SEXUAL ABUSE, HEALTH, AND SAFETY OF PERSONS WITH DISABILITIES

Kristen M. Lewis, Esq.
The Bowden Law Firm, LLC
Atlanta, Georgia
kristenlewis@bowdenlaw.com

Emma H. Barry, Esq.
The Bowden Law Firm, LLC
Atlanta, Georgia
emmabarry@bowdenlaw.com

SEXUAL ABUSE, HEALTH AND SAFETY OF PERSONS WITH DISABILITIES

Kristen M. Lewis, Esq.
Emma H. Barry, Esq.
The Bowden Law Firm, LLC
Atlanta, Georgia
kristenlewis@bowdenlaw.com
emmabarry@bowdenlaw.com

This outline will address the national epidemic of persons with disabilities being victimized by known perpetrators of sexual abuse, including the scope and prevalence of such abuse, and commonly cited reasons for this societal plague, as well as the detection and reporting of sex crimes against our most vulnerable citizens. The outline will suggest numerous steps to prevent the sexual abuse of persons with disabilities, as well as an action plan to maximize the sexual health and safety of persons with disabilities.

I. SEXUAL ABUSE OF PERSONS WITH DISABILITIES.

A. The Epidemic No One Talks About

1. 2018 may be described as the year of the "#MeToo" social media campaign that finally highlighted sexual abuse and harassment at the highest levels of the entertainment, academic and business worlds. As that movement picked up steam month by month in 2018, January of 2018 saw the New Year ushered in by National Public Radio with a multi-part series entitled "Abused and Betrayed: People with Intellectual Disabilities and an Epidemic of Sexual Assault." *See* https://www.npr.org/2018/01/08/570224090/the-sexual-assault-epidemic-no-one-talks-about (referred to hereafter as "the NPR series"). The individuals with intellectual or development disabilities who were highlighted in the NPR series included the following.

a. Pauline, a 46-year-old woman, was raped in her state-funded host home by the family's teenage boys, who were eventually charged with rape, involuntary deviate sexual intercourse, and other sex crimes.

b. Lynne, 38 years old, was a serial victim of rape when she was 14, by "an older guy" who knew her, and then again at 15, by a boy at her school, neither of whom was charged.

c. Maryann, a non-verbal 58-year-old woman who has lived in a state-sponsored institution for more than forty years, was repeatedly raped for twenty years by a staff member. Only when he was accidentally caught in the act by another staff member was the abuse discovered.

d. Natalie, a 35-year-old woman whose ability to communicate is limited to several hand motions, was diagnosed with gonorrhea that was likely contracted while attending an adult day care program funded by the state.

e. An unnamed female of indeterminate age was raped by a Medicaid-paid driver on the way to a routine medical appointment.

f. An unnamed man was repeatedly raped in his home by his HIV-positive step-father.

2. The NPR series was the culmination of a year-long investigation of victims from coast-to-coast, from the state of Maine to the state of Washington. Although this national coverage was an important first step in exposing a societal plague that few are willing to discuss, the sexual assault of persons with disabilities remains largely "unrecognized, unprosecuted and unpunished." *Id.*

3. Dr. Nora Baladerian, in her Risk Reduction Workbook for Parents and Service Providers: Policies and Practices to Reduce the Risk of Abuse, Including Sexual Violence, Against People with Intellectual and Developmental Disabilities (2014 Spectrum Institute, Second Edition) (referred to hereinafter as the "Risk Reduction Workbook"), sets forth a general definition of "sexual abuse" as follows:

> "Sexual abuse – the sexual touching of a person for the gratification of the abuser, ranging from fondling to rape. Sexual abuse includes non-touching violations including photos, forced nudity, and other sexually stimulating activities. For adult victims, when sexual

activities are done without the consent of or against the will of the individual, this is considered sexual assault or rape; for children, child sexual abuse." *Id.* at 21.

"Sexual abuse is best defined as an act in which one person intends/attempts to get sexual pleasure from another person who does not consent or is unable to legally consent due to age or other incapacity. The act is intentional on the part of the person seeking sexual pleasure, whereas the victim/target is an unwitting and unwilling recipient of the perpetrator's behavior." *Id.* at 22.

4. Each state has specific laws criminalizing the sexual abuse of children (under age 18) and vulnerable adults (over age 18), along with specific criminal penalties for rape, sexual assault, molestation and the like. *See Appendix* for a 50-state survey of such state laws. Nevertheless, the societal plague of sexual abuse of persons with disabilities remains largely unchecked.

5. Meanwhile, back in the authors' home state of Georgia, an increasing number of families for whom we have prepared comprehensive special needs estate plans in years past have recently shared that their newly-adult children with disabilities have been the victims of sexual assault. As these children are aging out of the public school systems and leaving the protective bubble of their parents' homes, they are increasingly vulnerable to sexual predators. Their parents are asking us: "What could we have done to prevent this from happening?" Until now, we had no snappy answers.

B. Perspectives on Sexual Abuse from Real Families and Allied Professionals

For the parents of children with disabilities, it is difficult to acknowledge that abuse can occur in places which are supposed to be safe environments, such as school. Easier to comprehend is the idea that their minor child or young adult child with a disability could wander outside of these "safe" venues and be victimized by a total stranger. Parents must recognize that there is no absolutely safe environment for their children with disabilities, and that even family members, and others who purport to be their support professionals, can be the perpetrators of sexual abuse.

1. Minor Children with Various Disabilities

a. Daughter with Down Syndrome ("Mattie")

(1) Even though Mattie's parents taught her a traditional sexual safety curriculum (*e.g.*, "good touch/bad touch" and "circles of intimacy"), and even though Mattie knew all of the "right" answers to questions regarding her personal and sexual safety, Mattie was unable to apply such abstract concepts to "real life" situations when another student sexually assaulted her during a high school theater class.

(2) While he was carrying out the acts of abuse, the abuser plied Mattie with platitudes such as "I am doing this because I love you," and "I am your boyfriend, and this is what boyfriends and girlfriends do." As a consequence of her desire for love and a romantic relationship, and her inability to apply abstract concepts regarding personal boundaries and what constitutes sexual abuse, Mattie truly believed that the abuser was her boyfriend. The abuser then manipulated her to keep silent about the abuse through threats of physical violence and emotional manipulation, stating that "no one would believe [her]" and that he "would not love [her] anymore" if she told anyone what happened. Not only did this belief that the abuser was her boyfriend help perpetuate the abuse, but it also created an additional layer of pain and complexity when the perpetrator faced consequences for his abusive actions. Mattie wanted to know what was happening to her "boyfriend" when he was expelled from the high school. Her initial focus was not her own healing, but rather on blaming herself for what was happening to her "boyfriend."

(3) Mattie's mother expressed her own ambivalence when first informed about the abuse, wondering whether Mattie was fabricating the story. While the mother eventually fully acknowledged that the abuse happened, she found it difficult to wrestle with her initial doubts inasmuch as Mattie often manufactured events that did not happen in reality. What was uncommon in Mattie's case was that there were two witnesses to the abuse to corroborate Mattie's claims. Mattie's mother concluded how infinitely more challenging it would have been to navigate this situation if there had been no third-party witnesses to the abuse.

(4) An effective part of Mattie's healing was participating in trauma-focused cognitive behavioral therapy (at the same level of complexity as

that designed for a seven-year-old child), which included workbook activities and picture therapy. One of the most cathartic steps of healing for Mattie was having her story documented in writing. Mattie directed her parents to write down her story as she explained it to them, and then she read the completed story back to her parents. Once she did so, she requested that the story be kept in a cabinet. Although she has not taken the story out of that cabinet since then, she will occasionally refer to "her story."

(5) Mattie's mother shared that her parental take-away from the experience was "fill in everything," "define everything," and "do not assume anything," regarding Mattie's preparedness to respond to a real life situation. Personal safety rules should have been explained to Mattie "in black and white," because she struggles with the nuances of the "grey" zone. Mattie's mother urges other parents to ensure that adult chaperones at social events should be knowledgeable about minimizing the risk of sexual abuse of those in their care. She also advises that parents should "keep trying" to reinforce concrete examples of ways to stay safe, but should also put an equal emphasis on monitoring who is allowed to be in their child's trusted circle of care and relationships.

(6) Mattie's mother believes there may be increased risk in "inclusion classrooms," which are comprised of both students with disabilities and students without disabilities, positing that students with disabilities could more easily be targeted for sexual abuse.

(7) Mattie's mother stated that Mattie is "not the same kid" after the trauma she survived. She continues to manifest symptoms of severe anxiety more than a year after the abuse. Mattie still experiences frequent nightmares and other classic symptoms of Post-Traumatic Stress Disorder. Mattie's parents are dedicated to supporting her as she continues to heal, and to minimizing the risk that such abuse will occur again.

b. Boy with Autism Spectrum Disorder ("Sid")

(1) Sid, who has been diagnosed with Autism Spectrum Disorder, received sex education at his school, a private school for children with Autism Spectrum Disorder, Attention Deficit Disorder, Attention Deficit/Hyperactivity Disorder, or other learning differences. Sid's mother is glad that he received some basic information regarding sexuality, as

many school programs designed for students with special needs do not include this important area in their curriculum. However, she did not know if this education regarded merely the "mechanics" of sexual intercourse (*i.e.*, the physical act), or if it also concerned the more complex facets of healthy sexuality (*e.g.*, what constitutes sexual abuse).

(2) Sid's mother emphasizes the need to keep repeating and reinforcing societal rules regarding what constitutes appropriate behavior in a "romantic" context. She fears that Sid may exhibit behavior that comes across as threatening (*e.g.*, not recognizing a girl's personal space and boundaries). Due to his eagerness to please others, she fears that Sid may simply admit to wrongdoing if he were to be accused of inappropriate sexual behavior, even if he had no intention of threatening another person.

(3) A particularly difficult transition for Sid is acknowledging the "different set of rules" that applied when he was younger versus those that now apply to him as a teenager. When Sid was a young child, others, including neurotypical peers, would often physically embrace him as a sign of support. However, as a teenager (no longer an "adorable" elementary school kid) he no longer receives those regular signs of physical affection, and he is devastated that those social rules have changed "in the blink of any eye." Regular counseling sessions are helping Sid to process those emotions of pain and confusion.

(4) Another challenge Sid's mother identifies is managing expectations regarding school social events that are meant to foster a sense of inclusion. For example, a local high school for neurotypical kids co-hosts an annual dance with Sid's private school, and many neurotypical students will go out of their way to dance with the students with special needs. Each year, Sid is almost wholly consumed by this event in the months leading up to the dance, and his mom strongly believes that there should be greater management of expectations (by the school, as well by the parents of the students) regarding the interactions at the dance (*e.g.*, dancing with a neurotypical young woman will not lead to a romantic relationship with her). Sid's mother believes that such instruction regarding perspective would be helpful in the context of any social interaction that is meant to be inclusive.

2. Adult Males with Cerebral Palsy Who Use Wheelchairs

a. Ken's Story

(1) Ken has been sexually assaulted multiple times by different paid professional care givers. On one of those occasions, which occurred during Ken's first year in college, the care giver sexually assaulted both him and his roommate (who also had cerebral palsy but was nonverbal), while all of them were in the same room. Although Ken verbally pleaded with the abuser to stop in each episode of abuse, each perpetrator refused to heed his pleas, and continued the abuse. Although these experiences resulted in great angst for Ken, he has used them as motivation to truly "find his voice." Ken encourages all survivors of sexual abuse to find their own voice and sense of empowerment while healing from this type of trauma. He credits those dark moments in his life with helping him to be a powerful and effective self-advocate today. For example, Ken now follows a rigorous process to assemble his team of direct care professionals to ensure that they are individuals of integrity who will respect his personal boundaries. While Ken has supportive, trust-based relationships with his caregivers, he also makes it very clear to them that if they ever violate one of his boundaries, their employment will be terminated immediately.

(2) As a result of the past sexual abuse, Ken has found it extremely difficult to consider future romantic relationships. He has not dated anyone since the last sexually abusive encounter more than 10 years ago.

(3) The college program that Ken initially pursued was designed expressly for students with various disabilities. These students were all housed in a designated dormitory, yet there was no curriculum offered regarding how to recognize sexual abuse, how to minimize the risk of sexual abuse, and how to respond if such abuse should occur. Ken believes that such a course would have empowered him to forestall the abuse that he endured there as a college student.

b. Tom's Story

(1) The authors began this interview session with Tom, now age 24, and his parents. Tom's parents began having discussions with him about sexuality when Tom was in eighth grade. Tom was in the regular education track at his public school, but did not receive formal sex education as part of his curriculum. When asked to identify their greatest concern regarding the potential for the sexual abuse of their son, Tom's mother highlighted

his physical vulnerability, and the increased access that his paid direct care professionals now have to perpetrate such abuse.

(2) In the past, Tom had a male certified nurse assistant who would tell him offensive jokes about sex, and who would occasionally make unsolicited, unwanted inappropriate comments, such as telling Tom that he was "beautiful." Although Tom would repeatedly deflect such comments, the care giver did not cease these unwelcome remarks. As a result, this care giver was terminated before he could perpetrate any blatant attempts to sexually assault Tom. Intuitively, Tom's parents hope to decrease the risk of sexual abuse by Tom's current direct care staff by "popping in for a quick visit" while they are assisting Tom in his room, keeping a baby monitor in Tom's room so that they can hear any problematic conversations, and providing Tom with a medical alert button in case a caregiver is actually attempting to abuse him. The fact that Tom requires intimate hygienic care (*e.g.*, assistance with toileting) poses significant challenges, as the opportunities to abuse hygienic access to sexual body parts are plentiful. Tom's father stated, "Tom has to be touched by others, so it is a matter of helping him know what is okay, and what is not okay."

(3) When Tom was still in high school, a male paraprofessional who worked with him also began to tell him inappropriate jokes about sex, and repeatedly spoke with Tom about high school girls in ways that were offensive to Tom. This unacceptable conduct put Tom in a difficult position, as he depended on receiving academic assistance from this paraprofessional, and requesting a different paraprofessional would have been a long and complicated process. Tom maintained open communication with his parents about this situation, and the paraprofessional did not attempt to sexually assault Tom. When the authors concluded their interview of Tom's parents, they asked the parents to step out of the room so that they could continue interviewing just Tom.

(4) Tom expressed frustration that his peers with disabilities do not wish to have serious conversations with him about the risk to them of sexual abuse, or generally about their sexual health and safety, procreation, and parenting supports for persons with disabilities. Tom believes that negative societal preconceptions (*e.g.*, "Why would this kid want to talk about sex when he can't even get out of his wheelchair by himself?") has

stymied the willingness of his peers to thoughtfully consider these sensitive topics. Many prefer to joke about these issues rather than engage in meaningful discussions.

(5) Tom also expressed how painful it is that his disability seems to preclude conversations with his guy friends about physical fitness, health, and athletic training (*i.e.*, the usual "guy topics"). In high school, Tom was an assistant "coach" on the football team, and his main role was to motivate the players while they trained. Tom quickly discovered that many members of the team would hesitate to discuss aspects of their training with him, presumably because they did not want to offend Tom due to his inability to engage in such training personally.

(6) Tom (like Ken) has harnessed these negative experiences to help find his "voice." Tom has since earned a chaplaincy certificate, and is considering making it part of his mission to speak to various audiences (including groups of persons with disabilities) about issues involving sexual abuse, health, safety, procreation, and parenting for persons with disabilities. Tom stated that he may also write a book regarding these topics. Needless to say, the authors were thrilled to hear this!

3. Adult Female with Cerebral Palsy and Autism Spectrum Disorder ("Cathy")

a. Cathy's Story

(1) Cathy is now a twenty-seven-year-old woman who has been diagnosed with Cerebral Palsy and Autism Spectrum Disorder, who is fully ambulatory. Cathy attended public school as a minor, and was fully integrated in the regular education classrooms until second grade, when she transitioned to the special education track. As is so often the case, Cathy did not receive the typical sex education that the regular students received. However, as Cathy matured, her mother read to her from a book that discussed sexual and reproductive body parts, and how babies were made. That book answered questions from a young neurotypical child's perspective, and Cathy's mom found this resource to be a helpful tool to broach these sensitive topics. Cathy's mom also taught her that her sexual body parts are her "private" parts, that no one is allowed to touch them without asking for her consent, and that even

if they were to ask for such consent, Cathy should seek the help of an adult if she becomes uncomfortable or concerned about handling such a situation.

(2) While Cathy's mom is not aware of any sexual abuse suffered by her daughter, she shared that another student at Cathy's high school inflicted unusual physical abuse on her. When Cathy was almost twenty-two and about to age out of the public school system, this other student would routinely and repeatedly pinch Cathy all over her abdomen, with a force sufficient to leave serious bruising. Cathy's mother discovered these bruises one night while assisting Cathy in the shower. Cathy's mother was alarmed when she saw the ring of bruises across Cathy's stomach. Not only were there "fresh" bruises, but she also noticed older bruises that appeared to be fading. When Cathy's mother asked her if someone had harmed her, Cathy initially avoided answering the question, before finally stating that someone had "probably" done so. Cathy's mother said that this response was consistent with how Cathy reacts to pain – she will brush it aside and minimize an incident if she has been hurt.

(3) Alarmed that such bruising could indicate that additional abuse was occurring, Cathy's mother took pictures of Cathy's bruised stomach, shared the photos with school administrators, and demanded that the school take action. School administrators had overheard the culpable student making derogatory comments about Cathy. An investigation by the school determined that she had been the student who had been pinching Cathy for an undetermined amount of time. The perpetrator was expelled from the school. Cathy refused to identify the abuser by name, but she did tell her mom that while the abuse was occuring, the abuser threatened Cathy that if she ever told anyone, she would kill Cathy's service dog.

(4) Cathy's mother finds it difficult to assess the full impact on Cathy of this odd physically abusive behavior. Cathy's behaviors and habits did not seem to change during the abuse. Cathy appeared relatively "unfazed" (which, Cathy's mother noted, was the complete *opposite* of how she, herself, was feeling). As Cathy's mother did not want to project her own trauma onto Cathy, she did not press the matter any further.

4. Allied Professionals

a. Developmental Sexuality and Relationship Educator ("Alana")

(1) Alana asserts that traditional psychotherapy is not sufficient for victims of sexual abuse who have developmental disabilities. People with disabilities need a strong foundation in healthy sexuality and relationships so that they can recognize and articulate their own sexual desires and preferences, and (equally important) recognize and articulate what kinds of sexual expression are not appropriate for them. Alana recounts an interview with "Bobby," a young man with Down Syndrome who told who told her that he was interested in sadomasochistic sexual activity that he had read about on the internet. While not pre-judging his stated interests, Alana investigated further, asking what drew him to those kinds of violent role-playing scenarios. Alana discovered that what seemed to resonate with Bobby was the ability to take a dominating role in an activity, giving him a sense of power and control, when he feels utterly disempowered in so many other areas of life. When Alana described to Bobby what the sadomasochistic sexual activities usually involve, and the philosophy behind it, Bobby quickly declared that, upon reflection, he did not want to take part in *that* kind of sex, but that he wanted a traditional romantic relationship in which he would feel empowered and respected. He then told Alana that he had planned to meet a person with whom he had chatted online and who had invited him to engage in sadomasochistic activity at a nearby location. After his discussion with Alana, Bobby cancelled those plans. If Bobby had kept that date, it could have led to unthinkable abuse and life-threatening physical harm. This anecdote illustrates the critical need for adequate education about sexuality and healthy relationships, as well as continued investigation by family members and caregivers, to discern the needs and wishes of the persons with disabilities in this sensitive area.

b. Disabilities Ministry Director/Special Education Teacher ("Mary")

(1) Mary shared her perception that the individuals with Down Syndrome with whom she has worked over the years demonstrate a "pureness of heart" that makes them particularly susceptible to sexual abuse. They tend to be very affectionate, and desire traditional relationships and family lives of their own. Mary has found that individuals with Down Syndrome and Autism Spectrum Disorder have a difficult time applying abstract concepts regarding sexual abuse to real life situations (echoing the conclusion of Mattie's mother, described

above). This widespread inability to connect abstract safety instruction with real life experiences results in an increased risk that such vulnerable persons will become victims of sexual abuse.

C. Scope and Prevalence of Sexual Abuse of Persons with Disabilities

The foregoing stories of the families the authors serve, and those highlighted in the NPR series, are not isolated incidents. There are untold numbers of families who have not admitted (or do not yet realize) that their children with disabilities have been sexually abused. The scope and prevalence of sexual abuse of persons with disabilities is staggering.

1. The CRIME VICTIMS WITH DISABILITIES AWARENESS ACT ("CVWDAA") (P.L. 105-301), passed in 1998, requires the federal Department of Justice to keep records of "violent victimization against persons with disabilities." In July 2017, the Office of Justice Programs, Bureau of Justice Statistics ("BJS"), issued Report No. NC5250632, *Crime Against Persons with Disabilities, 2009-2015 Statistical Tables*, written by Erika Harrell, Ph.D., a staff statistician with the BJS (referred to hereafter as the "2017 BJS Report") (available at http://www.bjs.gov/content/pub/pdf/capd0915st.pdf). [N.B.: this is the most current report as of September 1, 2018.] The findings are based on the BJS "National Crime Victimization Survey ("NCVS"), that collects data from U.S. residents age 12 or older *excluding the 373,000 persons living in group homes or other institutions (where sexual abuse is highly likely to occur).*

a. The CVWDAA purports "to increase public awareness of the plight of victims of crime with developmental disabilities, to collect data to measure the magnitude of the problem, and to develop strategies to address the safety and justice needs of victims of crime with developmental disabilities." Disabilities are classified according to six limitations: hearing; vision; cognitive; ambulatory; self-care; and independent living.

b. The 2017 BJS Report sets forth the following statistics.

(1) During the five-year aggregate period from 2011 to 2015, for each age group measured except persons age 65 or older, the rate of violent victimization against persons with disabilities was at least 2.5 times the unadjusted rate for those without disabilities (citing table 1).

(2) Among those with disabilities, persons age 12 to 15 had the highest rate of violent victimization among all age groups measured.

(3) The rate of "serious violent crime," including rape or sexual assault, for persons with disabilities was more than three times the rate for persons without disabilities (citing Table 2). Erika Harrell, the author of the 2017 BJS Report, was also interviewed for the NPR series, and reported to the NPR investigators that persons with disabilities are actually *seven times as likely* to be victims of rape or sexual assault than persons without disabilities (presumably once the 373,000 people who live in group homes or other institutions are accounted for in the calculation). The NPR series acknowledges that this much higher rate of victimization is based on "unpublished federal crime data." A chart detailing this unpublished federal data reflects that the rate of rape and sexual assault against persons with *intellectual disabilities* (vs. the "cognitive disabilities" measured in the 2017 BJS Report) is more than seven times the rate against persons without disabilities. Among women with intellectual disabilities, it is *twelve times* the rate against persons without disabilities. *See* https://www.npr.org/2018/01/08/570224090/the-sexual-assault-epidemic-no-one-talks-about, at page 8 of 38.

(a) The NPR series cites the definition of "intellectual disability" used by the American Association on Intellectual and Developmental Disabilities (https://aaidd.org) as "characterized by significant limitations in both intellectual function and in adaptive behaviors." The term "developmental disability" includes not only persons with intellectual disabilities, but also those with cerebral palsy and autism.

(4) The NPR series cites an estimate by the national organization of The Arc that 4.7 million people in the United States have intellectual disabilities.

(5) The 2017 BJS Report indicates that for both males and females, the rate of violent victimization was higher for persons with disabilities than for those without disabilities (citing table 3). For both males and females, approximately 32 persons with disabilities per 1,000 (compared to 11 persons per 1,000 without disabilities) were victims of violent crimes.

(6) For each racial and ethnic group measured, persons with disabilities had higher rates of victimization than persons without disabilities.

(7) For both males and females, persons with "cognitive" disabilities (*i.e.*, "serious difficulty in concentrating, remembering, or making decisions because of a physical, mental, or emotional condition") had the highest victimization rates of total violent crime, serious violent crime (including rape, sexual assault, robbery and aggravated assault) among the eight disability types measured (citing table 5).

(8) Sixty-five percent of rapes or sexual assault against persons with disabilities were committed against those with multiple disability types (citing table 6).

(9) The rate of rape or sexual assault against persons with a single disability type (1.4 per 1,000) was lower than the rate for those with multiple disability types (2.8 per 1,000) (citing table 7).

(10) A higher percentage of violence against persons with disabilities (40%) was committed by persons the victims knew well or who were casual acquaintances than against persons without disabilities (32%) (citing table 8).

(11) "Intimate partners" (*i.e.*, spouses, ex-spouses, boyfriends and girlfriends) were perpetrators in 15% of crimes against persons with disabilities (and in 13% of crimes against persons without disabilities). Other relatives (*i.e.*, parents, children, other relatives) account for 10% of perpetrators against persons with disabilities (and 6% for persons without disabilities).

2. The Federal Bureau of Investigation publishes an annual report on "hate crime" statistics. Crimes against persons with disabilities is included as a specific category of hate crime. *See e.g.*, FBI, Hate Crime Statistics, 2016 (Washington, D.C.: U.S. Department of Justice, 2016). Table 1. http://www.fbi.gov/hate-crime/2016/topic-pages/victims.pdf.

3. Dr. Nora Baladerian, a pioneer in the field of therapy for persons with intellectual disabilities who have been the victims of sexual abuse and violence, is a co-founder of the Disability and Abuse Project, which tracks violence against persons with disabilities. She and co-founder, Thomas Coleman, surveyed more than 1,300 people with disabilities and their families in 2012. More than 70% reported being the victims of abuse, including verbal-emotional (87.2%), physical (50.6%), sexual (41.6%), neglect (37.3%), and

financial (31.5%). *See* Nora J. Baladerian, Thomas F. Coleman, and Jim Shearn, *Findings from the 2012 Survey on Abuse of People with Disabilities* (Los Angeles, CA: Spectrum Institute, Disability and Abuse Project, 2013), at http://www.disabilityandabuse.org/survey/findings.pdf.

a. The Disability and Abuse Project also publishes a weekly "newsfeed" compilation of national and international articles addressing the following categories of abuse: sexual assault; human trafficking; seclusion/restraint; physical abuse; emotional/verbal abuse; murder; and financial abuse. In any given week, the compilation will include 90+ articles. Archived compilations are available at http://disabilityandabuse.org/newsfeed/contents.htm. Contact Tom Coleman at tomcoleman@disabilityandabuse.org to subscribe to current newsfeed compilations.

D. Perpetrators of Sexual Abuse

The perpetrators of sexual abuse of persons with disabilities are mostly male, of any age, socio-economic class, sexual orientation, or education level. Studies have concluded that the vast majority of perpetrators are known to the victim. It is generally agreed that more than 95% of persons with a disability who were victims of violent sex crimes could identify the perpetrator.

1. Perpetrators include family members, in-home direct care workers, day program staff, work site staff, educators and other school staff, medical personnel, transportation providers, and *any other person* who has contact with persons who have disabilities. Sometimes, perpetrators of sexual abuse are other persons who have disabilities ("peer-to-peer" abuse), a topic which the authors address in Section III of the outline.

2. Perpetrators generally do not voluntarily stop their abusive actions – they are life-long abusers. Many do not believe that their behavior is harmful to their victims.

3. Perpetrators often avoid inflicting observable physical bodily injury, which delays the discovery of the abusive behavior.

4. The actions of perpetrators typically unfold on a "continuum," starting with benign social touching and escalating to sexually abusive touching and rape once the

trust of the victim has been cultivated. By then, the victim may not recognize the behavior as sexual or abusive.

5. Perpetrators make victims feel complicit in the abusive behavior, leading to feelings of guilt and responsibility, and fear of being punished by parents or guardians.

6. Perpetrators threaten violence against the victim's family members and pets if the abuse is reported.

7. Perpetrators convince the victim that no one will believe the victim if the abuse is reported.

8. Perpetrators convince the victim that sexually abusive behavior is what everyone does!

9. Perpetrators prefer victims who are not "abuse aware" and who do not have a plan to identify, survive and report the abuse. *See infra* at Section I.G.

10. Only 3% of the perpetrators of sexual abuse of persons with disabilities are ever prosecuted and convicted, leaving the other 97% to continue abusing. Background checks reflect only convictions, not mere arrests.

E. Frequently Cited Reasons for Increased Risk of Sexual Abuse of Persons with Disabilities

1. Many children with disabilities are excluded from traditional sex education in the "special needs curriculum" at public schools, which typically do not have access to a modified sex ed program for such students. Furthermore, it is assumed that students with disabilities will grow up to be asexual adults and therefore do not need such education as students.

2. Traditional sex ed programs are too abstract for many persons with disabilities. The concepts of "good touch/bad touch" cannot be recalled and applied to "real life" situations as they unfold. Teaching "stranger danger" is largely irrelevant considering that most perpetrators of sexual abuse are *not* strangers to the victim.

a. Many persons with disabilities need more concrete instruction in this area, utilizing "experiential" teaching techniques such as role playing with puppets and anatomically correct dolls.

3. The parents of children with disabilities are hamstrung by their own attitudes and phobias about sex, preventing them from successfully imparting meaningful sex ed to their children.

a. Based on an informal survey of the clients served by the authors, the vast majority do not teach their children the correct names for their sexual body parts. Why? Talking about sex is difficult!

(1) Addressing the sexual abuse of persons with disabilities requires, at a minimum, a discussion of "observable" sexual body parts. In case any person reading this outline is still uncomfortable discussing sexual body parts, Dr. Nora Baladerian has the following advice, taken from her *Risk Reduction Workbook*.

> "In our culture, we are usually stuck between using very formal medical/Latin terms for these body parts, or gross and vulgar terms. Some stick to baby-talk, others make up words. . . . This becomes particularly important when a forensic interview of a suspected sexual assault victim is being conducted, and the victim has no words at all to describe their body parts!
>
> "Really, there are only [a few] body parts that need to be named. Are you ready? For the female, the breasts, the vulva, and the anus. "What?" I hear you cry!! "What about the vagina?" Well, you cannot see the vagina without a great deal of effort, as anyone who has had a pelvic exam will verify. What one sees on the outside of the female's genitals is called

> the vulva. Within that, one can literally see the clitoris, the urethra, and the opening to the vagina.
>
> * * * *
>
> "For males, all you can see is the penis, the scrotum, inside which reside the testicles, and the anus. These are not difficult words to pronounce. They are difficult to say because you have been taught that these words are . . . . "dirty" or it is wrong to name your body parts . . . . All other body parts seem to be free of this problem. We easily say elbow, wrist and arm . . . .
>
> "Many people have now become accustomed to referring to the genital areas of the body as "private parts." For literal thinkers, especially people on the Autism Spectrum, among others . . . this causes me to think, ok, what are the public parts? Obviously if there are private parts there are public parts . . . I prefer to refer to genital areas as such or as sexual body parts. Which, of course, being part of my body, belong only to me. They are neither public nor private." *Id.* at 32-33.

Gentle reader, the worst is over! Practice saying the words for a person's sexual body parts over and over (as the authors had to do when preparing this outline!), and you too will become more comfortable discussing these matters with those who depend on you for sage advice about how to stem the societal plague of sexual abuse of persons with disabilities.

4. Many parents of children with disabilities of all ages fear judgment by their peers for tackling the "taboo" topics of sexuality, especially sex between persons with

disabilities. Many parents irrationally fear that discussing sexuality with their children will promote sexual promiscuity.

5. Perpetrators of sexual abuse of persons with disabilities are statistically more likely to succeed if the victim hails from a family that has not openly and effectively addressed sexual safety matters with their child and those in the child's support network.

6. Families wrongly and tragically assume that many of the places that their loved one frequents are "safe" and could not possibly be the scene of the crime of sexual abuse. Sexual abuse of persons with disabilities happens in *all* of the following venues: (i) public and private schools; (ii) day programs; (iii) private single family homes, group homes, private high-end residential communities for persons with disabilities; (iv) churches and other houses of worship; (v) day camps and overnight camps; (vi) scouting facilities; (vii) hospitals, nursing homes, mental health facilities, doctor's offices; and (viii) vehicles used to transport victims to such venues. In short, sexual abuse of persons with disabilities can, and does, occur in any and every place they are found.

7. Many persons with disabilities are attended by a large number of third parties (*e.g.,* direct care professionals), thus increasing their exposure to potential perpetrators. The risk increases exponentially if those third parties are rendering "intimate care," such as assistance with toileting and bathing.

8. Many persons with disabilities are non-verbal, and traditional augmentative communication devices do not include pictures or words that describe the elements of sexual abuse.

9. Many persons with disabilities are largely isolated from the wider community of persons likely to observe and report suspected sexual abuse, including law enforcement personnel and other "mandatory reporters." *See infra* at Section I.F.3 for a discussion of mandatory reporters.

10. Almost total reliance on third parties for transportation vastly increases the risk that the providers of such services will perpetrate the crime of sexual abuse, from

the Medicaid-paid accessible van driver, to the day program bus driver, to the Uber or Lyft driver, to a family member or friend driving the SNT-owned car.

11. The signs of sexual abuse are often so subtle that the victim is re-victimized many times before it is suspected. Changes in a victim's behavior, habits, and demeanor are often wrongly attributed to other causes.

a. *Behavioral changes* that may indicate sexual abuse include changes in modesty, being overly focused about one's body, and inappropriate new sexual behaviors (learned from the perpetrator). The victim may exhibit selective mutism or other changes in prior communication abilities, changes in eating and sleeping habits, dressing skills and preferences, regression in other skills previously mastered. The victim may ask questions about sex and pregnancy "out of the blue," manifest increased sexualized conduct, commence self-injurious behaviors (*e.g.*, cutting), attempt suicide, act abusively towards others, destroy property, refuse to leave home, or insist on sleeping with parents (or other "safe" family members) at night.

b. *Physical changes* that could indicate sexual abuse include genital pain and itching, unusual discharge or bleeding, stomach aches and headaches, changes in monthly menstruation, diarrhea or constipation, weight loss or gain, symptoms of sexually transmitted diseases, and burning or pain with urination or defecation.

c. *Psychological changes* that could evidence sexual abuse include sleep disturbances, bed-wetting, new fears or phobias, difficulties interacting with peers, excessive crying, depression, clinginess, aggression, running away, drug or alcohol use, isolation, moodiness, general social anxiety, irritability or anger, and a pronounced inability to concentrate or focus.

d. The absence of behavioral, physical or psychological changes does not necessarily indicate the absence of sexual abuse, especially if the perpetrator has "groomed" the victim so successfully that the victim remains comfortable with the perpetrator's presence and actions.

12. Since many persons with disabilities do not receive complete annual physical exams of their reproductive systems, discovery of physical evidence of sexual abuse is often delayed for weeks or months.

13. Many persons with disabilities have been trained since childhood to be "compliant" and obedient to those in charge of them. Such behavior is rewarded, while non-compliant or disobedient behavior is punished. Many persons with disabilities cannot discern that sexually abusive behavior should be resisted (and the perpetrators know this).

14. The families of persons with disabilities do not have a plan for addressing an incident of sexual abuse when (not if) it happens. According to Dr. Nora Baladerian, perpetrators of sexual abuse target those who do not have a plan to (i) minimize (not eliminate) the risk of sexual abuse before it happens; (ii) help the victim endure the abuse as it happens; and (iii) report the abuse effectively after it happens. *See* Section I.G., *infra*.

F. Definitions of Sexual Abuse of Persons with Disabilities

1. The specific language used to define the sexual abuse of persons with disabilities varies among the different states and U.S. territories, but the generic description of such abuse (as defined by statutes and case law) is sexual contact, or sexual activity, with the person with a disability without his or her consent. The below summary analysis is based on the "50 State Survey of the Criminal Statutes Concerning the Sexual Abuse of Persons with Disabilities," found in the Appendix.

a. Defining Rape and Sexual Assault

(1) The Bureau of Justice Statistics ("BJS"), a federal government agency tasked with collecting, analyzing, and publishing data relating to crime in the United States (http://www.bjs.gov), defines rape as follows:

> "Forced sexual intercourse, including both psychological coercion and physical force. Forced sexual intercourse means vaginal, anal, or oral penetration by the offender(s). This category also includes incidents where the penetration is from a

foreign object, such as a bottle. It includes attempted rape (including verbal threats of rape), male and female victims, and both heterosexual and same sex rape."
(https://www.bjs.gov/index.cfm?ty=tp&tid=317.)

(2) The BJS defines sexual assault as follows:

"A wide range of victimizations, separate from rape or attempted rape. These crimes include attacks or attempted attacks generally involving unwanted sexual contact between victim and offender. Sexual assaults may or may not involve force, and include such things as grabbing or fondling. Sexual assault also includes verbal threats."
(https://www.bjs.gov/index.cfm?ty=tp&tid=317.)

(3) Under the criminal laws of the states and U.S. territories, the following crimes (as defined in the relevant state statutes) constitute felonies.

(a) Rape, First Degree Rape, Second Degree Rape, Second Degree Forcible Rape, Third Degree Rape, Aggravated Rape, Rape of a Child, Aggravated Rape of a Child, Mitigated Statutory Rape, Statutory Rape, Aggravated Statutory Rape, Object Rape, Statutory Rape by an Authority Figure.

(b) Sodomy, First Degree Sodomy, Second Degree Sodomy, Third Degree Sodomy, Forcible Sodomy.

(c) Sexual Assault, First Degree Sexual Assault, Second Degree Sexual Assault, Third Degree Sexual Assault, Criminal Sexual Assault, Aggravated Criminal Sexual Assault, Aggravated Felonious Sexual Assault, Felonious Sexual Assault, Aggravated Sexual Assault.

(d) Sexual Abuse, First Degree Sexual Abuse, Second Degree Sexual Abuse, Third Degree Sexual Abuse, Third Degree Aggravated Sexual Abuse, Fourth Degree Sexual Abuse.

(e) Sexual Battery.

(f) Unlawful Sexual Conduct.

(g) Second Degree Forcible Sexual Offense, Third Degree Sexual Offense.

(h) First Degree Criminal Sexual Conduct, Second Degree Criminal Sexual Conduct, Third Degree Criminal Sexual Conduct.

(i) Second Degree Criminal Sexual Act.

(j) Gross Sexual Imposition.

(k) First Degree Unlawful Sexual Penetration.

(l) Aggravated Indecent Assault.

(m) Sexual Contact with Someone Incapable of Consenting.

(4) Among the different states and U.S. territories, the following sex crimes constitute misdemeanors.

(a) Fourth Degree Sexual Assault.

(b) Third Degree Unlawful Sexual Conduct.

(c) Misdemeanor Sexual Abuse.

(d) Fourth Degree Criminal Sexual Conduct.

(e) Indecent Assault.

(f) Sexual Contact by an Authority Figure.

(5) Whether the following sex crimes are classified as felonies or misdemeanors varies significantly from state to state.

(a) Sexual Assault.

(b) Second Degree Sexual Abuse.

(c) Aggravated Sexual Battery.

(6) In some states and U.S. territories, the following sex crimes are not specifically classified as either felonies or misdemeanors.

(a) Indecent Assault and Battery on a Person Fourteen or Older, Indecent Assault and Battery on a Person with an Intellectual Disability.

(b) First Degree Criminal Sexual Conduct, Second Degree Criminal Sexual Conduct, Third Degree Criminal Sexual Conduct, Fourth Degree Criminal Sexual Conduct.

(c) Sexual Battery.

(d) Sexual Assault.

(e) First Degree Unlawful Sexual Conduct.

(f) Rape or Assault With Intent to Ravish.

(7) Each U.S. state and territory has distinct laws regarding the sentencing of perpetrators convicted of sex crimes, with the specific circumstances and facts of each case often influencing the final punishment for a specific crime (*e.g.*, the age of the victim, and whether or not the perpetrator used or threatened to use a deadly weapon). For felonies, the punishment can range from serving several years in prison (potentially at "hard labor," and with or without parole), to serving a lifetime sentence in prison, electronic monitoring and/or community supervision for life (if no longer incarcerated), and/or fines ranging from $30,000 to $100,000. For misdemeanors, punishment ranges from up to five years of imprisonment and/or fines up to $2,500.

(8) Except in limited circumstances, federal laws do not typically apply to an incident of sexual abuse if that incident occurred wholly inside a single state (*i.e.*, such a matter would be prosecuted under the laws of the state in which the incident occurred). However, an offense may be prosecuted under federal law if the offense occurred on federal lands

(*e.g.*, military bases, Indian territories, and other lands or properties owned by the federal government). *See* 18 U.S.C.A. § 7. Moreover, some sex crimes that involve crossing state lines implicate both state and federal laws (*e.g.*, crossing a state line with intent to engage in a sexual act with a person who has not attained the age of 12 years; *see id.* at § 2241). When violations of both state and federal laws are connected to an offense, both state and federal courts may try the offender.

(9) Federal criminal statutes governing sexual abuse (including the sexual abuse of persons with disabilities) expressly prohibit Aggravated Sexual Abuse, Sexual Abuse, Sexual Abuse of a Minor or (Prison) Ward, and Abusive Sexual Contact. *See id.* at §§ 2241-2244.

(a) Sexual Abuse is the specific crime that involves engaging in a sexual act with another person, if that person is "incapable of appraising the nature of the conduct" or "physically incapable of declining participation in, or communicating unwillingness to engage in, that sexual act, or attempts to do so," such as if the person has a cognitive or physical disability. *See id.* at § 2242.

(b) As used in the statutes referenced hereinabove, "sexual act" means "(A) contact between the penis and vulva or the penis and the anus, and for purposes of this paragraph contact involving the penis occurs upon penetration, however slight; (B) contact between the mouth and penis, the mouth and the vulva, or the mouth and the anus; (C) the penetration, however slight, of the anal or genital opening of another by hand or finger or by any object, with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person; or (D) the intentional touching, not through the clothing, of the genitalia of another person who has not attainted the age of 16 years with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person." *Id.* at § 2246. In general, these laws prohibit any sexual act that occurs as a result of the perpetrator threatening or placing the victim in fear, as well as any sexual acts by the perpetrator occurring when the victim is incapacitated.

(10) Perpetrators found guilty of a federal sex crime face imprisonment (a term of years, up to lifetime in prison) and fines, which may be enhanced due to the aggravating circumstances of the crime, such as if the offender used force or threats, inflicted

serious bodily injury, or kidnapped a child in the process of committing the sexual abuse (if the victim was a child). *See* THE UNITED STATES DEPARTMENT OF JUSTICE, "Citizens Guide to U.S. Federal Law on Child Sexual Abuse," https://www.justice.gov/criminal-ceos/citizens-guide-us-federal-law-child-sexual-abuse (last visited on Sept. 14, 2018).

2. Issues Regarding Consent

a. Definition of Consent

(1) The definition of consent varies among the states and U.S. territories, but some of the most common approaches to defining consent include the following: acquiescence or compliance [with the proposition of another]; intelligent, knowing, and voluntary agreement or concurrence; and a freely given agreement to the act of sexual penetration or the sexual conduct in question.

(a) In California, there is a very high burden to meet to prove consent: consent is positive cooperation in act or attitude pursuant to the exercise of free will. The person must act freely and voluntarily and have knowledge of the nature of the act or transaction involved. Similarly, in the District of Columbia, Minnesota, Montana, Vermont, Washington, and Wisconsin, consent means words or overt actions indicating a freely given agreement to the sexual act or contact in question (in the District of Columbia, the lack of verbal or physical resistance, or submission by the victim resulting from the alleged perpetrator's use of force, threats, or coercion, shall not constitute consent).

(b) On the other end of the spectrum, numerous states and U.S. territories, including Georgia, Guam, Hawaii, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, North Dakota, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Tennessee, the U.S. Virgin Islands, Virginia, and Wyoming, do not statutorily define consent within the context of sexual activity.

b. Definition of Lack of Consent

(1) Similarly, what constitutes the lack of consent also varies from state to state, but frequently-used definitions include: forcible compulsion (physical

force that overcomes earnest resistance or a threat, express or implied, that places a person in fear of immediate death or serious physical injury to himself or another person, or of kidnapping to be inflicted on anyone); incapacity to consent (including as a result of an act of the defendant, such as through application of alcohol or other drugs or intoxicants); any circumstances, in addition to forcible compulsion or incapacity to consent, in which the alleged victim does not expressly or impliedly acquiesce in the alleged perpetrator's conduct; false imprisonment; extortion; coercion during the course of therapy, medical treatment, or examination; concealment or surprise; age of the alleged victim; use or threat of weapons; and the alleged perpetrator stands *in loco parentis*.

(a) Importantly, some state laws specifically provide that a lack of consent can be demonstrated with or without the victim showing physical resistance (*e.g.*, Alaska, Florida, Iowa, and Michigan).

(b) Especially noteworthy statutes:

(i) Arizona law provides that "without consent" includes when a victim is intentionally deceived as to the nature of the act (including when a victim is intentionally deceived to erroneously believe that the perpetrator is the victim's spouse).

(ii) Illinois and Montana law state that the manner of dress of the victim at the time of the offense shall not consitute consent. Moreover, Illinois law specifically states that even if a person initially consents to sexual activity, he or she is not deemed to have consented to any further sexual activity that occurs after he or she withdraws consent during the course of that sexual encounter. Montana law states that a current or previous dating or social or sexual relationship, by itself, does not constitute consent.

c. Consent of a Person with a Cognitive Disability

(1) Numerous laws in different states and U.S. territories, as well as the District of Columbia, specifically provide that a person is or may be deemed to be incapable of consenting if he or she has a cognitive disability (Alabama, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Guam, Idaho, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota,

Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, the U.S. Virgin Islands, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming). The most commonly used phrase in these laws to describe a cognitive disability is "mentally defective," which is shockingly insensitive. Under these laws, this phrase means suffering "from a mental disease of defect which renders [a person] incapable of appraising the nature of his conduct."

(a) Similarly, in Arizona, the victim is incapable of consent by reason of mental disorder, "mental defect," drugs, alcohol, sleep, or any other similar impairment of cognition, and such condition is known or should have reasonably been known to the defendant.

(b) Likewise, in Arkansas a person is "mentally defective" if he or she suffers from a mental disease or defect that renders the person incapable of understanding the nature and consequences of a sexual act, or unaware that a sexual act is occurring.

(2) Thus, in these states, in a case where an individual with a cognitive disability is the survivor of sexual abuse, it may be deemed that he or she is not capable of consenting to the act by virtue of his or her having a cognitive disability.

(3) In some states, such as Connecticut, it is an affirmative defense that the perpetrator, at the time of the conduct constituting the criminal offense, did not know that the victim had a cognitive disability.

(4) In Florida, there are increased penalties for a sexual battery carried out on a victim that the accused either knows or has reason to believe is "mentally defective." Similarly, in Massachusetts, the punishment for sexual abuse of a person with a cognitive disability is more severe.

(5) The laws in Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, and Puerto Rico do not specifically address the impact of a cognitive disability on the victim's ability to consent.

d. Consent of a Person with a Physical Disability

(1) Under the laws of numerous states, and of the District of Columbia, a person who has a physical disability is, or may be, deemed to be unable to consent (including Alabama, Alaska, Arkansas, California, Connecticut, Florida, Georgia, Idaho, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming). The most common phrase used in these laws to describe such a physical disability is "physically helpless," which is disturbingly insensitive.

(a) In Florida, for example, a person who is "physically helpless" may not be able to provide intelligent, knowing, and voluntary consent, with "physically helpless" defined as "unconscious, asleep, or for any other reason physically unable to communicate unwillingness to an act."

(2) Thus, in these states, in a case where an individual with a physical disability is the survivor of sexual abuse, it may be deemed that he or she is not capable of consenting to the act by virtue of his or her having a physical disability.

(3) In some states, including Connecticut, it is an affirmative defense that the perpetrator, at the time of the conduct constituting the criminal offense, did not know of the victim's physical disability.

(4) In Illinois and Massachusetts, the crime and punishment of sexual abuse is more severe if the victim has a physical disability.

(5) In Maryland, if a victim has a physical disability but is still mentally competent, the victim must show some degree of physical resistance, or an explanation of why the will to resist was overcome by force or fear of harm, offering less protection for the victim.

(6) Laws in Arizona, Delaware, Indiana, Oklahoma, and Puerto Rico do not specifically address the impact of having a physical disability on the ability to consent.

3. Mandatory Reporters of the Sexual Abuse of Persons with Disabilities

a. "Mandatory reporters" of sexual abuse of persons with disabilities vary significantly among the different states and U.S. territories, and are also categorized by whether the victim is a child or an adult (who is elderly or otherwise vulnerable, such as having a physical or cognitive disability). *See Mandatory Reporting Requirements: Children*, https://apps.rainn.org/policy/compare/children-export.cfm (last updated on Dec. 2017; last visited on Sept. 8, 2018); *see also Mandatory Reporting Requirements: The Elderly*, https://apps.rainn.org/policy/compare/elderly-export.cfm (last updated on Dec. 2017; last visited on Sept. 8, 2018). Often, such individuals include medical personnel; educators, counselors, and other school administration personnel; law enforcement; social workers; counselors who specialize in the treatment of sexual assault survivors; child care workers; and clergy.

(1) For example, under Georgia law, the following persons are mandatory reporters of such suspected abuse if the victim is a child with a disability:

(a) Physicians licensed to practice medicine, physicians' assistants, interns, or residents;

(b) Hospital or medical personnel;

(c) Dentists;

(d) Licensed psychologists or persons participating in internships to obtain licensing;

(e) Podiatrists;

(f) Registered professional nurses, licensed practical nurses or nurses' aides;

(g) Professional counselors, social workers, or marriage and family therapists;

(h) School teachers;

(i) School administrators;

(j) School guidance counselors, visiting teachers, school social workers or school psychologists;

(k) Child welfare agency personnel;

(l) Child counseling personnel;

(m) Child service organization personnel;

(n) Law enforcement personnel;

(o) Reproductive health care facility or pregnancy resource center personnel and volunteers; and

(p) Persons who process or produce visual or printed matter.

(2) Under Georgia law, the following persons are mandatory reporters if the victim is an adult with a disability:

(a) All persons who are required to report child abuse;

(b) Physical therapists;

(c) Occupational therapists;

(d) Day-care personnel;

(e) Coroners;

(f) Medical examiners;

(g) Emergency medical services personnel;

(h) Any person who has been certified as an emergency medical technician, cardiac technician, paramedic, or first reponder;

(i) Employees of any public or private agency engaged in professional health related services to persons who are elderly, or adults with disabilities;

(j) Clergy members (outside of the confessional);

(k) Any employee of a financial institution, except when that employee is acting as a fiduciary (but only for such assets that the employee is holding or managing in a fiduciary capacity); and

(l) For long term care facilities, the persons listed above, plus administrators, managers, or other employees of hospitals or long-term care facilities.

(3) Importantly, in the following states and U.S. territories, *any person* who knows, or in good faith suspects (or has reasonable cause to believe), that the sexual abuse of a child has occurred is a mandatory reporter: Delaware, Kentucky, Mississippi, Nebraska, New Jersey, North Carolina, Oklahoma, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, and Wyoming.

(4) Moreover, in the following states and U.S. territories, *any person* who knows, or in good faith suspects (or has reasonable cause to believe), that the sexual abuse of an adult (who is elderly, or otherwise vulnerable/at risk due to having a disability) has occurred is a mandatory reporter: Delaware, Florida, Indiana, Kentucky, Louisiana, Mississippi, New Hampshire, North Carolina, Oklahoma, Pennsylvania, Puerto Rico, Tennessee, Texas, Utah, and Wyoming.

(5) If the victim is a child, the mandatory or permissive reporter must call the local Child Protective Services ("CPS") agency. (This child-serving agency may have different monikers, including Department of Family and Children's Services or

Department of Social Services.) A database of contact numbers for CPS agencies nationwide is accessible at https://www.childhelp.org/hotline or by calling 1-800-422-4453.

(6) If the victim is an adult, the mandatory or permissive reporter must call the local Adult Protective Services ("APS") agency. A database of contact numbers for APS agencies nationwide is accessible at https://eldercare.acl.gov/Public/Index.aspx or by calling 1-800-677-1116.

b. Under federal law (34 U.S.C. § 20341), mandatory reporters of suspected child abuse (including sexual abuse or exploitation, pornography and child prostitution) include the following "covered professionals" and "covered individuals."

(1) "Covered professionals" include:

(a) Physicians, dentists, medical residents or interns, hospital personnel and administrators, nurses, health care practitioners, chiropractors, osteopaths, pharmacists, optometrists, podiatrists, emergency medical technicians, ambulance drivers, undertakers, coroners, medical examiners, alcohol or drug treatment personnel, and persons performing a healing role or practicing the healing arts.

(b) Psychologists, psychiatrists, and mental health professionals.

(c) Social workers, licensed or unlicensed marriage, family, and individual counselors.

(d) Teachers, teachers' aides or assistants, school counselors and guidance personnel, school officials, and school administrators.

(e) Child care workers and administrators.

(f) Law enforcement personnel, probation officers, criminal prosecutors, and juvenile rehabilitation or detention facility employees.

(g) Foster parents.

(h) Commercial film and photo processors.

(2) "Covered individuals" include:

(a) An adult who is authorized by a national governing body, or a member thereof, or an amateur sports organization, that participates in interstate or international amateur athletic competition (*e.g.*, Special Olympics), to interact with a minor or amateur athlete at an amateur sports organization facility, or at any event (including travel, lodging, practice, competition, health or medical treatment) sanctioned by such body or organization.

(3) The Attorney General is charged with designating an agency to receive and investigate the reports of suspected child abuse required by this statute, which need not be a federal agency (*i.e.*, a state Child Protective Services agency). Allegations of child sexual abuse shall be referred immediately to law enforcement and investigated promptly.

(4) The failure of a mandatory reporter to report suspected child sexual abuse is punishable by a fine and up to one year in federal prison, or both. 18 U.S.C. § 2258.

G. Individualized Response Plan for Persons with Disabilities to Plan For, Survive and Report Sexual Abuse

1. Fact: it is not possible to completely eliminate the risk of sexual abuse of persons with disabilities.

2. Fact: perpetrators have a plan to sexually abuse persons with disabilities.

3. Fact: most victims of sexual abuse did not have a plan.

4. Fact: an "Individualized Response Plan" ("IRP") will minimize (not eliminate) the risk that a person with a disability will become a victim of sexual abuse, and will improve the outcomes for the survivor of sexual abuse, including (i) preparing the person and their family for the abuse *when* (not if) it occurs, (ii) facilitating faster, more effective response by law enforcement in the aftermath of the abuse, and (iii) accessing appropriate post-abuse services for the survivor to ameliorate psychological (and physical) trauma.

5. An IRP has three stages: Before the Sexual Abuse, During the Sexual Abuse, and After the Sexual Abuse. Dr. Nora Baladerian describes in detail how an IRP is developed and implemented in her *Risk Reduction Workbook*. The following issues must be addressed in the preparation of an IRP by a person with a disability and their adult "IRP Partner."

a. Acknowledge and internalize the scope and prevalence of the sexual abuse of persons with disabilities.

b. Learn to recognize the signs of sexual abuse. *See supra*, at Section I.E.11.

c. Identify and *list every single person who has any contact whatsoever* with the person with a disability, including family members ("The List"). Review the resume and current background check of each person on The List, and check the state and national Sex Offender Registries. Inform each person on The List that the IRP exists so that all of them know that the person with the disability and the IRP Partner are "abuse aware."

d. Make the IRP part of an Individualized Education Plan ("IEP") or Individual Habilitation Plan ("IHP") that the person with the disability maintains.

e. "Pop in" unannounced when the person with the disability is in the company of any of the persons on "The List."

f. Insist that any school, agency or transportation company serving the person with the disability advises the IRP partner when a *substitute* teacher, staff or direct care worker will have contact with the individual. Make sure any IEP or IHP reflects this insistence.

g. Install video cameras in the residence/bedroom inhabited by the person with a disability, and advise those who are in contact with the person that the video cameras are both visible and hidden, and that the footage is reviewed by the IRP Partner both in "real time" and periodically during the day.

h. Monitor the routes taken by transportation companies to drive the person with the disability to appointments and events. Determine whether other

individuals and aides are transported with the person with the disability. Consider installing audio recording devices in the backpack of the person with the disability.

i. Insist that new background checks be reviewed before the subject of the check is allowed to have any contact with the person with a disability. Update initial background checks every six months.

j. Insist that staff serving the person with the disability be "rotated" from time to time.

k. Develop an effective method by which the person with the disability can communicate to the IRP Partner the essential facts of a sexual abuse. Teach the correct names for sexual body parts (*see supra* at Section I.E.3.), and prepare an "Abuse Communication Picture Book" or flash cards that can easily illustrate the who, what, when and where elements of a sexual abuse incident. Update augmentative communication devices with all relevant terms.

l. Practice story telling skills with routine events in daily life so that it will be natural to describe the story of any future sexual abuse.

m. The "During Stage" of an IRP will vary widely depending on the victim's intellectual capacity. The goal of this stage is threefold: (i) to survive the abusive behavior or event (most of the time the victim cannot "escape"), (ii) to observe every aspect of the abuse using all senses, and (iii) to report the completed abuse immediately to the IRP Partner using the communications techniques developed and practiced during the "Before Phase." The mantra for all victims of sexual abuse while it is happening is "My power is after."

n. The adult IRP partners need to hone the following skills: listening; remaining calm in the face of shocking revelations of sexual abuse; asking pertinent questions; reassuring the person with a disability that they know exactly what to do next; communicating with law enforcement; knowing how to preserve physical evidence of the abuse for the forensic medical exam; ignoring personal feelings of rage, disgust, and trauma to better serve the survivor of the abuse; reassuring the victim that the IRP is being implemented; believing the victim's story of sexual abuse and verbalizing this belief. *See Appendix* for a helpful *Guide on Responding to Suspected Abuse of People with Developmental Disabilities*.

o. After the sexual abuse has been reported by the IRP Partner to the appropriate social services agency and to law enforcement, resist the temptation to get involved in the investigation. Let law enforcement do their job!

p. Withdraw or remove the victim from the setting where the sexual abuse occurred and deny the perpetrator any further contact with the victim during the investigation by law enforcement.

q. Obtain appropriate trauma counseling services for the survivor, the IRP partner and others who have helped implement the IRP.

r. Practice the IRP monthly, and update the IRP as needed to account for developments in the life of the person with the disability.

II. ON-CAMPUS SEXUAL ASSAULT OF PERSONS WITH DISABILITIES.

Sexual violence against college-aged students with disabilities is a key concern for many parents whose young adults with disabilities plan to attend traditional college or an inclusive post-secondary education program that is otherwise part of a campus environment.

A. Scope

1. The subject of sexual assault on college campuses has received increased attention in recent years; however, there is a great need for increased awareness and advocacy regarding this issue as it pertains to students with disabilities. On January 30, 2018, the National Council on Disability ("NCD") issued a report (the "NCD Report"), *Not on the Radar: Sexual Assault of College Students with Disabilities* (available at https://www.ncd.gov/sites/default/files /NCD_Not_on_the_Radar_Accessible.pdf, last visited on Sept. 11, 2019). The Report describes an investigation by the NCD into the current state of campus sexual assault programs, policies, and barriers to students with disabilities. The investigation is based largely on extensive interviews of experts on sexual assault on college campuses or on sexual abuse of persons with disabilities in general, college professionals and staff (including disability services administrators, Title IX coordinators, and sexual assault services administrators), as well as national questionnaires sent to college professionals and college students with disabilities. The NCD Report notes that federal-level research studies, such as those funded by the Department of

Justice's Office on Violence Against Women and the National Institute of Justice, which seek to measure the prevalence of sexual assault and reporting on campuses, have consistently failed to include disability status as a demographic. Thus, much of this prior research does not provide meaningful insight into the prevalence of sexual assault on campus concerning students with disabilities. *Id.* at 11 and 12.

2. Moreover, the April 2014 report from the White House Task Force to Protect Students from Sexual Assault, *Not Alone*, did not include disability status as a demographic in its sample campus climate survey, which may have set the precedent for colleges and researchers to exclude disability status as a demographic in campus climate studies. *Id.* at 12.

a. It is encouraging, however, that the subsequent 2017 report from this same Task Force did include recommendations for campuses to consider the needs of diverse groups of students, including students with disabilities. *Id.* at 19.

3. A study by the Association of American Universities (the "AAU Study"), issued on September 3, 2015, examined the prevalence of sexual assault against students at twenty-seven universities and included 150,000 participants. *Id.* at 11. The AAU Study, one of the largest surveys on sexual assault and sexual misconduct in terms of both the number of schools and number of students who participated in the study, *did* include disability status as a demographic. *Id.* The AAU study found that 31.6 percent of female undergraduates with a disability reported nonconsensual sexual contact involving physical force or incapacitation, compared to 18.4 percent of female undergraduates without a disability. *Id.* In other words, approximately one out of every three female undergraduate students with a disability was the victim of sexual assault during her time at college.

4. Having a thorough and current knowledge of relevant federal and state law regarding the prevention of on-campus sexual assault may help families minimize the risk that their students with disabilities become victims. For those students with disabilities who nevertheless become victims of sexual violence, knowledge of the remedies and rights afforded by these laws to victims can be invaluable to families as they deal with the aftermath of such assaults.

B. Federal Law Pertaining to On-Campus Sexual Assault of Persons with Disabilities

1. Laws Specifically Protecting Persons with Disabilities

a. Section 504 of the Rehabilitation Act of 1973 ("Section 504")

(1) Section 504 prohibits any program receiving federal financial assistance from discriminating against a person because of his or her disability. *See* NCD Report, at 27.

(2) Section 504 applies to institutions of higher education that receive direct or indirect federal financial assistance, even if that assistance consists solely of federal student financial aid. *Id.*

(3) Section 504 states, in pertinent part: "[n]o qualified handicapped student shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any academic, research, occupational training, housing, health insurance, counseling, financial aid, physical education, athletics, recreation, transportation, other extracurricular, or other postsecondary education aid, benefits, or services to which this subpart applies." *Id.*

(a) Section 504 pertains to qualified students with disabilities who have a physical or mental disability that substantially limits one or more major life activities, or have a record of such a disability, or are regarded as having such a disability. *Id.*

(4) If buildings were constructed prior to 1977, Section 504 allows, but does not require, campuses to relocate programs or services in order to make them sufficiently accessible. *Id.* at 28.

b. Title II of the Americans with Disabilities Act ("Title II of the ADA")

(1) The protections of the ADA apply to "qualified individuals with a disability," with disability defined as a physical or mental impairment that

substantially limits one or more major life activities, or a record of having such an impairment or being perceived by others as having such an impairment. *See* Sara Rosenbaum, *The Americans with Disabilities Act in a Health Care Context*, *in* THE FUTURE OF DISABILITY IN AMERICA, Inst. of Medicine (US) Comm. on Disability in America; M.J. Field & A.M. Jette eds., 2007. Available at: https://www.ncbi.nlm.nih.gov/books/NBK11429/ (last visited on Sept. 11, 2019).

(2) Title II of the ADA prohibits state and local governments from discriminating on the basis of disability and, as with Section 504, applies to public colleges, universities, and graduate and professional schools. NCD Report, *supra*, at 27.

(3) Title II of the ADA is applicable to such institutions without regard to whether they receive federal funding. *Id.*

(4) The requirements regarding the provision of auxiliary aids and services under Section 504 are generally also included under Title II of the ADA. *Id.*

(5) Title II of the ADA emphasizes that colleges are not required to make structural changes to existing facilities that were built prior to the enactment of federal accessibility requirements where other methods are effective in achieving compliance. *Id.* at 28.

c. Title III of the Americans with Disabilities Act ("Title III of the ADA")

(1) Title III of the ADA prohibits discrimination on the basis of disability "in places of public accommodation," which include private colleges and universities. *Id.*

(2) Both Titles II and III of the ADA require that newly constructed facilities are fully accessible to people with disabilities. *Id.*

d. State Law Remedies for Violations of the ADA

The authors of this outline have concluded that only one state, California, provides state law remedies for violations of the ADA.

(1) The Unruh Civil Rights Act (the "Act"), Section 51, which seeks to provide protection from discrimination in places of public accommodation, entitles specific protected groups "to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever." Cal. Civ. Code § 51 (West).

(2) Section 51 of the Act incorporates the ADA by making "a violation of the right of any individual under the American with Disabilities Act of 1990" a violation of the Act, as well. Cal. Civ. Code § 51 (West).

(3) Section 52 of the Act provides remedies, such as a private right of action, for violation of the Act. Cal. Civ. Code § 52 (West).

(a) A reasonable interpretation of Section 51, when read together with Section 52, is that the Act authorizes a private action for damages for ADA violations. *See Munson v. Del Taco, Inc.*, 46 Cal. 4th 661 (2009).

(4) Various California Supreme Court decisions interpreting the Act have instructed that the phrase "business establishments" must be interpreted "in the broadest sense reasonably possible." *See, e.g., Curran v. Mount Diablo Council of the Boys Scouts* (1998) 17 Cal. 4th 661, 670. The Act applies not only to any type of for-profit commercial enterprise, but also to non-profit entities that serve the business or economic interests of its owners or members. *Id.*; *see also Rotary Club of Duarte v. Bd. of Directors*, 178 Cal. App. 3d 1035 (Cal. Ct. App. 1986) (discussing a nonprofit civic association of business and professional men where a primary purpose of the organization was to promote the business interest of its members); *Stevens v. Optimum Health Ins.* (S.D. Cal 2011) US Dist LEXIS 95372 (religious organization); *Nat'l Fed'n of the Blind v. Target Corp.*, 452 F. Supp. 2d 946 (N.D. Cal. 2006) (retailer's website considered a business establishment under the Act). However, a charitable social organization whose formation and activities are unrelated to economic or business interests will not be considered a business for purposes of the Act. *See, e.g., Hankins v. El Torito Restaurants, Inc.*, 63 Cal. App. 4th 510, 520 (1998); *Moeller v. Taco Bell Corp.*, 816 F. Supp. 2d 831 (N.D. Cal. 2011).

(a) Regarding colleges and universities, whether an educational institution is considered to be a "business establishment" for purposes of the Act is

fact-specific. Colleges and universities may be considered business establishments for purposes of the Act when engaging in commercial activities. For example, the California Supreme Court noted in *Doe v. California Lutheran High Sch. Ass'n.* that a high school would not be permitted to discriminate in its nonmember transactions, such as the sale of football tickets (although such school's admissions and disciplinary practices, based on a particular religion, may *not* be subject to the Act). 170 Cal. App. 4th 828 (2009).

2. Federal Laws Regarding the Reporting of Sexual Assault on College Campuses

a. The Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Act ("The Clery Act")

(1) The Clery Act, a federal consumer protection law passed in 1990, requires all colleges and universities that receive federal funding to report information about crime on or around campus and their efforts to improve campus safety, and to publish this information in an annual security report ("ASR"). NCD Report, *supra*, at 28.

(2) Since its passage, the Clery Act has been amended several times with the goal of increasing the required reporting and augmenting college responses specific to sexual violence. *Id.*

(a) Most recently, the Clery Act was amended by the Violence Against Women Reauthorization Act of 2013, which imposed new obligations on colleges and universities under its Campus Sexual Violence Act ("The Campus SaVE Act") provision, Section 304. *Id.*

(3) The Clery Act specifies how information about crime must be reported. Colleges are required to make information publicly accessible through ASRs that provide data regarding incidents of sexual assault, dating violence, domestic violence, stalking, and hate crimes occurring (i) on campus, (ii) in any building off campus that is owned, controlled by, or used by a student organization or by the college in support of educational purposes, and (iii) public property within the campus area that is adjacent to the institution (such as sidewalks, streets, or parking facilities). *Id.* at 28-29.

(4) Under the Clery Act, colleges must disseminate timely warnings and notification of such crimes. Colleges must also disseminate the policies and procedures to be followed after an incident of sexual assault, dating violence, domestic violence, or stalking. *Id.* at 29. Colleges must articulate their policies on how students may report crimes, and outline the rights of both the alleged perpetrator and the alleged victim in the campus disciplinary process. *Id.* The Clery Act also outlines the rights of, and options available to, survivors of sexual assaults and related violations, including changes to academic transportation and living or work situations, as well as assistance in notifying local law enforcement. *Id.*

b. Campus Sexual Violence Elimination Act ("The Campus SaVE Act")

(1) The Campus SaVE Act amended the Clery Act to outline specific procedures for serving victims of sexual violence and to strengthen standards of investigation, such as requiring colleges to create policies addressing victims' confidentiality and training college officials to ensure that hearings are conducted in a manner that protects victims. NCD Report, *supra*, at 29.

(2) The Campus SaVE Act requires educational institutions to have policies that clearly describe the jurisdiction of security personnel and identify any protocols regarding the investigation of alleged criminal offenses. *Id.*

(3) The Campus SaVE Act mandates that colleges provide prevention and awareness programs regarding sexual misconduct that educate students on the concept of consent, promote positive and healthy student behaviors, and encourage safe bystander intervention. *Id.* Colleges must provide education programs to students and employees when they are first enrolled or hired, as well as on an ongoing basis. *Id.*

3. Title IX of the Education Amendments of 1972 ("Title IX")

a. Title IX is a federal civil rights law that prohibits discrimination on the basis of sex in any educational program or activity that receives federal funding. NCD Report, *supra*, at 29.

(1) Under Title IX, discrimination on the basis of sex can include sexual harassment, rape, and sexual assault. *Id.*

(2) A college or university that receives federal funds may be held legally responsible when it knows about and ignores sexual harassment or assault that occurs in the context of its programs or activities. *Id.*

(3) Colleges have great latitude to adopt the relevant standard of proof in sexual assault cases, from the lowest standard (preponderance of the evidence) to the highest standard (clear and convincing evidence). *Id.* at 29-30.

(4) Colleges are required to appoint a Title IX coordinator to ensure that the educational institution is in compliance with federal law and to oversee investigations and the disciplinary process. *Id.* at 30.

(5) Like the Clery Act, Title IX requires colleges to adopt and publish grievance procedures that outline the complaint, investigation, and disciplinary processes. These processes must be expedient (but no specific time frame is specified by Title IX), equitable, and allow for impartial investigation. *Id.*

(6) As with the Clery Act, Title IX requires college employees that address issues of sexual assault on campus to have proper training, and requires educating the campus community at large regarding its policies and procedures concerning sexual assault. *Id.*

C. Sexual Assault Policy Compliance by Educational Institutions

1. The Clery Act

a. Several existing reports and audits suggest that educational institutions are struggling to comply with the requirements of the Clery Act. The absence of policy statements or procedures constitute the main violation. NCD Report, *supra*, at 59. Another key violation of the Clery Act is the failure to report accurate crime statistics. *Id.* The United States Department of Education levies fines on colleges or universities that violate any aspect of the Clery Act. *Id.*

2. Title IX

a. In January 2017, the United States Department of Justice released a list of 304 colleges and universities that were under investigation for violating Title IX by mishandling sexual misconduct or assault issues. NCD Report, *supra*, at 60. Alleged violations include failing to provide prompt responses to students who made complaints about sexual assault and failing to adequately train faculty and staff (including coaches and resident advisors) to respond to, and report on, reported incidents of sexual harassment or sexual assault. *Id*.

D. State Legislative Responses to On-Campus Sexual Assault

1. Various states have responded to on-campus sexual violence by developing specific policies to work in tandem with federal laws. NCD Report, *supra*, at 61. While none of these laws specifically address students with disabilities, they have meaningful implications for the experiences of students with disabilities on college campuses. *Id.* Below are some of the issues that such laws address.

a. The role of local and state law enforcement versus the role of campus police during an investigation of alleged sexual assault. *See, e.g.*, S.C. Code Ann. § 59-154-10 (1976).

b. The specific components that must be included as part of an educational institution's sexual misconduct policy (*e.g.*, definitions of forms of sexual misconduct consistent with federal and state law and policy; reporting options for sexual misconduct; procedures for investigating reports of sexual misconduct; education and training requirements regarding sexual assault; and publication requirements regarding the institution's resources concerning sexual assault). *See, e.g.*, Colo. Rev. Stat. § 23-5-146.

c. The difference between the process of investigation and disciplinary proceedings of the educational institution and the various remedies under civil and criminal law that a survivor can choose to pursue following an incident of sexual assault. *See, e.g.*, La. Stat. Ann. § 17:3399.15.

d. Opinions to disseminate information about state and community-based services and resources that are available to victims of sexual assault. *See*, *e.g.*, Oregon Revised Statutes Annotated § 350.255.

e. The adoption of policies to eliminate barriers for victims to report incidents of sexual assault, *e.g.*, exempting the victim from campus sanctions for being in violation of alcohol or substance abuse policies at the time of an incident. *See, e.g.,* California Codes Annotated § 67385.7.

E. Recommendations of the National Council on Disability to Colleges and Universities

1. To address the unique needs of survivors of sexual assault who have disabilities, the NCD recommends that colleges and universities should take the following steps:

a. Develop, implement, and publicize sexual assault prevention protocols, and support service training that is inclusive and meaningful to students with disabilities. NCD Report, *supra,* at 69.

b. Provide disability-related and trauma-informed practice training to prevention and first responder staff (*e.g.*, advocates, crisis counselors, peer advocates, and sexual assault nurse examiners), as well as to campus security personnel, so that they understand how to reduce incidents of sexual assault and to support students with disabilities after an incident of sexual assault has occurred. *Id.*

c. Establish and maintain active collaborative relationships between the Title IX coordinator, and campus-based sexual assault services, counseling and health services, and disability services. *Id.*

d. Require the active involvement of college disability services staff in college sexual assault prevention and support efforts and training on Title IX procedures. *Id.*

F. Accessibility Challenges in the Context of On-Campus Sexual Assault Programs and Services

In compliance with federal law, educational institutions are increasingly engaging in efforts to better prevent and respond to incidents of on-campus sexual assault, including (i) providing educational and training programs to prevent sexual assault; (ii) disseminating information regarding reporting incidents of sexual assault; (iii) providing multiple sexual assault reporting options; (iv) offering victims' advocate services, mental health counseling, and/or support groups; and (v) conducting investigations of alleged instances of sexual assault. NCD Report, *supra*, at 31. Nevertheless, such efforts often do not include programs and services that are fully accessible to students with disabilities. *Id.* Moreover, even if students with disabilities can technically access these services, they may experience a significant delay while they wait to receive the disability accommodations that facilitate full participation. *Id.*

1. Institutions of higher education covered by Section 504 must provide appropriate and effective auxiliary aids to students with disabilities (*e.g.*, sign language interpreters, captioning services, assistive listening devices, and telecommunications devices). *Id.* at 27. If an aid is necessary for an appropriate use, the institution must make it available, unless the provision of the aid would cause undue burden. *Id.* A student with a disability cannot be required to pay any of the costs of the aid or service, and the institution cannot limit what it spends for such aids or services or refuse to provide them because other providers of these services exist. *Id.* Institutions cannot condition the provision of such aids on the availability of funds to pay for them. *Id.*

2. The Rehabilitation Act and the ADA are the source of important implications regarding the sexual assault of college students with disabilities. *Id.* at 12. For example, (i) survivors of sexual assault who have mobility impairments need physical access to victims' services and related campus offices; (ii) survivors with hearing impairments need interpreters or other auxiliary aids to communicate; and (iii) students with visual impairments or print-based disabilities (*e.g.*, dyslexia), need access to resources that they will be able to understand. *Id.*

3. Campus sexual assault prevention and education programs (as well as resources for the victims of sexual assault) are often not readily available to students with

disabilities. *Id.* College staff frequently lack awareness that such programs must be made accessible to persons with disabilities, and college staff are not trained in specific disability accommodations. *Id.*

a. For example, students with auditory impairments have reported that in-person educational programs about the prevention of sexual assault lacked interpreters, while students with mobility impairments have reported that the classrooms in which such trainings take place are not wheelchair-accessible. *Id*. at 34. Students have reported that they are not aware of the process for requesting accommodations, or that students who do request such accommodations ahead of the trainings are made to feel like an "inconvenience" to the staff. *Id*. Online and print resources concerning the prevention of sexual assault and victims' services are often inaccessible to persons with visual impairments. *Id*. at 34-35. Some Title IX coordinators have reported that they do not provide accommodations for such resources (such as larger print, or braille) unless they are specifically requested, admitting that such accommodation is reactive rather than proactive. *Id*. at 35.

b. Many universities have no explicit policies for providing such accommodations for students with disabilities. *Id*. at 40-41.

4. The dearth of policies or procedures to address the needs of students with disabilities who have experienced sexual assault may be due to what some college staff consider the "siloing" of disability services and sexual assault services. *Id.* at 48. For example, the Title IX coordinator's office is not linked with the offices of those who coordinate obtaining auxiliary aids for use by students with disabilities in a classroom setting. *Id.*

5. Another reason for the lack of such policies may be that counselors, sexual assault advocates, faculty, or other college staff who interact with students after incidents of sexual assault are not trained to recognize or address the special needs of students with disabilities. *Id.* at 50.

6. An additional reason for the lack of targeted educational programming at colleges may be the lack of research and best practices on effective sexual assault prevention programs for students with disabilities. *Id.* at 56. Many colleges fail to identify

students with disabilities as a population at increased risk of sexual assault; thus, these colleges are not developing programs to address the unique needs of students with disabilities. *Id.*

7. Overall, a failure to develop clear sexual assault policies and procedures to serve students with disabilities is a significant problem at many colleges and universities and represents a clear violation of the ADA and Section 504 of the Rehabilitation Act. *Id.* at 54.

a. However, it is a sign of progress that the 2017 report from the White House Task Force to Protect Students from Sexual Assault specifically recommended that materials and services regarding sexual assault prevention, outreach, and support be accessible and comply with the ADA. *Id*. at 19. Moreover, the Department of Education, Office of Civil Rights, also issued a "Dear Colleague Letter" that (i) outlines the responsibility of colleges to address disability in cases of sexual violence, (ii) outlines issues that campuses should consider, and (iii) states that colleges should ensure accessibility of information and training concerning sexual assault. *Id*.

8. These sobering realities need to be addressed so that students with disabilities are no longer on the periphery when it comes to sexual assault prevention, outreach, and services. *Id.* at 12.

9. To help ensure access for students with disabilities to sexual assault supports and services, educational institutions are increasingly called upon to implement the following practices.

a. Include students with disabilities as a demographic in campus climate surveys on sexual assault. *Id*. at 68.

b. Create crisis policies and procedures on how to provide sexual assault services to students with sensory disabilities, so that students receive services within 24 hours of a sexual assault. *Id*.

c. Guarantee that sexual assault first responders and support providers have access to emergency interpreter services or other augmented communication methods, so that students can communicate with staff immediately after an incident of assault. *Id*.

d. Ensure that information regarding sexual assault support and services (*e.g.*, fliers, posters, and websites) are accessible to students with visual, cognitive, and other learning disabilities. *Id*.

e. Ensure that students can access sexual assault reporting, and connect with crisis counseling or other supports, through various modes of communication (*e.g.*, online, text messages, or via telephone). *Id.*

f. Create formal agreements with community-based providers that have the expertise to support survivors with disabilities. *Id*. at 69.

g. Include information about disability and accommodations on the campus Title IX web page. *Id*.

h. Include contact information in Title IX policies and related materials for any person to request disability services and accommodations for a person with a disability. *Id*.

G. Recommendations for Families

1. The authors recommend that families do the following in order to minimize the risk of on-campus sexual violence against their loved ones with disabilities, and to maximize the probability that their loved ones with disabilities will be able to access adequate resources in the event that an incident of sexual abuse should occur.

a. As previously discussed in this outline, a critical step families can take to minimized the risk of on-campus sexual violence against their loved ones with disabilities is to acquire a thorough and current knowledge of relevant federal and state law regarding the prevention of on-campus sexual assault.

(1) Families must have a clear understanding of the remedies and rights afforded to victims by these laws, so they can pursue all available options should their loved ones with disabilities experience sexual assault.

(a) Families should communicate such information and concepts to their loved ones with disabilities, in ways which will be understandable and empowering. It is recommended that families seek the advice of counselors

and other experts who serve persons with disabilities in the context of sexual assault prevention and response in order to accomplish this goal.

(b) By establishing a strong knowledge base about such laws before an incident of sexual abuse occurs, families will also be better situated to focus on helping their loved ones with disabilities obtain the resources that they need in order to heal in the aftermath of an assault, instead of spending time and energy building an understanding of such laws.

b. Families should conduct research regarding the sexual assault prevention education, survivors' resources, and related policies of the colleges or other on-campus post-secondary educational programs which their loved ones with disabilities may attend, in order to evaluate which have more robust programs and procedures that are both appropriate for, and accessible to, students with disabilities.

c. Families should become, and remain, well-versed in the sexual assault education, resources, and policies of the colleges or programs in which their loved ones with disabilities ultimately participate, so that they can check in with their students on a regular basis about those specific programs, resources, and policies.

d. Families should regularly address the topic of sexual safety with their loved ones with disabilities while they are attending the colleges or programs. Of course, such conversations will be much easier (likely, for both families and their students), if they are a continuation of a developing dialogue about sexual safety that families have established with their loved ones throughout their lifetimes.

III. PEER-TO-PEER SEXUAL ABUSE OF PERSONS WITH DISABILITIES.

A. Risk Factors for Engaging in Sexual Abuse

1. Researchers have identified numerous risk factors which can lead to an increased chance that a person with a disability may commit sexual abuse of another. *See* The Arc's Nat'l Ctr. on Criminal Justice and Disability ("NCCJD"), *Sex Offenders with Intellectual/Developmental Disabilities,* at 7 (The Arc ed., 2015). The reader will note that many of these same risk factors often increase a person's vulnerability to becoming a victim of sexual

abuse, as discussed elsewhere in this outline. Indeed, as demonstrated throughout this outline, persons with intellectual or developmental disabilities are often targets for sexual abuse, and frequently become perpetrators of sexual abuse not long after having been abused themselves. *Id.* at 9. Commonly cited risk factors for peer-to-peer sexual abuse include the following.

a. Having been a victim of sexual abuse. *See* Leigh Ann Davis, *People with Intellectual Disabilities and Sexual Offenses*, found at thearc.org, http://thearc.org/wp-content/ uploads/2019/07/Sexual%20Offenses.pdf (last visited on Sept. 5, 2019).

b. Having been a victim of physical abuse. *Id*.

c. Exposure to violence and/or pornography. *Id*.

d. Behaving inappropriately for age level, preferring to socialize with, and over-identifying with, people who are younger. The Arc's NCCJD, *supra*, at 7.

e. Being easily influenced by others and anxious to please others. *Id*.

f. Acting impulsively and failing to understand the consequences or the seriousness of one's actions. *Id*.

g. Lacking an ability to express sexuality in an appropriate manner. *Id.*

h. Living in an isolated fashion, such as spending time mostly with family or in a supervised setting. *Id*.

i. Lacking access to appropriate social activities or a peer group with whom to explore sexuality in a safe, positive, and respectful manner. *Id*.

j. Failing to receive appropriate sex education at home or at school. *Id*.

B. Persons with Disabilities Need to be *Taught* "The Rules of Sex"

1. Dr. Nora Baladerian is a licensed psychologist, certified sex therapist and certified sex educator. Her workbook *The Rules of Sex: Social and Legal Guidelines*

for Those Who Have Never Been Told (2006) (referred to hereinafter as *The Rules of Sex*), highlights a common sense conclusion: if no one discusses the "rules of sex" with a person with a disability, the person will not know what is "okay" and what is "not okay." Such an untaught person may only discover a legal or social rule when he unwittingly breaks the rule and faces dire consequences for the legal or social conduct violation. (*The Rules of Sex* is available at http://norabaladerian.com/books.htm.)

2. For persons with disabilities, the sexual act itself is not generally the problem; rather, not knowing *where* it should be done, *when* it should be done, and *with whom* it should be done is usually the root cause of breaking the rules. Legal or social rules that a person unknowingly violates on the where-when-with-whom spectrum represent stumbling blocks for many persons with disabilities whose parents or guardians feel ill-equipped to impart this important knowledge.

3. Dr. Baladerian's *The Rules of Sex* workbook answers some of the most frequently asked questions about sex in "plain English" that can be comprehended by persons with intellectual or developmental disabilities (and their parents or guardians!) who are 18 years of age or older. Included in the book's helpful Q&A format are the following questions.

a. What is "having sex"?

b. Who can you have sex with?

c. What are possible outcomes of having sex?

d. Can I have sex in my bedroom?

e. What is masturbation, and where can I do it?

f. When is it okay to look at or touch someone?

g. When can you discuss sex with someone?

h. What is "privacy"?

i. What are my "sexual rights"?

j. Where can I do sexual things?

k. What is "gay" sexuality?

l. What are "bisexuality," "transgendered" and "transsexual"?

m. What actions can be done in public?

n. What is sexual abuse?

o. What about sex on the internet?

p. What are rape, incest and sodomy?

The *Rules of Sex* workbook is mercifully easy to work through, even for those neuro-typical adults who never got "plain English" answers to these questions when they were teenagers.

C. Defenses When an Alleged Perpetrator Has an Intellectual or Developmental Disability

1. Defense: Incompetency to Proceed

a. The standard for the defense of incompetency to proceed in a criminal trial for sexual assault is high in most jurisdictions. Even if an alleged offender has an intellectual or developmental disability and cannot understand the complexity of the court system, he or she may still be found competent to stand trial. The Arc's NCCJD, *supra,* at 23.

(1) This determination involves evaluations by court-appointed psychologists and psychiatrists. To satisfy the standard of incompetent to proceed, the alleged offender must be found incapable of currently assisting in his or her own defense or unable to understand the proceedings against him or her. *Id.* at 24.

(2) The ultimate determination of this defense is made by a judge. *Id.*

b. A person with an intellectual or developmental disability who is determined to be incompetent to stand trial for an identified offense may be placed in a residential treatment program with "open" charges remaining against him or her. The goal of the prosecuting attorney in such a placement may be for that person to make enough progress in the treatment program to be found competent to face trial. Thus, ironically, the putative defendant's defense attorney may advise his or her client to limit participation in the program, lest his or her

client face broader legal sanctions for successful progress in the program. This inherent conflict between what might be best in terms of treatment for an offender, and what might result in harsher punishment for that offender, is often irreconcilable. *See* G. D. Blasingame, K. Creeden, and P. Rich, *Assessment and Treatment of Adolescents with Intellectual Disabilities Who Exhibit Sexual Problems or Offending Behaviors*, at 30 (2015).

2. Defense: Not Guilty by Reason of Insanity

a. If an alleged offender is unable to understand the crime with which he or she is accused because of his or her intellectual or developmental disability, then the defense of "not guilty by reason of insanity" may be a possibility. As with proving incompetency to proceed, the standard for proving not guilty by reason of insanity is also high. The Arc's NCCJD, *supra*, at 24.

(1) This determination also involves evaluations by court-appointed psychologists and psychiatrists. To satisfy the standard of not guilty by reason of insanity, an alleged offender must not have been able to understand the crime at the time it was committed. *Id.*

(2) The ultimate determination of this defense is made by a jury. *Id.*

D. Sentencing and the Civil Commitment of a Sexually Violent Predator

1. The Arc has suggested that there is a great need to advocate for creative sentencing for persons with intellectual or developmental disabilities who have been found guilty of committing sexual abuse. *See* Leigh Ann Davis, *People with Intellectual Disabilities and Sexual Offenses*, thearc.org, http://thearc.org/wp-content/uploads/2019/07/Sexual%20Offenses .pdf (last visited on Sept. 5, 2019). The Arc recommends that these sentences include specialized education and training on appropriate relationships and sexual activity, as espoused in a "personalized justice plan ("PJP")." *Id.* A PJP can be developed by a case manager or an advocate from a local chapter of The Arc in collaboration with the district attorney's office and the probation department. *Id.* The PJP is then presented to the judge by the district attorney. *Id*. Elements of a PJP may include minimal incarceration in a safe environment, along with sex/relationship training, restitution for damages, confinement to a residential facility for a specific

period of time, or required treatment. *Id.* Such PJPs have been used successfully by several local chapters of The Arc that conduct criminal justice programs (*e.g.*, The Arc of New Jersey). *Id.*

2. Some commentators, including The Arc, are of the opinion that those who serve time in prison for their offenses are more likely to reoffend since quality sex education and related services are simply not available through the present day criminal justice system. *Id.*

3. As of 2019, twenty-one states and the federal government have enacted laws allowing the confinement of individuals who have been adjudicated as "sexually violent predators" to civil commitment facilities post-incarceration and/or conviction. *See* Michael Perlin, Heather Cucolo, & Alison Lynch. (2017). *Sex, Sexuality, Sexual Offending and the Rights of Persons with Mental Disabilities*. Laws. 6. 20. 10.3390/laws6040020.

a. The states which have enacted civil commitment laws include Arizona, California, Florida, Illinois, Iowa, Kansas, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Oregon, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin. *Id.*

(1) Some of these laws require an assessment of the sex offender which includes an analysis of diagnosable mental illnesses, abnormalities, or disorders, as well as the various factors known to be associated with the risk of recidivism among sex offenders. *See, e.g.*, West's Ann.Cal.Welf.&Isnt.Code § 6601. Risk factors may include criminal and psychosexual history; the type, degree and duration of sexual deviance; and the severity of the mental illness, abnormality, or disorder. *Id.*

b. The federal Adam Walsh Child Protection and Safety Act of 2006 (the "Act") allows the government to civilly commit individuals who have been determined to be "sexually dangerous." 18 U.S.C.A. § 4248 (West 2006).

c. The Act seeks to protect the public from people who engage in sexually dangerous activity by confining individuals who are unable to control their sexual desires [because they] suffer [from] a serious functional impairment. *United States v. Wooden*, 217 F. Supp. 3d 843, 853 (E.D.N.C. 2016), *aff'd*, 887 F.3d 591 (4th Cir. 2018).

d. To civilly commit a person under this Act, the government must show by clear and convincing evidence that a person is "sexually dangerous." *Wooden*, 217 F. Supp. 3d at 851.

e. To prove that someone is "sexually dangerous to others," the government must show that:

(1) The offender (i) "has engaged or attempted to engage in sexually violent conduct or child molestation," and (ii) the offender currently "suffers from a serious mental illness, abnormality, or disorder, (iii) as a result of which he would have serious difficulty in refraining from sexually violent conduct or child molestation if released." 18 U.S.C. § 4247 (West 2006).

(a) The third element, above, "refers to the degree of the person's 'volitional impairment,' which impacts the person's ability to refrain from acting upon his deviant sexual interest." *United States v. Hall*, 664 F.3d 456, 463 (4th Cir. 2012).

f. To determine whether a person's mental illness, abnormality, or disorder rises to the level of being sexually dangerous to other people "is fact specific as viewed by expert psychiatrists and psychologists." *Wooden*, 217 F. Supp. 3d at 851 (citing *United States v. Francis*, 686 F.3d 265, 275 (4th Cir. 2012)).

4. Whether someone with an intellectual or developmental disability can be civilly committed as a sexually violent predator requires the following analysis.

a. In order for an offender to be civilly committed, *i.e.*, confined in a secure treatment facility after incarceration and/or conviction, there must be a sufficient nexus between the diagnosed mental illness, abnormality, or disorder and sexual dangerousness. *Wooden*, 217 F. Supp. 3d at 853.

b. Because there must be a nexus between the mental illness, abnormality, or disorder and the sexually dangerous behavior, it cannot be concluded that individuals who have "benign, non-culpable, disorders" necessarily meet the requirements to be committed under this Act. *Id.* at 853-854.

c. Intellectual Development Disorder

(1) The *Wooden* court found that mere diagnosis of Intellectual Development Disorder ("IDD"), in and of itself, does not establish a "sufficient nexus with sexually dangerous [behaviors] to support a commitment under the Act." *Id.* at 854.

(2) Furthermore, the Court found that IDD is not a "deviant mental disorder as to rise to the level of a serious mental illness, abnormality, or disorder under the Act." *Id.*

(a) Disorders that courts have often found sufficient to satisfy the requirement of a serious mental illness, abnormality, or disorder when ordering a sexually violent predator to be civilly committed include pedophilia (a psychiatric disorder in which an adult or older adolescent experiences a primary or exclusive sexual attraction to prepubescent children (typically under eleven years old)) and hebephilia (a psychiatric disorder in which an adult or older adolescent experiences a primary or exclusive sexual attraction to pubescent children (typically ages eleven to fourteen years old)).

(b) In *United States v. Castle*, the court established that the offender's diagnosis of pedophilia disorder and hebephilia disorder were sufficient to establish that he suffered from a serious mental illness, abnormality, or disorder within the meaning of the Act, such that he should be civilly committed. No. 5:17-HC-2204-FL, 2018 WL 3762990, at 13 (E.D.N.C. Aug. 8, 2018).

(c) In *United States v. Perez*, the court concluded that the offender was sexually dangerous because he had pedophilia, a serious mental disorder under the Act, and would have trouble refraining from child molestation if he were to be released. 752 F.3d 398, 408 (4th Cir. 2014).

(d) It is worth noting that for many of those with intellectual or developmental disabilities who are civilly committed as sexually violent predators, such persons often have great difficulty fully participating in treatment programs. Successful treatment that leads to a significant reduction in sexual deviance is the trigger for release from confinement. An individual's difficulty or inability to understand treatment protocols and to

advance successfully through the program can thus result in a life sentence to civil commitment. The Arc's NCCJD, *supra*, at 9.

d. Personality Disorder

(1) Courts have held that a mere personality disorder, *e.g.*, borderline personality disorder, may contribute to a serious mental illness, but by itself is not sufficient to meet the serious mental illness, abnormality, or disorder requirement to allow civil commitment under the Act. *United States v. Springer*, No. 5:12-HC-2009-BO, 2012 WL 3957857, at 1 (E.D.N.C. Sept. 10, 2012), *aff'd*, 715 F.3d 535 (4th Cir. 2013). It must be demonstrated that an offender's mental illness, abnormality or disorder is *sufficiently related* to his sex offense in order to satisfy the serious mental illness, abnormality, or disorder requirement under the Act. *Id.* at 3.

E. Compliance with Megan's Law and Other Registration, Community Notification, and Supervision Statutes

Criminal convictions for offenses such as sexual assault, improper sexual contact, and endangering the welfare of a child require registration as a sex offender for both adult and juvenile offenders. *See* The Arc's NCCJD, *supra*, at 6. While versions of sex offender registration and notification laws have existed in the United States for over seventy years, sweeping legislative reform took place in the early 1990's. *Id.*

In 1993, Megan Kanka, a six-year-old girl, was lured by Jesse Timmendequas, who had previously been convicted of a sex offense and had been released from custody, into the home of his mother, where he sexually assaulted and killed Megan. *Id.* The federal Jacob Wetterling Crimes Against Children and Sexually Violent Offender Act of 1994 was passed in response to the enormous public outcry over the previous lack of local notification when convicted sex offenders are released into the community. *Id.* This Act resulted in a federal requirement that every state also enact statutes mandating the public registration of convicted sex offenders and notification to the public by means of various methods and in certain circumstances. The first of these state statutes was named after Megan Kanka, and passed by New Jersey in 1994. *Id.* Registration and notification statutes passed since then have been commonly referred to as "Megan's Law" statutes. The minimum standards that jurisdictions must meet regarding

registration and notification requirements are set forth in the Sex Offender Registration and Notification Act of 2006 ("SORNA"), which is Title I of the Adam Walsh Child Protection and Safety Act of 2006. *Id.*

1. Other than criminal incarceration, convictions of sexual crimes result in additional consequences and requirements under each state's Megan's Law statute. *Id.* Each state Megan's Law statute requires convicted sex offenders to register their whereabouts, and to update those registrations on a regular basis. *Id.* In addition, under Megan's Law statutes, all states have some level of community notification, including public access to a website with information about convicted sex offenders. *Id.* In addition to the Megan's Law statutory requirements regarding registration and notification, most states have some form of community supervision of convicted sex offenders. *Id.* Each of these statutory obligations imposes responsibilities upon registrants which must be met over a long period of time. *Id.* Individuals with intellectual or developmental disabilities often need support to understand and comply with these requirements. *Id.*

2. Types of Sex Offender Statutes

a. Registration Statutes

(1) These laws require offenders to register regularly their current home address (and work and school addresses, if different from their home address). *Id.* at 7.

(2) Failure to register is a crime in every state, and penalties vary from imprisonment of one or more years to a fine. The length of a prison sentence or amount of a fine largely depends on whether the crime is considered a misdemeanor or a felony, and whether it is the offender's first or repeated failure to register. *See, e.g.*, Ga. Code Ann. § 42-1-12 (West).

(3) SORNA makes it a federal offense for sex offenders who are required to register pursuant to SORNA to fail to so register. 18 U.S.C. § 2250. State convicted sex offenders may also be prosecuted under SORNA if the sex offender (i) knowingly fails to register, or update a registration, as required, and (ii) engages in interstate travel, foreign travel, or enters, leaves, or resides on an Indian reservation. *Id.* A sex offender who fails to register

in violation of SORNA is subject to fines and a sentence of up to ten years in prison. *Id*. Furthermore, if a sex offender knowingly fails to register, or update a registration, as required, and commits a violent federal crime, then he or she may receive a sentence of up to thirty years in prison. *Id*.

b. Community Notification Statutes

(1) All states require some level of community notification regarding released sex offenders. The states vary as to who has the responsibility of distributing information regarding released sex offenders to citizens and community organizations, but the designated person must always be an "appropriate official," such as a member of a law enforcement agency. 34 U.S.C.A. § 20923. In some states, citizens are notified about the release of every sex offender from incarceration. *Sex Offender Community Notification: A Review of Laws in 32 States,* Wash. State Inst. for Pub. Policy, available at http://www.wsipp.wa.gov/ReportFile/1223/Wsipp_Sex-Offender-Community-Notification-A-Review-of-Laws-in-32-States_Full-Report.pdf. (March 1996) (last visited on Sept. 10, 2019). In other states, community notification is only authorized when it is deemed necessary to protect the public from a specific offender being released from incarceration (*e.g.*, one who may be classified as a habitual or predatory sex offender who has shown little ability to reform). *Id.*

(2) For example, a community notification statute can mandate a display of home addresses, photographs, and other basic information about offenders on the internet. *See* The Arc's NCCJD, *supra*, at 6.

c. Supervision Statutes

(1) These laws require convicted sex offenders to check in regularly with probation or parole officers. *Id.* Most states also mandate some level of community supervision of convicted sex offenders, including the use of electronic monitoring by means of a global positioning system (GPS) so that law enforcement and other responsible authorities may verify an offender's whereabouts at all times. In such states, a violation of community supervision statutes is a felony, and a conviction can result in a fine or a prison sentence for a term of years. *See, e.g.*, S.C. Code Ann. § 23-3-540 (1976).

d. Megan's Law statutes, and other registration and community notification statutes, focus on two primary issues.

(1) The public registration of offenders who have been convicted, adjudicated delinquent, or found not guilty by reason of insanity for one of the offenses listed in the statute. *Id.*

(2) Whether law enforcement, community organizations, schools or neighbors will be informed of the offender's home, school, and work address. *Id.*

e. The purpose of such registration and notification statutes is not punitive, but rather to inform communities so that persons in the vicinity of a sex offender may take certain preventive actions to protect themselves. *Id.* at 6. However, because persons with intellectual or developmental disabilities face significant challenges in complying with such statutes, such non-compliance often leads to new criminal charges against them and a return to incarceration. *Id.* Moreover, these laws, while intended to reduce sexual assault recidivism, can create obstacles to successful reintegration in the community in the areas of housing, employment, and education:

(1) Most housing options for persons with disabilities do not assist sex offenders with meeting their statutory registration requirements. *Id.* Moreover, fear and stigma reduce the chance that such persons will be accepted into such housing arrangements in the first place. *Id.* In addition, the rules governing federally subsidized housing (*e.g., "*HUD" housing) prohibit sex offenders from living in these communities. *Id.* These limitations make it impossible for many sex offenders to obtain affordable housing, resulting in homelessness for many offenders with intellectual or developmental disabilities. *Id.*

(2) A sex offense conviction compounds the challenge for a person with an intellectual or developmental disability to gain employment, and registration requirements further limit the available employment opportunities. *Id.*

(3) Moreover, Megan's Law notification requirements may mandate notification in and around a school such that, effectively, no school will allow attendance by the offender. *Id.*

f. For a fifty-state survey regarding sex offender registration requirements and timelines, public notification, electronic monitoring, and other requirements pertaining to juvenile sex offenders (*i.e.*, those under eighteen years old), see *State Sex Offender Matrix*, Interstate Commission for Juveniles, https://www.juvenilecompact.org/resources/state-sex-offender-matrix (last updated on Aug. 29, 2019; last visited on Sept. 4, 2019).

F. Educational and Treatment Programs

1. Early intervention and preventative measures are critical to prevent persons with disabilities from committing sex offenses, and to help convicted sex offenders learn healthy and appropriate ways to express their sexuality. *See* Leigh Ann Davis, *People with Intellectual Disabilities and Sexual Offenses*, found at thearc.org, http://thearc.org/wp-content/uploads/2019/07/Sexual%20Offenses.pdf (last visited on Sept. 5, 2019).

2. Community agencies that address the treatment of sex offenders commonly use the following interventions: increased supervision; behavioral intervention; mental health services; environmental modifications; appropriate sex education; and legal sanctions. *Id.*

3. Some communities offer treatment programs designed specifically for individuals with intellectual or developmental disabilities. *Id.* The Safer Society Foundation, Inc. has a treatment referral program, and can be reached at 802-247-3132. *Id.* It is also recommended that persons contact their local or state chapter of The Arc, as well as their county's mental health system, to determine whether such programs exist or are in the process of being developed in their area. *Id.* Often, persons seeking such treatment must travel out-of-state in order to obtain these services. *Id.*

4. Some studies have found that when offenders with intellectual or developmental disabilities participate in group therapy, recidivism for sex offenses is infrequent. *Id.*

5. Counseling which has been modified for clients with intellectual or developmental disabilities is an effective part of an overall program intended to reduce recidivism and allow offenders to live safely in the community. *See* The Arc's NCCJD, *supra*, at 8.

6. Many experts who work with sex offenders who have intellectual and developmental disabilities believe that treatments which aim (i) to decrease the presence and influence of risk factors, and (ii) to identify strengths and new pro-social behaviors, are most effective to achieve lasting change and growth. *See* Blasingame, Creedan & Rich, *supra*, at 24.

a. This approach is founded on positive psychology, which aims to recognize and build upon the strengths and abilities of individuals rather than focusing on deficits or limitations. *Id.* at 11. A key principle of positive psychology is that individuals are capable of, and want to develop and lead, positive, meaningful, and satisfying lives. Therefore, focusing assessment and treatment only on disorders or deficits may lead to deficit-based treatment rather than to a treatment that is rehabilitative (*i.e.*, leading to a replacement of harmful and offensive behaviors with beneficial and pro-social behaviors). *Id.* According to such experts, it is important, to ensure that treatment includes helping an offender focus on desired and achievable "approach" goals, *i.e.*, exhibiting desired behaviors, rather than having the individual focus only on avoiding problematic behaviors, *i.e.*, "avoidance" goals. *Id.* Other strategies that conform to positive psychology include: attempting to prevent environmental factors which may trigger undesired behaviors in the offender, teaching what are known as "replacement" skills (*i.e.*, teaching pro-social means to meet one's needs), and using positive reinforcement interventions when an offender exhibits positive behaviors. *Id.* at 13.

b. When focusing on building upon an individual's strengths, for example, a person with an intellectual or developmental disability may have stronger "performance" skills than language processing and expressive skills. For that person, experience-based therapy, which addresses treatment and stimulates change in ways which rely more on performance skills, can be much more effective than non-experience-based therapy. *Id.* at 24. Such treatment often involves multisensory learning (auditory, visual, and tactile or kinesthetic), which is considered more effective than purely verbally-based learning among individuals with intellectual or developmental disabilities. *Id.* In addition to written and verbal therapies, art, drama, music, recreational, and other largely nonverbal therapies encourage self-expression and discovery, and may result in more effective treatment and lasting changes in behavior than therapies that do not engage several different senses. *Id.* However, as individuals with intellectual or developmental disabilities may struggle with applying learned information to new situations,

treatment strategies and interventions should be developed and implemented so as to allow the application of new learning to a wide range of situations. *Id.* Therefore, in addition to a multi-sensory approach, treatment materials should (i) be taught in a manner that best supports the individual's comprehension, (ii) be taught repetitively to help promote the individual's retention of information, and (iii) be taught and applied across a variety of situations that best support generalization for that individual. *Id.* at 26. Ideally, such education will include instruction in the context of modeling "real life" circumstances, rather than only those provided in controlled treatment settings. *Id.*

7. As discussed elsewhere in this outline, persons with disabilities who are charged with sexual offenses may have engaged in acceptable sexual behavior, but with someone who is not an appropriate age. *See* Davis, *supra*. Such behavior, which is sometimes referred to as "age discordance sex play," can be managed through social skills training and sex therapy with a qualified sex therapist who has experience working with individuals with cognitive disabilities. *Id.* Experts urge that treatments for offenders with this particular issue should include a deepening of the offender's knowledge regarding the concept of age and its relation to socially appropriate sexual interests, relationships, and healthy sexuality. *See* Blasingame, Creedan & Rich, *supra*, at 27.

8. Community agencies cite a lack of expertise, a lack of training about people with intellectual or developmental disabilities and sex offenses, a lack of funding for resources, and poor coordination between the various systems involved (*e.g.*, disability-related agencies, mental health systems, and police departments) as the primary barriers to achieving progress on these issues. Davis, *supra*, at 3.

9. Many challenges remain regarding the effective treatment of sexually offensive behavior: the lack of mental health professionals, sex therapists, and other allied professionals with expertise in this area; inaccurate diagnoses; and the absence of understanding among, and intervention by, law enforcement concerning the unique obstacles and considerations when persons with intellectual or developmental disabilities exhibit such behavior. *Id.*

IV. HEALTHY SEXUALITY OF PERSONS WITH DISABILITIES

Fact: Persons with disabilities are sexual beings. Medical professionals who work with this population have known this fact for decades. *See, e.g.*, Nancy A. Murphy, M.D., Ellen Roy Elias, M.D., for the Council on Children With Disabilities, *Sexuality of Children and Adolescents With Developmental Disabilities*, PEDIATRICS, Vol. 118, Number 1, July 2006 (available at www.aappublications.org) (referred to below as the "Clinical Report").

A. Common Impediments to Healthy Sexual Development

1. There are many impediments to the healthy sexual development of children and adolescents with disabilities, including the following (drawn from the Clinical Report).

a. Societal and psychosocial barriers.

b. The often unpredictable timing of puberty.

c. Inaccessible medical equipment, including exam tables, weight scales, and imaging equipment. *See* Elizabeth Pendo, *Disability, Equipment Barriers, and Women's Health: Using the ADA to Provide Meaningful Access*, 2 St. Louis U.J. Health L. & Policy, 15 (2008).

d. Lack of appropriate routine and preventative gynecological care for females and urological care for males.

e. Lack of adaptations in examinations to accommodate the patient's physical or neuromuscular disabilities, and lack of adjustable exam tables to facilitate exams of persons who use wheelchairs.

f. Lack of information regarding abstinence, contraception and pregnancy, and the impact of medications on the effectiveness of contraceptives, as well as the impact of contraceptive drugs on the patient's overall health.

g. Historically inappropriate imposition of sterilization as the default approach to preventing persons with disabilities from procreating. (*See infra* at Section V.)

h. Ineffective management of the impact on fertility of a person's disabling condition.

i. Lack of pre-pregnancy counseling for females with disabilities.

j. Lack of "developmentally appropriate" sexuality education.

k. Avoidance of topics such as sexual orientation, sexually transmitted diseases, contraception and abstinence, and the health implications of pregnancy.

l. Lack of effective methods to present sexuality education that can be understood by adolescents with disabilities.

m. Failure of IEPs to require developmentally appropriate sexuality education for students with disabilities, including the following topics.

(1) Sexual body parts and their proper identifying names.

(2) Puberty and expected body changes.

(3) Personal care and hygiene.

(4) Medical examinations.

(5) Sexual expression.

(6) Contraception strategies.

(7) Rights and responsibilities of sexual behaviors.

n. The adverse impact of cultural, religious and personal experiences of parents or guardians on their willingness to facilitate the sexual education of their children.

B. "Public Indecency" and "Public Lewdness" Laws

The healthy development of an individual's mindset regarding his or her sexuality requires attention to many issues, including appropriate education on society's "rules of sex." *See supra,* Section III. B.

1. One of the many reasons why it is critical to teach the rules of sex to persons with disabilities is to prevent such individuals from unknowingly violating "public indecency" or "public lewdness" laws. Such laws concern sexual activities that are inappropriate in a public context, such as public nudity or indecent exposure, sexual intercourse in public, masturbation in public, and public urination.

2. Penalties for violating these laws include incarceration, fines, probation, and community service. States vary on whether a conviction requires proof that a defendant had a particular intent when engaging in the offensive behavior (*e.g.,* to shock, offend, arouse, *etc.*).

3. The Appendix includes a fifty-state survey regarding such laws.

C. The Provision of Sexual Health Care Services to Persons with Disabilities

It may be impossible for an individual with a disability to build a foundation for healthy sexuality without obtaining appropriate medical care from providers who are well-versed in the special medical needs of persons with disabilities and who are trained to address and meet such needs within the context of the provision of sexual health care services.

1. In 2010, the American College of Obstetricians and Gynecologists ("ACOG") issued a presentation ("ACOG Presentation") entitled "Reproductive Health Care for Women with Disabilities" (available at https://www.acog.org/About-ACOG/ACOG-Departments/Women-with-Disabilities/Interactive-site-for-clinicians-serving-women-with-disabilities, last visited on Sept. 10, 2019).

a. The ACOG Presentation recommends that providers probe deeper than routine information gathering to determine how an individual's disability may uniquely impact that person's sexual health. For example, providers are urged to ask if there are

specific disability-related symptoms which may be influenced by the hormonal and other physiological changes which take place over the course of a woman's menstrual cycle (*e.g.*, whether seizure activity increases, or whether mood changes are particularly severe, at certain stages of a monthly cycle).

b. The ACOG Presentation also emphasizes that because women with disabilities are often seen as asexual beings, providers should specifically ask about a woman's sexual activity, past and present, and any history of abuse. Of course, knowledge regarding a patient's sexual health history is equally important for the appropriate care of male patients.

c. The ACOG Presentation urges that regular screenings for cervical cancer, breast cancer, and sexually transmitted infections are just as needed among patients with disabilities as those without, due to a similar incidence of these conditions among both populations.

d. The ACOG Presentation outlines numerous failures on the part of medical providers that have exacerbated the problem of inadequate provision of sexual health care to persons with disabilities: to ask about the sexual practices and possible sexual abuse of patients with disabilities; to screen patients with disabilities for sexually transmitted infections; to educate patients with disabilities about safe sex practices; and to offer information regarding resources concerning sexual abuse.

e. ACOG also recommends in the ACOG Presentation that caregivers be educated in atypical physical symptoms that could help indicate that there is an issue with an individual's sexual health (*e.g.*, abdominal pain could indicate that an individual has a sexually transmitted infection).

f. For patients with cognitive disabilities, the ACOG Presentation recommends that medical providers adapt their communication so that concepts about sexual health will be more understandable to such patients.

g. The ACOG Presentation recommends that patients with mobility impairments or developmental disabilities undergo regular "skin checks" for breakdown, infection, and bruising, and that all pressure wounds discovered be treated immediately.

2. The above examples illustrate the great need for medical providers who are sensitive to, and well-equipped to handle, the unique challenges that patients with disabilities encounter. Equally important is the patient's support network, which can serve as a bridge between the patient and his or her medical providers, when necessary, and when desired by the patient with a disability.

D. Accessibility Challenges in the Context of Sexual Health Care

Despite having an equal need for comprehensive and appropriate sexual health care services, men and women with disabilities often do not receive such services at the recommended regular intervals due to the lack of meaningful access to such services, a fundamental barrier. A national survey of people with disabilities conducted by the Kaiser Family Foundation in 2003 found that less than half of female respondents reported having a mammogram in the past year and approximately one third of male respondents reported having a prostate exam over the same time period. *See* Pendo, *supra*, at 19. Without regular and appropriate examinations and tests, patients may not receive important diagnoses or may be misdiagnosed, which can lead to a delay in treatment critical to stave off or combat harmful conditions, such as cancer. *Id.* at 28. Barriers to adequate health care can also lead to a sense of stigmatization and isolation in patients with disabilities, which may cause individuals to withdraw from society and loved ones. *Id.*

1. Assuring the provision of equal access to health care for people with disabilities requires a focus on two main elements.

a. Facility Access

(1) For people with mobility impairments, facility access requires accessible routes from parking or bus stops into a medical office building, accessible parking, accessible entry doors with the necessary clearance width, clear floor space, maneuvering clearance, accessible restrooms, and modified signage for people who are blind or have other visual impairments. *See* R.F. Singer, I. Dickman & A. Rosenfeld. *Increasing the Physical Accessibility of Health Care Facilities*. Ctrs. for Medicare & Medicaid Services, Office of Minority Health Issue Brief, May 2017, at 2.

b. Health Care Services Access

(1) Meaningful health care services access includes accessible scales and exam tables to facilitate medical exams, accessible treatment and diagnostic equipment (including mammography machines and radiology equipment), appropriate resource materials for individuals with auditory and visual impairments, and staff who are trained to assess patient needs and to safely help patients move in between, and transfer on and off, medical equipment. *Id.*

2. Section 504 prohibits discrimination on the basis of disability by any program or activity which receives federal financial assistance, including Medicare or Medicaid reimbursements. Section 504 requires compliance with specific standards for design and construction of new facilities and ensures the accessibility of health care services as a whole. *Id.* at 3.

3. Title II regulations, applicable to covered public entities, and ADA Standards for Accessible Design, include specific requirements regarding new construction and alterations to existing buildings and facilities, including health care facilities, as well as requirements for service animals, communications, and telecommunications. *Id.* For existing buildings that are not accessible, program access requirements under Title II allow, but do not require, public entities to relocate programs or to provide accessible services at other locations. *Id.* Regarding health care services, Title II of the ADA requires equal access to such services, with accessibility to such services being considered as a whole. *Id.*

4. Title III of the ADA applies to certain categories of private entities known as "places of accommodation." *Id.* Such places include a "professional office of a health care provider, hospital, or other service establishment." *Id.* Title III requires removal of architectural barriers at existing facilities where barrier removal is readily achievable, as well as compliance with the ADA Standards for Accessible Design for new construction and alterations to existing buildings. *Id.* Title III and its regulations generally require medical providers to provide equal services to individuals with disabilities, to make reasonable modifications in policies and practices where necessary in order to provide equal access, and to provide auxiliary aids and services where necessary in order to provide effective communication. *Id.*

a. It is worth noting that private entities can be contractually bound to adhere to nondiscrimination laws that are applicable to state and local government entities, and can also be obligated to adhere to the nondiscrimination requirements under Section 504 if such entities receive federal funds (*e.g.*, a private nonprofit hospital which serves Medicaid patients is in a contractual relationship with the state Medicaid agency and is also a recipient of federal Medicaid funds). *See* National Council on Disability, *The Current State of Health Care for People with Disabilities*, available at https://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d.pdf (last visited on Sept. 11, 2019).

5. The ACOG Presentation notes that medical providers should consider adopting the following guidelines in order to make their offices more accessible to patients with disabilities.

a. If permanent ramps are too costly, consider using portable ramps outside of an office.

b. Install electric, automatic hinged, or sliding doors to allow the passage of wheelchairs.

c. A reception/in-take desk should have a lowered counter for use by persons who use wheelchairs.

d. Secretarial staff should be trained to be aware of the special needs of patients with disabilities so that they can offer help, if needed (*e.g.*, assistance completing forms).

6. The ACOG Presentation includes recommendations that medical providers abide by the following guidelines in preparation for a gynecological appointment with a women with a disability, many of which are also applicable to the preparation for any appointment to ascertain the health of a person with a disability.

a. Be mindful that patients with disabilities may require flexible appointment times due to: (i) a lack of reliable public or private transportation, (ii) a reliance on the punctuality of a care attendant, and (iii) a possible inability to read.

(1) For the above-stated reasons, and for a multitude of other reasons, it is prudent for providers to be proactive and to ask new patients if they have special needs or circumstances that may need to be accommodated.

b. Schedule a longer appointment, to include extra time to address the special needs of such a patient.

c. Visit with the patient in the most accessible exam room and have the necessary equipment available in that room.

d. Invest in adapted equipment, such as a platform scale, which can be used to weigh a person who uses a wheelchair without the necessity of first transferring that person out of the wheelchair.

e. Regularly practice the following with staff:

(1) Asking for the patient's preferences regarding any accommodations.

(2) Providing specialized assistance, such as safe transfer techniques to help position a patient on an exam table or platform scale.

f. Note in a patient's chart for future reference that she requires specific accommodations.

g. Assure that a patient feels safe, well-supported, and confident that she will not fall from the exam table.

h. Consider using extra padding on an exam table.

i. Consider adapting an office with an electric examination table for ease of transfers.

j. Do not perform exams on a patient while she is using her wheelchair unless it is preferred by the patient and no other option is available.

k. When positioning a patient on an examination table, be mindful that the patient may have, as a consequence of her disability, impaired balance or muscle

weakness, spasticity, a sensitivity to pressure on her skin, or contractures, and adapt positioning techniques, accordingly.

l. During an exam, alternative exam positions and/or alternative examination tools should be considered in order to maximize the patient's comfort and to better comport with the patient's preferences.

m. Just as an electric examination table can better facilitate pelvic examinations for women with disabilities, so too can mammography machines which can be lowered to a height appropriate for a woman using a wheelchair help facilitate proper breast cancer screenings.

7. The ACOG Presentation notes that affirmative defenses to claims under the ADA include: (i) providing a certain accommodation would fundamentally alter the nature of the service requested, (ii) providing a certain accommodation would cause an undue burden, and (iii) providing a certain accommodation would cause a direct threat to others.

8. In 2010, the United States Department of Justice and the United States Department of Health and Human Services released technical guidance for medical providers, entitled "Access to Medical Care for Individuals with Mobility Disabilities," addressing the requirements of the ADA in medical settings with respect to people with mobility disabilities or impairments, including persons who use wheelchairs, scooters, walkers, and crutches, as well as those who do not use any mobility devices at all (available at https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm (last visited on Sept. 10, 2019)).

a. In this report, the United States Department of Justice and United States Department of Health and Human Services emphasized the need for medical staff to be specifically trained to assist patients with disabilities, and, especially (i) how to operate accessible equipment, (ii) how to assist with transfers and positioning of patients with disabilities, and (iii) how to comply with anti-discrimination laws. *Id*. The following resources are available to medical providers to obtain such training.

(1) Local and national disability rights advocacy organizations may provide such training for medical staff. *Id*.

(2) Technical assistance materials from the ADA website (www.ada.gov) can also provide guidance to medical providers. *Id.*

(3) The United States Department of Justice ADA Information Line (800-514-0301 (voice) or 800-514-0383 (teletype) employs ADA specialists who are able to assist with questions regarding ADA compliance. *Id.*

V. STERILIZATION OF PERSONS WITH DISABILITIES

A. Background

1. The topic of the forced sterilization of persons with disabilities can invoke images from a bleak (and not so distant) time in the history of the United States, when such procedures were performed, in large part, to prevent those with disabilities from passing on their genes to a new generation, and without regard for the opinions or best interests of those being sterilized. In that prior and shameful era, persons with disabilities were often cruelly cast as sources of societal ills. *See* Michael G. Silver, Note, *Eugenics and Compulsory Sterilization Laws: Providing Redress for the Victims of a Shameful Era in United States History*, 72 Geo. Wash. U. L. Rev. 862, 864 (2004).

2. Perhaps no quote better captures this dark history than the infamous and chilling words of Justice Oliver Wendell Holmes in the Supreme Court's 1927 *Buck v. Bell* decision (upholding the sterilization law of the State of Virginia), that "[t]hree generations of imbeciles are enough." *See id.* at 862-863. This shameful philosophy, born of the eugenics movement, lead to widespread abuse of persons with disabilities through perilously unrestricted sterilization procedures. Under the sterilization laws of that era, over 60,000 people were involuntarily sterilized in various states. *Id*. at 863.

3. Today, as a result of the backlash against the eugenics movement, and the abuse it promoted, many state statutes have built-in protections to help ensure that court-ordered authority to consent to a sterilization procedure on behalf of a person with a disability can only be granted within the context of the demonstrated best interests of such individual. *See id*. A majority of states (thirty-nine and the District of Columbia) have either statutes or case law governing the sterilization of persons with disabilities. Of the states with statutes that specifically address this issue, thirty-three have statutes that either directly or indirectly authorize the

sterilization of persons with disabilities (with six states having substantial statutory restrictions). Court-ordered sterilization is not permissible under any circumstances in four states, due to an absence of statutory endorsement of the procedure. Three states have court decisions that authorize court-ordered sterilization in the absence of statutory endorsement of the procedure. The below analysis is based on the "50 State Survey of the Statutes and Case Law Governing the Sterilization of Persons with Disabilities," found in the Appendix.

B. States With Statutes Authorizing the Court-Ordered Sterilization of Persons With Disabilities

1. The following states (in addition to the District of Columbia) have statutes that directly or indirectly authorize the sterilization of persons with disabilities: Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Utah, Vermont, Virginia and Wyoming.

a. The states that have the most severe restrictions on the sterilization of persons with disabilities include: Alaska, Colorado, Maine, Massachusetts, North Carolina, and Ohio.

(1) In Alaska, a person may only consent to sterilization on behalf of an individual who is incapacitated (a "ward") "when necessary to preserve the life or prevent serious impairment of the physical health of the ward." Similarly, in Colorado, six criteria must be satisfied for a court to grant such authority, including that the sterilization be medically necessary to preserve the life or health of the person with a disability. Likewise, Maine law permits court-ordered sterilization of persons who cannot give informed consent to the procedure, but for whom sterilization is in their best interest. It must be necessary to preserve the physical or mental health of the person with a disability, and less permanent methods of contraception must be unworkable.

(2) In Ohio, "no resident shall be subjected to sterilization without the resident's informed consent." Similarly, in Massachusetts, physicians are not permitted to perform sterilizations without written consent from the person to be sterilized. In

North Carolina, sterilization must be "medically necessary and not for the sole purpose of hygiene or convenience," and the person to be sterilized must also consent to the procedure or be unable to understand the implications of the procedure.

C. States Without Statutes Authorizing the Court-Ordered Sterilization of Persons With Disabilities

1. In the following states, the court-ordered sterilization of a person who is incapacitated is not permissible under any circumstances, due to an absence of statutory authority for courts to hear such petitions: Alabama, Missouri, Texas, and Wisconsin.

a. In these states, the courts view this area of the law as "untouchable," as they do not have robust methodologies to use when determining a case that would be a matter of first impression. *See* Mindy K. Fersel, Note, *Liberty and Justice for All? Protecting the Right to Privacy for Incapacitated Individuals: The Need for Comprehensive Sterilization Legislation in All Fifty States*, 20 Cardozo J. L. & Gender 827 (2014).

b. The following states have court decisions that authorize the court-ordered sterilization of persons with disabilities in the absence of statutory endorsement: Pennsylvania, South Carolina, and Washington.

(1) Regarding South Carolina, in *Brode v. Brode*, the Supreme Court of South Carolina, while not directly ruling on the issue of courts' authority to hear petitions regarding the sterilization of persons with disabilities, nevertheless upheld an order issued by the Family Court permitting the sterilization of a minor with a disability. 278 S.C. 457, 298 S.E.2d 443 (1982)

(2) Pennsylvania employs the doctrine of *parens patriae*, or the "inherent" power to extend "equitable authority" to state citizens who are deemed unable to protect themselves (which doctrine originally applied in Orphan's Court). *See Matter of Terwilliger*, 304 Pa. Super. 553, 450 A.2d. 1376, 1380 (1982). In other words, under the philosphy of *parens patriae,* it would be inequitable not to hear such petitions, for it would deny the constitutional rights of people who cannot protect themselves because of a legal disability. *Id.* at 1381.

(3) Regarding Washington, in the *Matter of Guardianship of Hayes*, the Supreme Court of Washington held that the Superior Court had the authority to hear petitions for sterilization under the broad grant of judicial power found in the state's constitution. 93 Wash. 2d 228, 608 P.2d 635, 637 (1980).

c. The following states do not have statutes or case law which address the sterilization of persons with disabilities, and thus have not taken a clear position regarding this issue: Arizona, Mississippi, Montana, Nebraska, New Mexico, Oklahoma, Rhode Island, South Dakota, Tennessee, and West Virginia.

D. <u>Common Requirements for Obtaining Court Approval for Sterilization Procedures</u>

1. In states where a court order is required to authorize a sterilization procedure for a person with a disability, an independent third party is appointed for the sole purpose of ensuring that the procedure would be in the best interests of the person with the disability. Such person is often called a guardian *ad litem*, or a "facilitator," such as in California.

2. Most courts use one of three methods to determine whether to grant petitions for the sterilization of persons with disabilities: the Substituted Judgment Analysis, the Best Interests Analysis, and a hybrid of the Substituted Judgment Analysis and the Best Interests Analysis. Fersel, *supra,* at 839.

a. Substituted Judgment Analysis

(1) This analysis is often used by courts tasked with making medical decisions for persons who are incapacitated. *Id*. Courts must determine whether the petitioner, who is the substitute decision maker for the person who is incapacitated, "effectuates as much as possible the decision that the incompetent patient would make if he or she were competent." *Id*. Critics of this approach declare that such substitution creates a "fictional competency" which purports to give those who are incapacitated authority which, according to the definition of mental incompetency, does not truly exist. *Id*. Some critics even suggest that such an analysis should only be done when a person was formerly competent, and expressed his or her wishes for or against sterilization, in the event he or she were to become subsequently incapacitated. *See id*.

b. Best Interests Analysis

(1) This analysis requires courts to examine objective factors in determining whether or not to authorize sterilization. *Id.* In order to grant a petition for the sterilization of a person who is incapacitated, the court must conclude that the factors demonstrate by clear and convincing evidence that sterilization is in the best interests of the person who is incapacitated. *Id.* at 840. Through weighing these different factors, the court must determine whether sterilization is the best option for the person who is incapacitated, to the exclusion of all other alternatives. *Id.* Many celebrate the relative objectivity of this analysis. *Id.* Critics, on the other hand, deem it to strip too much power away from guardians, and state that its application is overly narrow in an overzealous attempt to prevent abuse. *Id.* at 841.

(a) The factors which courts consider vary among the states which employ this analysis, but may include: whether pregnancy is possible; whether pregnancy or sterilization will cause the individual trauma or psychological damage; the likelihood that the individual will encounter both forced and consensual sexual situations; the individual's capacity to comprehend reproduction or contraception, and the likelihood such comprehension will change; whether medical advances in the present or foreseeable future will offer any less drastic methods; whether postponement of the sterilization procedure at the time of the petition is advisable; whether the individual would be able to care for a baby on his or her own, or with a marital partner; whether any medical breakthroughs are expected that could improve the person's condition or make sterilization less drastic; and a showing that the petitioner seeks sterilization of the ward in good faith and in his or her best interests, rather than for the petitioner's own or society's benefit. *See id*. at 840.

c. Hybrid: Substituted Judgment *and* Best Interests Analysis

(1) Using this hybrid analysis, courts must first apply the Substituted Judgment Analysis, and attempt to determine what the person who is incapacitated would want if he or she were not incapacitated. *Id.* at 841. Then, unless clear and convincing evidence of the person's wishes is apparent from this first step analysis, the second step is to use a Best Interests Analysis to determine whether to allow the proposed sterilization to be performed. *Id.* Some believe the combination of the Substituted Judgment Analysis and Best Interests Analysis is the best of both worlds – in circumstances where the preferences of the now

incapacitated individual can be shown by clear and convincing evidence, the decision can still effectively remain in the hands of that individual. *See id*. On the other hand, should there be no such evidence, the Best Interests Analysis serves to protect the individual against sterilization for the sake of improper motivations, such as for the convenience of the guardian. *Id.*

E. Especially Noteworthy Statutes and Case Law

1. California has a particularly complex process for obtaining a court order to approve a sterilization procedure. Not only must a "facilitator" be appointed for the person with a disability, but an investigation and report by a regional center for those with developmental disabilities is also required. Moreover, in California, "the fact that, due to the nature or severity of his or her disability, a person for whom an authorization to consent to sterilization is sought may be vulnerable to sexual conduct by others that would be deemed unlawful, shall not be considered by the court in determining whether sterilization is to be authorized…."

a. However, nothing shall "infringe on the rights of persons with developmental disabilities who are capable of giving consent to sterilization to give that consent without the necessity of a court order or substitute decisionmaker."

2. Florida law specifically prohibits legal guardians from authorizing sterilization without a court order. Florida law also specifically states that there is no right to a sterilization procedure. Florida law requires that a court appoint counsel for a person deemed to be incapacitated; that the court-appointed counsel meet personally with the person deemed to be incapacitated; that the court-appointed counsel find by clear and convincing evidence that the incapacitated person cannot consent to the procedure; and further find by clear and convincing evidence that the sterilization procedure is in the best interests of the person deemed to be incapacitated.

3. Georgia law requires that a team comprised of an independent psychologist/psychiatrist and an independent physician examine the person with the disability, and determine (i) whether sterilization is appropriate, and (ii) what less permanent family planning methods may be more appropriate. A committee from the hospital where the sterilization is to be performed must then approve the procedure. Only once all of these requirements have been met

can a court grant authority to a guardian to consent to the procedure on behalf of the person with the disability.

4. Idaho law prohibits sterilization by hysterectomy or castration unless medically necessary.

5. Illinois law requires the court to enter an order for sterilization if the person to be sterilized indicates a clear desire to be sterilized.

6. Indiana law highlights the issue of consent, stating that a legal guardian may petition the probate court to consent to medical care on behalf of an adult capable of consent. While that statute does not specifically address a situation where an adult is not capable of consent, Indiana case law permits sterilization of an adult incapable of giving consent if the petitioner acts "in good faith," and if the sterilization procedure is "in the best interest of the incompetent adult."

7. New Jersey law provides that no person with a developmental disability who is receiving inpatient treatment for his or her disability may be sterilized without the consent of a guardian ad litem specifically appointed for the matter; however, this restriction does not apply in situations where the person with the developmental disability is not receiving inpatient treatment. In such situations, trial courts have the power to order sterilization under the *parens patriae* doctrine.

8. Utah law provides that a court must meet with the individual proposed to be sterilized in order to determine whether the procedure is in the individual's best interest. Utah law also provides a right to a jury in cases where a party is petitioning for the sterilization of someone with a disability.

9. Vermont law prohibits the sterilization of minors, in addition to requiring that the sterilization procedure is the most effective method of contraception for the person with a disability.

10. Virginia law requires that a full description of the sterilization procedure is given to the person with a disability, and to his or her parent or guardian, and that the court consider the opinions of the person with a disability.

11. Washington law provides a strong presumption against sterilization. All less severe means of contraception must be futile, and the proposed method of sterilization must be the least invasive means.

CONCLUSION

The authors are deeply grateful to the individuals, professionals and organizations that have inspired and informed the foregoing discussion. The readers of this outline have been among the very first to review the efforts of the authors to tackle the difficult and sensitive issues that all persons with disabilities (and their families) are pondering, but few are discussing. The authors hope that the foregoing discussion will serve as a resource and conversation-starter so that persons with disabilities, with the help of their support systems, may achieve greater sexual health and safety.