednesday, Thursday, and Friday. Last Saturday, we had brunch for action club for action club for pancakes and bacons.

>> Were you supposed to have one today?

>> That was last Saturday.

>> We were supposed to go do one today weren't we?

>> Yeah, we were supposed to be doing one day.

>> What happened? How come you didn't?

>> What happened? Oh, we just had a good time and it was a good time.

>> Was it supposed to rain today or something?

>> Well, it was raining last week because, but the problem is the rain has come all the way from the clouds last night because it was raining last night. So and that's the whole story.

>> Do you know the Amtrak is Joey?

>> Uh.

>> I can't find the Amtrak schedule. I can't find the Amtrak.

>> Oh, right here huh. _____. Right here. Do you see it there? _____ the map _____ because he takes the train. It's right here. Do you see there?

>> The train. Oh yeah.

>> Joseph will get interested in something and walk away sometimes and I have to go looking for him. And that's my fear, that he's gotten out of the bounds and away you go. So I mean he's, when he was younger, he scared the heck out of me. He got, you know left the front door. We used to keep the front

door alarmed so I'd know when they left the house. But he'd go out, he'd wander off, he was hungry for a doughnut. He'd walk three blocks over to the doughnut shop and we didn't know. And we had to go call the police and say we're missing an autistic child who got out of the house and off he was going. And again he didn't have the capability at that time, as he still really doesn't, to say here I live at this location. And that's a great fear for a parent.

>> Are you guys going to do it one more time?

>> Yeah.

>> Okay, this time I'm not going to tell you guys anything.

>> Her hearing loss was about 80%. Now it's dropped down, it's gone to about 90%. So she's actually, through the years, she's actually gotten a little bit worse. Although you wouldn't be able to tell with her hearing aids. But when we do take tests she has gotten worse so she could even go completely deaf in the years down the line. We don't know. But she is at a 90% hearing loss. When her hearing aids are out it's, she's basically completely deaf, yeah, yeah. So.

>> Well what if I'm at a 100.

>> What if you're at 100. I don't know we'll have to see what happens then. I kind of hope you don't. I kind of hope you kind of stay the way you are.

>> So did you guys have to sign before? Did you read lips with them?

>> We had to sign.

>> But in the pool mostly.

>> In the pool.

>> Yeah and I had to jump up and down because I couldn't reach the dog.

>> Yeah because, Erin, you can't hear when you're in the pool because you're not wearing your hearing aids. So that's when we.

>> Yeah because I wear earplugs.

>> You have to wear earplugs. That when we have to.

>> Because if I don't, water gets in my ear and I get ear infection.

>> Oh my God.

>> In here it sounds like.

>> Don't lick it please.

>> And then I have FM and I use it in the classrooms and my teacher wears a mic.

>> The FM system.

>> Without them how good is your hearing?

>> Bad.

>> Completely no hearing.

>> Yeah. Completely silent.

>> Now, Erin, if you were to lose your hearing aids and you're not at home would you be able to not be stressed out and be able to communicate with people okay? How would you handle a situation like that?

>> I would be, but um I wouldn't like it if I didn't have my hearing aids in because I can't hear a thing. I like hearing things that's why.

>> Does it make it much more difficult for you? It's a lot more work isn't it?

>> 'Cause if I read lips sometimes they're like talking too fast and I can't tell what they're saying.

>> Would you be able to tell someone that they need to speak slower?

>> Yeah sometimes, but not really. Because if I just knew that person and I didn't have my hearing aids in I'd be too shy.

>> Go inside. _____. And my sweatshirt like that. Okay. I do this. I always bring out the trays. I put this in the front too. And the straws goes in the front too. That's why I do it. This is Roberto. He works right here. That's where I work. He's one of the managers too. Okay she works right here and she works with the tomatoes, ketchup, mayonnaise, pickles, tomatoes, ham, and turkey. That's what she does. Okay. Let's go this way. Excuse me. Okay move the trays. You're welcome. Hi. Hello. Okay. Close it. There you go. Over there some kid's always making a mess with the salt shakers. That's what they did.

>> She knows my standards and she knows the owner, Mike Corey. She knows how he likes you know we treat the customer and keep our dining room. So she's, she's making my job easier to keeping this dining room clean, nice and clean. Thank you, Janine.

>> You're welcome.

>> With employees, with the co-workers, she gets along real good. She dances the Macarena for us everyday and you know. So we don't go hey Janine anymore, we call her Macarena, Macarena and when we say Macarena she start dancing for us also.

>> Always in a good mood. She never has anything negative to say. She's diligent about what she does. She's proud of what she does. And the most important thing is, what you want out of every employee, is that she's just reliable and always happy.

>> Hey. And thank you. Thank you very much. Anytime. Thanks.

>> Part 4: Methods of Communication.

>> In this section we will cover pre-interview considerations specifically regarding communication issues, including working with an interpreter.

>> Westminster Police. Do you have an emergency?

>> A dispatcher's radio call is the first opportunity to provide preliminary information to a first responder such as that the victim has a communication, physical, cognitive, or other disability along with a need for a special method of communication.

>> What's the resident's name please?

>> In some cases, the responder may be informed that the child or adult is nonverbal. It is important to ask exactly what that means for this particular individual. In most cases, the person will have limited language skills, including an ability to say or signal yes or no. Some may not have an identifiable method of communicating. In such cases, the information needed for this case will most likely be based upon a report of someone other than the child or adult.

>> These books over here are the daily behavior books where we um keep the daily behavior, the skill development each day. So we settle down at the end of the evening with the staff and you know see how the day went and this is what we enter into these books right here. Any _____ that happen on that day, if she got hurt at the day program or something like that.

>> The responders will be in the difficult position of acquiring such information from individuals who may be the suspects. They may be group home or other residential program staff, work or training coaches and supervisors, transportation providers, family members, or friends. The responder will need to determine how the individual best communicates. If the person requires the use of a communication system or board the parent or other adult will be able to provide information on how you can use this.

>> Most of the interview will involve verbal or sign interchange. However, you could ask for paper and crayons or other tools such as photos of people or places familiar to the person.

>> When we came over to the farm for the restaurant.

>> Or use a communication book such as this one. This will enhance the communication and allow the person to describe their story to you.

>> If a sign language interpreter is normally used, the first responder will need to know how to get the interpreter to the scene or the next intervention location. But every situation is different and sometimes there is no other option but to use a family or household member, a neighbor, or other child or adult to act as interpreter. The disadvantages to this are obvious. The family member could be the abuser or have a personal bias. There could be inaccuracies of the interpretation or the subject matter could be too emotional. And because of the close relationship, the victim may avoid disclosing some of the information fearing what the interpreter may think or say, as well as hurting the interpreter's feelings.

>> Hello. Hi.

>> The ideal situation would be to have an appropriate qualified and certified sign language interpreter on call. The interpreter's role is to bridge communication between two or more parties. The interpreter is not part of the interview.

>> Thank you.

>> My name is Sherene Holly. I'm an APS social worker and this is my interpreter, Paula.

>> Oh, okay.

>> They should remain impartial and not input their personal feelings or opinions.

>> Can we sit down and talk with you for a while?

>> A brief review of procedures for using an interpreter includes the following main points. 1, before the interview, speak with the interpreter and provide them with any necessary background information.

>> Um is there anything you can see that might be a problem or?

>> Do you know what kind of sign language she uses? Did they say anything?

>> Nothing at all. Even on the report it doesn't state anywhere in here.

>> 2, during the interview do not engage in direct conversation with the interpreter.

>> Um. Oh. I forgot. I don't remember it. I don't have it memorized.

>> Oh that's okay. And these are just questions that I have to ask you.

>> Okay.

>> 3, assure proper physical placement of the interpreter. Next to the interviewer is usually the ideal position. Check with the victim to ensure that they are comfortable with the placement. 4, watch for direct lighting sources such as windows to avoid glare for the victim and interpreter. Lip reading and the ability to understand or express one's self can be affected by lighting. 5, speak directly to the victim. Do not say to the interpreter, tell her I want to ask her some questions.

>> What's your doctor's name?

>> Um Dr.

>> 6, do not over exaggerate your lips movements or over enunciate if the individual is trying to lip read.

>> Finally, make sure the child or adult knows that you are there to help. And what may happen is not because of their disclosure but because of what the suspect has done. Assure the victim that they are not in trouble.

>> You're not the one at fault.

>> Okay.

>> My job is just to help you and to make sure that you're doing okay. In the event that you do have any questions.

>> As a first responder you will encounter numerous situations that pose a challenge and require a solution. Situations you may encounter off duty and in everyday life can be equally challenging. It could also provide an opportunity to communicate without the distraction of a uniform or critical situation.

>> Hey, Danny, how long have you had that hat?

>> I used to wear this hat on when we went to the _____ Steamers on Sunday.

>> You may notice that some people with a developmental disability will not be able to respond to an open-ended question. Their story or answer may come out as it occurs to them and not in chronological order.

>> Do tell me about on the weekends when you come here on Sundays? What do you do on Sunday?

>> We used to have lunch here at the _____ Steamers. Then we'd go lots of good lunches. We have hot dogs and burgers and all good stuff. We had chips and they got cookies and they have good granola bars.

>> If this happens do not interrupt the flow. Be patient with delays. They may require time to prepare the response or express it due to slower mental processing. If the person is unable to respond to a broad, open-ended question, use more limited questions before going to direct questions.

>> What do we tell the public?

>> You have to sit properly on the train. Before we get started we keep our hands inside the train also. Do not touch and also we'll have a big problem for motion for the car.

>> And if you drop something?

>> And if you drop something the conductor will have to stop the train.

>> So we'll pick it up for them.

>> And then we'll have to pick it up for. And have a safe trip and enjoy your ride and all aboard.

>> All aboard, yeah.

>> These are just some of the pre-interview considerations you will need to keep you on track. For more information on working with various communication techniques and interpreters consult the DVD training guide.

>> Part 5: Initial Contact.

>> The following scenarios are not actual true victimization events and no crime has been committed to our individuals with disabilities, but these scenarios may represent a situation a first responder could encounter.

>> Hi, we need to speak with an officer.

>> Okay regarding?

>> Well, actually she's staying with me right now and she has told me about, about a week ago she had been assaulted. So I tried to contact her father and can't get a hold of him so we figured that we would come on in here and talk to an officer.

>> Okay and is she a minor?

>> No she's an adult.

>> Okay. And did this happen in Westminster?

>> Yes.

>> Okay, if you want to have a seat I'll go ahead and get an officer for you.

>> Okay thanks.

>> You're welcome.

>> Okay let's go sit right over here.

>> As a point of reference, prior to any initial contact with a first responder, we showed our victims a photo of a male suspect and asked them to look at the photo and remember what he looks like.

>> Okay he's tall.

>> The first responders have not seen the photo and will be meeting our individuals for the first time.

>> He doesn't have to learn to tie his shoes then guess what he's, he's, he might trip and fall down. He was a little bit too warm. When he got cold he wear his jacket.

>> There are many levels of disabilities and our individuals represent only a small section of the population. In a true encounter you may or may not experience a similar individual. This exercise will provide an understanding as to the perceptions of how much information an individual with a disability actually does remember and how they can later communicate the descriptions to a first responder.

>> Study the photo yourself and try to recall the specific details to compare with the victim's descriptions later in the video.

>> 7, 13 Bravo and 15 Bravo, 21 I in Freedom Park _____.

>> 527, 15th and Jackson.

>> From call to call a first responder wears many hats and adjusting your mind set for each new situation and interview may take time.

>> Thanks.

>> Hi, I'm Cindy.

>> Hi, I'm Janine.

>> Nice to meet you, Janine.

>> You too.

>> And.

>> Hi, I'm Robin.

>> Robin, okay.

>> Nice to meet you.

>> Okay, Janine, I'm going to have you sit in this room right here and I'm going to talk to Robin real quick if that's okay.

>> Yeah.

>> Okay. Why don't you just find a chair in there and make yourself comfortable okay?

>> Okay.

>> The interview with the victim will follow the usual stages of getting to know the child or adult. Identifying yourself and making assessments of communication and intellectual abilities. Modifying the interaction to meet your assessment. Directing the conversation from the general to the specific. Acquiring the information needed to determine whether a crime has occurred or the child or adult needs protection and including the interview.

>> How are you doing? Did you call us?

>> Yes.

>> What can we do for you today?

>> He took my bag with my ID and my wallet.

>> He took your bag.

>> Yeah.

>> Who took your bag?

>> This guy. He was wearing a blue shirt and a blue hoody and he had brown.

>> For an officer initial contact varies depending on the urgency of the call.

>> Did he have a gun or a knife or a?

>> No.

>> Just his hands.

>> Yeah.

>> Okay.

>> And he had a skateboard and headphones.

>> Was he a white guy or a black guy?

>> White guy.

>> White guy. He was wearing a blue shirt.

>> Yes. Blue shirt with number 93 _____ on his shirt.

>> If a victim has been assaulted, injured, or threatened by a suspect with a weapon, and the suspect is still on the loose, the officer will want to get information quickly versus a less urgent matter.

>> Did he hit you?

>> I fell out of my wheelchair.

>> Oh, okay. Did you hit your head?

>> I hit.

>> But once the officer has identified the victim as someone with a communication disability the officer

should remember to slow down in order to get the information they need.

>> Fight, trying to fight him off.

>> You hurt anywhere else bro?

>> No.

>> Okay, so he was a white guy?

>> Yeah.

>> Wearing a blue shirt that said 93 on it.

>> Yeah and he had on a blue hoody.

>> A blue hood?

>> Like a blue jacket with a hood.

>> Okay.

>> Anybody else see this?

>> No I was going _____ to come with me to take me home but my friend never showed.

>> So you're not here with anybody else then?

>> No.

>> Okay. Which way did the guy go?

>> I think he went that way.

>> Toward the baseball field.

>> Yeah.

>> Was there anybody else with him?

>> No. He was all by his self.

>> Handling Distractions. By nature of the job and the uniform, an officer or an EMT is a walking distraction. Try to minimize as much as possible any controllable influences such as turning your radio down lower and avoid using sirens and flashing lights when possible. Attempt to record. If at all possible and if allowable in your jurisdiction, record the interview. This will allow a later examination of this statements or audio cues that may be of importance. When the victim is a deaf individual, audio recordings capture only the interpretation of the message and not the actual message. A videotape recording with both the victim and the interpreter visibly clear in frame will provide a complete record of the information gathered on the scene.

>> It is essential to remain aware of the importance of first impressions. These include the impact of the first responder's impression of the crime victim who has a disability. The first responder should display genuine interest, compassion and respect even when feeling at a loss as to the socially correct method of conducting the initial greeting and introductions. Rather than barraging the person with questions at the beginning, to develop rapport you take charge of the conversation by describing the reason you are there and your purpose.

>> And are you Danny?

>> I'm Danny Harris by the way.

>> You're the one that called. Hi, I'm Officer Paul Walker with the Westminster Police Department. You

called about somebody in the neighborhood.

>> Yep. I just saw him on the picture and somebody for the police, for the picture for that guy.

>> Okay. What did this guy look like?

>> He, well here's the question about this picture. Okay, the first question is for the day for you is that guy was holding that skateboard which was on the first day and then he's wearing a purple hat and a purple shirt with number 9 on it and he's got a big purple hat on it and he's got a blue jacket on it and he's got blue pants on him. But he was look like a skateboard. He's turning around and then he's turning around back at me again.

>> Have you had any problems with this person at all?

>> Nope.

>> Did you ever seen them before today or was today the first time?

>> Because I'm not sure what he saw him or saw somebody today but sometimes I used to see him a lot.

>> So you've seen him before.

>> Well I see him before because.

>> Using interaction skills. Use this as your opportunity to assess their ability to respond, pacing, speed, and delays. Match your pacing and speed to them. Use age and developmental level language appropriate to the child or adult. Use the language technique of plain English. That means use the most basic term or phrase possible.

>> How long ago did you see him? Was it earlier today or was it like before lunch?

>> Sometimes I used to see him for lunch for a long time ago. But it's a long time ago but I never seen him.

>> What is his diagnosis?

>> He's autistic.

>> Autistic. Does he have issues with time, telling time, you know timeframes?

>> Time and ah I want to say tense, yeah.

>> Okay. So he may say a long time ago, but it very well could have been today.

>> Could have been today, yeah.

>> Okay.

>> Voice. Make sure that the tone of your voice, pacing, vocabulary, volume of voice, and intonations offer comfort, demonstrate an interest and concern for the individual's well being. Don't use a loud or forceful voice. And don't talk down to the person or use baby talk.

>> Eye contact. Similar to touch, for some children and adults, particularly those with autism spectrum disorders, eye contact is not a pleasant experience. Actually, eye contact is not necessary for excellent communication to occur. It is best not to demand that the child or adult look you in the eye. If the individual is deaf, eye contact is a necessity for communication

>> Law enforcement chaplains provide emotional and spiritual care and support the victims or witnesses to critical incidents in crimes.

>> And, Janine, this is Sid; he's a chaplain and he's here to talk to you and help you out.

>> Hi, Janine.

>> Hi.

>> I'm Sid Bradshaw.

>> I'm Janine.

>> You Janine?

>> Yes.

>> Do you know what a chaplain is?

>> It sounds like a guy's name right.

>> A chaplain is what?

>> He's the name of a guy; he's the name of the chaplain right.

>> Chaplain is someone that spends some time with people just to talk to you about how you're doing.

>> It is at this point that the chaplain understands the needs and conditions that affect the individual and possibly facilitate any needed support and services to the victim. In most situations the chaplain will not be asked to participate in any formal investigative interviews. Although depending on the circumstances, the chaplain may find him or herself present during such interviews.

>> You know is there anybody that you'd like for me to call and tell them that you're here, like you're dad?

>> Uh-huh.

>> Would you like me to call your dad?

>> Yes you can now.

>> We can. Can I get, just really quick if you'd give me the number I'd appreciate it.

>> I don't have the number because I can call my dad on my cell phone.

>> Oh you can call him on your cell phone.

>> Yeah.

>> Okay. Then maybe that's what we'll do is we'll use your cell phone in a few minutes after Cindy comes in and just give your dad a call. Is that okay with you?

>> Yeah.

>> You have his number programmed in there.

>> I always push 3 and that's the number I call my dad.

>> Great. Well Cindy's going to come in in a few minutes and just visit with you.

>> Physical position. In most cases, your physical position is important. Seating yourself at eye level or lower with the victim minimizes problems of authority and intimidation that may be felt. By positioning yourself directly in line of sight of your communication partner, universal communication methods are enhanced. This means that the child or adult can use lip reading skills if necessary, can read your body language, can primarily focus upon you, and will see your concern and interest in their welfare. Space. In addition to level, how much space is designed between you and the child or adult is an important consideration. This may be affected, however, by the child or adult's disability and they may require less or more space to feel at ease or for communication purposes.

>> Okay. You're doing good Nick, you're doing good.

>> I'm so glad you guys are here.

>> In some instances, teamwork is a daily routine and working together can help retrieve information and increase a victim's comfort level. For some victims, fire, rescue, and EMT units can appear to be less physically intimidating than law enforcement officers. Use this to your advantage when situations require a different approach.

>> This is Nick. He's 22-years-old. He was the victim of a robbery. No weapons. There was a slight struggle. He fell out of his chair. He keeps complaining about his neck hurting and he's got some scratches back there.

>> Hi Nick, my name's Todd. I'm one of the paramedics. Nice to meet you. Do you mind if I take a look at you?

>> It's okay.

>> Alrighty. What happened?

>> This guy just took my bag and my wallet and my _____.

>> Okay. And do you hurt anywhere?

>> My neck.

>> Your neck. Do you mind if we take a look at you?

>> It's okay.

>> Alrighty. Mike here's going to take your blood pressure.

>> Hi Nick, can I take your blood pressure? Oh thank you.

>> Robbery, took his backpack, no witnesses.

>> Right fell out of the chair. He's got a little neck pain right now.

>> Thank you, sir.

>> Okay, Mike's going to get your blood pressure. I'm going to take your pulse real quick. Excellent. You don't hurt anywhere else?

>> No.

>> Relax that one for me.

>> Just my neck.

>> Just your neck. Alrighty. I'm going to take a quick look at it. Right back here.

>> Yeah.

>> Alrighty. Your head doesn't hurt at all.

>> No.

>> No. Can you take a look at me? I'm going to take a look at your eyes real quick.

>> In developing rapport, if time allows, after you have described your job and specific role, engage them in conversation about their interests, activities, and family.

>> Who do you live there with?

>> I live; I live with my dad and my dogs.

>> Your dad and your dogs.

>> Uh-huh.

>> How many dogs do you have?

>> I have two pugs.

>> Yeah.

>> Yeah.

>> What are their names?

>> Bonnie and Clyde.

>> Bonnie and Clyde, huh.

>> I love it.

>> When you feel the person is ready, begin your interview. One at a time beginning with those questions of most interest to the individual. Allow plenty of time to respond and an opportunity to go outside your question to areas they may wish to discuss.

>> And where do you work, Janine?

>> I work at Wendy's by Culver and Walnut in Irvine.

>> And what do you do at Wendy's?

>> I work there for 15 years.

>> What do you do there? Do you cook?

>> I do the dining room.

>> You do the what?

>> I do the dining room.

>> The dining room.

>> Oh the dining room. Okay.

>> Yeah she's in the dining room. You're the one that brings all the food to us right.

>> Sometimes we do because I have to do that.

>> Look for the numbers on the counters and you bring the food to us and.

>> Yeah.

>> Great.

>> Yeah.

>> Do you remember what the suspect looks like?

>> He's tall, has a purple hat, purple shirt, blue eyes and brown shoes and blue pants.

>> That's a good memory.

>> Thank you.

>> Do you remember what nationality he was? Was he Hispanic, Asian, White, Black.

>> He was white.

>> He's white?

>> Yeah.

>> Do you remember how tall? Was he my height, a little bit taller?

>> He's taller, the same size like you are.

>> He's my height?

>> Yeah.

>> Is he bigger than me or is he skinnier than me?

>> He's skinny.

>> He's skinny?

>> Yes.

>> Is he a little bit skinnier than me or is he my size?

>> He's a little bit skinnier.

>> Skinnier.

>> Uh-huh.

>> Okay. Did you see any facial hair on him? Did he have a mustache, goatee?

>> He had, he has a goatee and a nose and a mouth and eyes and ears.

>> Okay. Did he have, like how Sid has a mustache; does he have a mustache at all?

>> Yeah he don't have a mustache at all.

>> No.

>> Just a goatee.

>> Oh okay he did have a goatee.

>> Yeah.

>> A little one.

>> But under her, his chin.

>> Under his chin.

>> Yeah.

>> Did he have any earrings or was he wearing glasses or anything?

>> No. He didn't wear glasses.

>> No.

>> No.

>> And do you remember was his head really thin shaped? Was it round?

>> It _____ being round.

>> It's round.

>> Nick what kind of medical problems do you have?

>> I just have cerebral palsy.

>> Okay. No seizures, no asthma, no diabetes, no heart conditions, no lung problems. No, just cerebral palsy. Do you take medicine on a daily basis for anything?

>> I used to take valium.

>> Valium. Do you take it anymore?

>> No, just for my back and _____ because my back's been acting up too.

>> Okay, so you're currently taking it now?

>> No.

>> No. Okay. And are you allergic to any medicine?

>> Um I forget what they did when I went for a root canal. They put.

>> Was it the numbing agent that they gave you that you were allergic to?

>> No they just gave me, I forget but they gave me something for I didn't take nothing, it put me to sleep.

>> Okay. And then you had a reaction to that.

>> Yeah I started wailing on the dentist.

>> Okay.

>> Because I didn't I was, they didn't tell me what they, they told me what they were going to do but you know I forgot.

>> Okay.

>> And he said I'm having problems with my shoes. And you're having problems and what is it. My shoe's untied. Your shoe's untied, okay. And well _____ tie your shoes in no time and you'll be free and you'll be ready to go.

>> So he actually knocked on your door?

>> Sometimes he does already.

>> Sometimes he knocks on the door.

>> In this scenario our officer is aware that there was not a real suspect or crime but Danny's recollection sounds as though it is reality. But remember Danny was shown a photo of a suspect and one of Danny's education skills at his school is to look at a photo and tell a story about the picture they see.

>> But the problem is he's, he's, he looked to go on his skateboard.

>> Okay.

>> And that's what he does already.

>> Okay. And did you see him today?

>> I just saw him. He, he, he looked like a skateboard kid.

>> Okay. And was he doing anything at all? Was he just walking down the street or was he hurting you or yelling at you or anything like that.

>> No.

>> No.

>> He's not yelling at me. He's not screaming anymore. He's looking at this and he's trying to say something to me. He said yes.

>> Danny's participation for this video was his best recollection of the suspect and the description he gave was very close to the actual photo. Had this been a real call, Danny's description would be valid and helpful in this case. Officers can establish knowledge of truth versus fantasy by asking questions they know the answer to in order to verify that the child or adult knows what the truth is.

>> How you end your interview is of critical importance. Letting the child or adult know that you understand what has been revealed. That what you have been told will lead to next steps and explaining what these are.

>> Um, given everything that's happened I'm going to go ahead and take you to Long Beach Hospital.

>> Okay.

>> And you're going to go with me in the police car.

>> Yeah.

>> Is that okay?

>> Yeah.

>> Okay let me give you this back. You can go ahead and put this in your wallet.

>> Okay.

>> So just that one neck thing. Would you like to go to the hospital with us today?

>> Yeah.

>> Okay. We'll go ahead and take you to Huntington Beach Hospital. James and Ryan are going to put you on the stretcher there. We'll get you on the gurney and we'll take your chair with you, okay. Do you have anything else? I know he took your bag. Do you have anything else that you need to go? No. Okay they're going to go ahead and wheel the gurney up here. We'll pick you up and move you on over and then take your chair. Okay. Do you have any questions?

>> No.

>> No. Okay. Go ahead and take that off. Great.

>> If you see him again and you think that you need to call us, go ahead and pick up the phone and call us again just like you did. I think you did a good job giving us a call and letting us know.

>> When ending your interview tell the victim that they have done a good job in talking to you. Regardless of your satisfaction with what you have been able to learn, it is likely that the victim has done their best and your recognition of this fact and expression of your appreciation go a long way. This may pave the way for the victim to later provide more information to you or another investigator.

>> I'll tell you what Danny, what we'll do buddy is I'll, I'll let dispatch know what you saw. I'll give them a description. I'll give the other officers a description of the guy that you saw. I'll let them know what you told me and we'll keep an eye out in the neighborhood to see if we can't find him. Okay.

>> Okay.

>> Does that sound good to you?

>> All right. If he doesn't see him, make sure you help somebody. If he, if this guy come and running up to us, to our house he, make sure he get on to the ground and make sure you arrest him and make sure

if he's having any problems he'll go to jail. Or if he's any problems he'll, he'll, he'll go to the hospital or somebody will have to pull into the driveway or somebody's going to have to.

>> If he's looking in the windows then that's not right and we'll sit and we'll talk to him and find out what he's doing. And if he's breaking any laws we'll take him to jail. Okay.

>> Yeah.

>> Can I give you a sticker for helping me out today?

>> I appreciate it.

>> Would that be okay? Is that okay?

>> Sure.

>> That's fine.

>> There you go. Okay.

>> Alrighty.

>> And this is for you. This is who I am here. If you have any questions you can reach, you call this number here and just ask for me and they'll punch you into my extension.

>> Part 6: Transportation and Intervention.

>> Okay Nick I'm going to come up behind you right here and I'm going to pick you up okay?

>> Do you want to get up on over yourself Nick? There you go. You're on your way. Perfect.

>> There you go.

>> Is it okay if I keep my knees up?

>> Oh yeah, sure, anyway you want.

>> We're going to put a seatbelt on you okay? Just kind of go under your arms here.

>> We'll ride in with him.

>> In many cases if the victim has been injured or needs to be removed from the site, this will involve transportation of the victim with a disability to a hospital for examination and/or treatment to an emergency residential program.

>> Okay, Janine, go ahead and have a seat right here.

>> Yeah.

>> The mode of transportation may vary from the officer transporting in the squad car or by ambulance or by the victim's family member, guardian, or caregiver.

>> Great, there. I'm going to close the door for you okay.

>> Okay.

>> For a victim with a disability there may be additional considerations for transportation, including the physical fragility of a child or adult requiring medical transport.

>> I'm going to put it in your pocket here so we don't lose it okay? It's got your report number on it. Make sure your sister gets that okay? I'm going to try and get a hold of her today so I can let her know what happened and let her know where you were at, okay?

>> Okay Nick we're going to load you up in the ambulance and we're going to take you over to Huntington Beach Hospital. Alright.

>> There may be behavior difficulties that may require special management through accompaniment or medication.

>> All right, Nick, how are you feeling buddy? We'll get you over to the hospital and we'll get you checked.

>> The first responder will need to include ambulation or communication equipment. This may include a wheelchair, walker, crutches, canes, service animal, or hearing devices among others. Medications or oxygen for ongoing medical conditions such as a seizure disorder, asthma, or other chronic life threatening condition will need to be transported with the victim.

>> If the individual requires the services of an interpreter or support person, the first responder should alert the receiving personnel to this and other special needs of the victim prior to their arrival. With these things in place, the victim will have a comfortable sense of being understood and provided for—allowing for a smoother transition and investigation.

>> Upon arrival at the next stop for the intervention plan, professionals, including forensic healthcare specialist, SANE, sexual assault nurse examiner, victim service providers, rape and sexual assault support personnel must all be prepared with the same interaction and communication skills as described previously in this video for working with individuals with disabilities. Throughout the country many cities have their protocols in place and are working efficiently and effectively. The following information regarding individuals with disabilities are additional considerations to add to your current intervention structure.

>> We're going to go talk to the nurse, Melinda.

>> Yeah.

>> Oh actually here's the room right here. So why don't we come on in here.

>> Oh here you are.

>> This is Janine. Janine, Melinda and Shawna.

>> Hi, Janine, it's nice to meet you. Yes this is my friend, Shawna, and she's an advocate that's going to be here just for you.

>> Okay.

>> And this is our examination room and interview space. So I'll show you around in just a minute, Janine. But do you think you and Shawna could have a seat right there.

>> Okay.

>> And then I'm going to take um the officer into the other room and just start some paperwork and then I'll be right back to talk to you a little bit. Okay.

>> Okay, yeah.

>> Great. Do you want to come with me officer?

>> At this phase of the response if the crime is sexual in nature, the SART, sexual assault response team, may be in place at the location. If the medical facility and community does not have a SART, it is likely that some protocol is in place for addressing the medical and forensic needs of these crime victims.

>> And she had confided in a friend that she was assaulted about a week ago. So that's kind of where we're at right now.

>> Okay.

>> She's 36 years old and has Down Syndrome.

>> Okay.

>> I'm working in the dining room. I do clean up.

>> Oh, okay.

>> Yeah.

>> As with any other victim of suspected assault, it is imperative to exclude family members who may be the perpetrator, another perpetrator, or perceived agent of the perpetrator from the proceeding.

>> _____ one next to me.

>> Hi, you two.

>> Hi.

>> Janine, how are you doing?

>> Preparing the victim for a sexual assault forensic exam is complex. This will be handled by a medical professional with special training. A person with physical disabilities may require specialized equipment, added assistance, and patience.

>> Okay. I have a few questions to ask you in some of my paperwork to do with you.

>> Okay.

>> So is that okay that we talk for a couple minutes?

>> Thank you.

>> So um, Janine, have you been to see a doctor, any type of doctor in the last couple months for any reason?

>> Yes, yes I have.

>> Okay can you tell me about that?

>> And my doctor always looks at my back and I have two metal bars in my back.

>> Oh, okay.

>> Depending upon the laws in your state, the victim may have the right to have a support person or two available during this time.

>> Okay, Janine, we're going to go in that room in just a couple minutes and I'm going to do an exam or a check up.

>> Communication is key when gaining the victim's understanding to consent to the exam. Conducting the exam in a manner consistent with the needs of the individual with the disability will differ with each individual situation. It is critical for deaf children and adults to have a qualified and certified sign language interpreter to give consent. A volunteer or someone who knows some sign language will not be able to interpret effectively for consent.

>> Have anybody in with you during the exam just to keep you company and make sure.

>> Yeah.

>> You know, make sure everything is okay.

>> Okay.

>> So I need to go over some information that's called a consent. Do you know what that word means?

>> Um, _____ to look at my body.

>> Yes. It means that whatever I'm going to do with you today is okay with you.

>> Okay.

>> So that everything that I do, every step I'm going to stop and explain it to you and make sure that it's okay with you.

>> Okay.

>> And if there's something that isn't okay we don't have to do it.

>> Okay.

>> Okay.

>> Okay.

>> So think about it, this is kind of your day and your check up, your examination.

>> Okay. Is it up to my dad too?

>> Yes. And we'll explain all that to your dad.

>> Yeah.

>> Okay. So I need you to actually sign and put your initials. Do you know how to write your initials?

>> Mine is JR, that's my initial.

>> That's very good. And I need you to put those initials in six different places on this form.

>> Okay.

>> Okay. And the first one talks about that it's okay that we tell the police about what happened and you know what we already did.

>> Yeah, she's here.

>> That's right. And you already told her about what happened.

>> Yeah.

>> For the officer again it is the SANE or medical examiner who will have the most experience with these sensitive and personal situations and will generally guide the course of action.

>> Okay and this one's going to allow me to use information from your paperwork, but your name is never ever going to be shared with anybody.

>> No.

>> Okay.

>> It'll be between me and you.

>> That's right.

>> Yeah.

>> Okay. So can I have you put your initials in those places, honey?

>> Okay.

>> Come on in. Shawna can just close the door and I want you to come on over here Janine. Come on over here. I want you to stand right here. I'm going to show you a couple things first before we get started. Some special cameras. Have you have had many pictures taken?

>> Yeah I have my own camera at home.

>> You do.

>> It is essential to provide opportunities to speak with the victim out of eye shot and ear shot of those living with or in charge of the victim.

>> And then I wanted to show you this envelope and all these other little envelopes is that these are the steps for the exam. And remember I told you that before I do any little part of the exam I'm going to stop and tell you all about it first and then ask you if it's okay. And then so you can tell me if it's okay and that's what that word consent means that I check and make sure it's okay with you first. Does that sound okay?

>> Yeah.

>> Okay.

>> It's hard for me though.

>> Okay. What's hard for you?

>> It's hard for me because some people have to test me because I have my own doctors because my doctors always test me before.

>> Okay.

>> And that's why.

>> Okay. Well there's no testing. I'm just going to make sure that it's okay with you just to check everything on your body. It's up to you.

>> Okay. I will be okay.

>> Okay.

>> Yeah.

>> As part of the multidisciplinary team, for our response each member along the way must ensure practices that encourage positive techniques for working with individuals with disabilities. Each step along the way is important. It is a sequence of practices that enable other first response team members to effectively complete their role and move the legal case ahead for the crime victim with a disability.

>> And here's a police report number for you. It's a police report and my name on there. If you have any questions go ahead and give me a call. Okay.

>> Thank you very much officer. I appreciate it.

>> Thank you.

>> And here you go.

>> Alright.

>> It's nice to meet you, Janine.

>> Nice to meet you too.

>> Okay, take care of yourself.

>> Yes, I will.

>> And if you have any questions dad, my number is on there, you can call me anytime.

>> Thank you very much, I appreciate it.

>> Thank you for taking me.

>> Bye, Janine. You're welcome.

>> Thank you.

>> Good luck to you.

>> Thank you.

>> Thank you.

>> I talked to Sid and I said how I'm doing and I hold his hands. And we prayed together.

>> Did you?

>> Uh-huh. Yeah.

>> Sid was a.

>> He's the.

>> Priest?

>> Yeah.

>> Oh.

>> Yeah.

>> Very good.

>> Uh-huh.

>> Everything's okay then huh?

>> Yeah.

>> That's super.

>> Yep.

>> Part 7: Report Writing. In this section, we will highlight the importance of complete documentation and corroboration. In documenting what is observed and said, it's important to keep in mind that some cases can be prosecuted without the victim's participation making your documentation critical.

>> When developing the report, your characterizations and wording is very important. How we name or characterize the victim or their disabilities can be enhancing or pejorative. Use people first language, that ensures that the victim is considered a person first with later or lesser emphasis on the disability.

>> You'd write this child has mental retardation rather than this child or adult is retarded. The concept is that one has a disability, but that the disability is not their entire identity. Examining language and taking care of what is put on the page has an impact on the case and others who read the report.

>> Changing thinking from a disease to a condition model is one technique for making this transition. Avoid pejorative terms such as crippled, retarded, lame, or wheelchair bound. When describing observations indicate observations not interpretations. For example, write on my arrival the victim was standing, rocked back and forth, and moaned rather than the victim was clearly hysterical or was out of touch with reality. Describe behaviors and conduct, not conclusions or your assessments. If a person had mental retardation, describe the traits, behaviors, and language as they are observed rather than assessing or judgment. If someone provides an assessment, their opinion, include that information along with the source and the context in which the remark was made. If it was an interpreter who states that the person has no language or struggled to understand, you may want to consider rescheduling an interview with a certified interpreter. If an individual has a qualified developmental disability they may be registered

at their local disability service center, which is a rich source of information for the investigation. This information can be vital to the case and the testimony.

>> This DVD and accompanying training guide covers specific material with an overall emphasis that concentrates on interaction with individuals with disabilities. In all cases, the initial contact is the beginning and most important step. The trust you earn with the victim and the victim's family or caregivers will be passed along through the entire legal process. By implementing as many steps as possible described in this training video, first response professionals will achieve a solid foundation for case building. By using these principles along with conventional first response tactics and protocols, you will be assuring the best possible outcome for crime victims with disabilities, and a positive and rewarding interaction with victims of crime of any age with any type of disability.

>> This is, these are the push bumpers. We use those to push cars out of the way if they get stuck.

>> Yeah.

>> These are our light bars. We use those to get people out of the way if they're.

>> Light bars.

>> Yeah.

>> Okay.

>> We'll turn those on in a second. Do you want to sit down?

>> I'm just checking to see, I've got to see.

>> Not sure if you want to sit down.

>> Well I'm just making sure. Let's see. It sure does kind of look like a front seat alright.

>> What's that?

>> It sure does kind of look like a front seat alright.

>> Yeah. You can sit down in there if you want. I'm going to leave this door open Danny and I'm going to walk around to the other side, okay.

>> That's fine.

>> Can you give us a ride?

>> You want a ride?

>> Yeah.

>> I can give you a ride. I can take you up the block and turn around and come back if it's okay with your dad. You got to ask your dad.

>> Yeah.

>> Can he give us a ride?

>> Is that okay? I'll take him up the street and turn around and come back. Okay. Shut your door.

>> So how do you close this door?

>> Just pull on it.

>> So you close the door like that.

>> Put your seatbelt on.

>> And that's what you do. So you have to do, it's just.

>> Just like that.

>> So you click it on and then. How do you steer this drive?

>> With the steering wheel.

>> How do you steer this way.

>> With the steering wheel.

>> So you're steering with this steering wheel.

>> Um-hm.

>> And what do you have to do when there's a problem with chasing somebody?

>> Then you turn on the lights.

>> So you turn on the lights.

>> Um-hm.

>> When you hear the siren on.

>> They'll pull over to the side.

>> Then you pull over to the side.

>> Um-hm.

>> Alrighty.

>> Okay.

>> And we'll make sure that there's not enough people to come back.

>> Right. Are you ready to go?

>> Then we're ready to go.

>> Okay. You can push it; push it with your thumb.

>> Well I'm trying to.

>> Push it with your thumb.

>> Let me see.

>> As hard as you can.

>> Well let me see if can do this again.

>> Okay, hang on. As hard as you can. Push it in. There you go.

>> Hey sir you better hang up the phone we're making a movie right now. We're making a movie. Just hang up the phone so I can hear you.

>> Okay. Good job, Danny.

END OF VIDEO



SECTION 6

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