Mental Health Consultants  
Nora J. Baladerian, Ph.D.  
P.O. Box “T”  
Culver City, CA 90230  
310.391.2420  
FAX 310 390 6994  
Email: DrNora@doctor.com

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The National Academies  
2101 Constitution Ave. N.W.  
Washington, DC 20418  
ATTN.: Nancy A. Crowell

**Children andAdults with Developmental Disabilities: Maltreatment Update**

Individuals with developmental disabilities are at higher risk for abuse of all types than the generic population. It is recognized that child abuse is an epidemic in the United States, with the 1998 National Committee to Prevent Child Abuse survey indicating that over 1 million children become victims of child abuse each year, and 3 million cases are reported for investigation. Their research has never inquired into whether the child had a disability prior to the abuse, or acquired a disability following the abuse. The Weststat study authorized by Congress and published in 1991, found that children with disabilities are approximately twice as likely to become victims of abuse as their generic counterparts. This is the only federally funded national inquiry into child abuse and children with disabilities.

There has been no federally ordered/authorized call for inquiry into the incidence or prevalence of abuse of adults with disabilities. The Baylor College program headed by Peg Nosek, has a multi-year research program underway. This project focuses exclusively on women with physical
disabilities. Although findings for prevalence are not available, the researchers state that crime victimization is quite high, usually involves individuals either working for their victims or others with whom the victim is familiar or even upon whom the victim is dependent for ADL (activities of daily living) support. The fact that there has never been an inquiry is of note. It speaks to the issue of the low perceived status of people with disabilities of those in power and who authorize inquires into the issues for many other constituencies based on gender, race, ethnicity, economic status, educational progress and on and on. It seems that it is only the factor of disability that is not brought to mind or is ignored or dismissed (which of these is not known) when making critical decisions that will effect public safety.

Smaller local studies of the prevalence of maltreatment of adults with disabilities have dismal findings. Overall, these studies have found that abuse of adults with disabilities exceeds the rate of crime victimization of generic adults by 4-10 times. Professionals with direct contact with individuals with disabilities concur with this finding.

Personal Impact

The impact of victimization on individuals with a developmental disability is at least as powerful as the impact upon the generic population, and may be more so. Due to a lack of preparation, information, education and support, it is likely that assaults may be more terrifying, and may cause greater levels distrust, depression, anxiety, and the other well recognized responses to trauma.
There is one recent study that found that PTSD occurs more frequently among people with intellectual impairments (Journal of Consulting and Clinical Psychology, April 1999). In addition, newer findings in the traumatology field have identified physical neurological changes in the brain which occur as a result of trauma, and remain unchanged thereafter. This helps to explain why symptoms of PTSD do not disappear over time, may be triggered at any time by factors known or unidentified by the trauma survivor. In some situations, this information has not yet trickled down, and inappropriate attempts to either eradicate PTSD symptoms continue, or these same symptoms are targeted for behavior modification intervention. What is required is that the program managers take steps to change the environment and/or staff response to trauma survivors that are responsive to the clinical effects of trauma.

Ongoing identification of issues affecting individuals with disabilities as a facet of the disability rather than recognizing the many other factors that impact a person’s life, has led to increased distress and trauma to many survivors, over periods of years and decades. For example, one woman with Down Syndrome exhibited sexualized behavior following a sexual assault. Rather than providing treatment for the assault, understanding the etiology of the behavior, or providing the parents with a plan for assessment, the clinician informed the parents that such conduct was normal for individuals with Down Syndrome as young adults proceeding through their developmental states. As to the woman, a behavior modification plan was designed to eliminate these behaviors.

This case illustrates the need for greater understanding and information by disability specialists and other mental health practitioners who do not training in sexual abuse.
The personal impact of maltreatment for the child or adult who crime victim can be viewed in many different aspects. Among the most important factors that determine the power of the response will be: the role of the perpetrator with the victim; the number of attacks; the response of the family and others to learning of the attack; the allowance of time and choice for future activities allowed the victim. Additionally, how the system responders let the victim know whether or not s/he is believed through actual verbal statements, repeated interviews or during an interview repeatedly asking the same question, or treating the individual as if she is a child when she is an adult.

Since it is widely agreed and substantiated in research that for victims of crime with disabilities the perpetrator will most likely be someone in a position of trust and perhaps love with the victim, the information regarding such relationships in the generic community applies: the closer the relationship, the more devastating the impact of the abuse. The result can be that the individual’s betrayal can lead to an inability to regain a general sense of trust. This can extend to the victim herself, believing, thinking or sensing that she cannot trust herself. This trust would be in regard to her own judgment skills or that something about her cannot be trusted because another person found her a viable target for maltreatment.

It is also widely acknowledged in child abuse, domestic violence, and sexual assault victims that one factor that victims have in common is a history of victimization. Although it is not clearly understood, the fact of having such a history exponentially increases the psychological response to the trauma. In the case of individuals with disabilities, it is quite common that none of the
prior assaults were ever disclosed, if they were if anything were ever done in response to these prior disclosures including most importantly action to deter the alleged perpetrator and therapy for the victim.

Both in generic child abuse and sexual assault, the response of others upon learning of the assault has been identified as a critical factor in the healing potential for the victim. When the family and others close to the victim have a negative reaction, blame the victim, do not want to ever talk about what happened, do not believe that it happened or protect the perpetrator, the results are psychologically devastating and set up a poor prognosis for the victim’s ability to heal from the trauma. Unfortunately, family and others are not trained in how to respond to such information, so they respond in ways that are natural and consistent with their own self-serving repertoire, probably consistent with their religious and cultural backgrounds. These may include denial that such traumas exist; in regard to sexual trauma that sexual assault occurs outside of the woman’s promiscuous or seductive conduct; that anyone who commits sexual assault upon one’s children should be killed upon learning of the assault (by the parent). To say this is not to denigrate the parent in any way...we all respond in self-serving ways. The problem is that the immediate response that works best for the victim is a self-denying one, of denying one’s own reaction or terror, rage, sadness and attending to the needs of the victim which may include calm listening, providing information, reassurance and action such as taking the victim to the hospital or going with the victim to the police. The victim needs the love, acceptance and reassurance of her family. Their natural response of possible vengeance against the perpetrator must be saved for later discussion outside earshot of the victim, who may became frightened that she may lose her parent(s) or that she has become responsible for violent acts to the perpetrator. One of the tenets
in the culture of disability is to not get anyone else into trouble. Contravention of this rule frequently can engender great anxiety and upset.

How the case is handled by the law enforcement agencies also has a powerful impact upon the victim. It is important to note that how each representative who comes into contact with the victim treats both the case and the victim will have lasting effects upon the victim, and can enhance or inhibit psychological healing, and conversion from being a victim to becoming a survivor.

As each person with a disability is a unique individual, with unique background, psychological make up and personality, how victimization effects her is also individual. To identify some significant factors, here is a brief list:

if the victim feels responsible for the crime or participation in the crime
if prior to the attack she had poor self regard as a chronic or temporary state of mind
if immediate response to learning of the attack is empowering and supporting
if she is informed that many women become victims of assault and that this did not happen because of who she is or because she has a disability, but because the perpetrator is a person of bad intentions and a criminal.

In assessing a crime victim either for adjudication or mental health treatment, an understanding of these factors is critical. The individual’s self image and sense of empowerment or dependency will be extremely important aspects that impact on her experience and self explanation of the
crime. It is important to tell crime survivors that crime victimization is a problem for all women regardless of their station, disability, or any other factor. Women are targeted by criminals, some by circumstance of time and place, some by the perpetrators' concentrated attention to selecting a victim with whom he believes an attack can be completed and there is a reduced likelihood that he will be arrested. Period.

Rape Trauma Syndrome and Post Traumatic Stress Disorder are well recognized as encompassing the range of normal psychological responses to trauma. It further has been learned that victims of sexual crimes have a recognizable/identifiable response to the crime put together by Roland Summit which he calls "Accommodation Syndrome", and addresses the stages through which many crime survivors pass in disclosing the crime. Understanding of this provides credibility for and an understanding of why victims fail to disclose or delay disclosure of their victimization, why when the disclosure is made it may contain misrepresentations of the perpetrator or other critical factor; why the victim later recants and denies that anything ever happened, and then, later, is psychologically able to provide an accurate description. Failure to apply this critical piece of information that is true in the generic population has led to cases being dropped and accusing the victim of not "being able, due to the disability" of providing an accurate description. This reaction also belies both a failure to understand that people with mental retardation have responses to trauma just like individuals in the generic population, and that the individual is not free from prejudices, myths or stereotypes that support such an action.

Victims of sexual assault have different physical reactions than do victims of any other type of crime. Physical changes that are more obvious are changes in eating, and sleeping routines,
mood changes and an overall level of more neediness (for children a reversion to an earlier stage of life which required greater nurturing and attention). Additionally, crime victims may: run away; stop eating altogether; only eat certain foods or a certain type or consistency of food; may refuse to change clothes, bathe, wash hair; may cut hair, may become aggressive, sexualized; may begin sexual self stimulation or mutilation; may acquire or request change in hair color, tabooring, piercing, type of clothing; may re-enact the crime; may become extremely overweight or dangerously underweight.

The family will most likely become secondary trauma victims. When a person you love is attacked, you will feel traumatized as well. These family members will have similar responses as described in PTSD including depression, anxiety, rage, denial, and reliving the event through the fantasy based on what they have learned. Additionally they will experience each of the responses identified by Elisabeth Kubler Ross as “stages” in response to learning one is dying: denial, anger, bargaining, depression and acceptance. Although she described these as stages through which one moves to resolution, this author has perceived that these responses may all be present at any time in the individual, although one response may take precedence over another for a day, an hour a week or a month. Further, I do not believe that the final stage is acceptance but rather acknowledgment. Acceptance implies that the victim “accepts” the victimization, which many do not. Acknowledgment simply means that the victim agrees that the crime occurred, but they do not have to bring it into their daily life or effect personality or belief systems.

How others who learn of one’s crime victimization is important. It is also important to recognize
that it is not necessarily a good idea that many people learn of the crime victimization, particularly if the crime is a sexual crime. At present, societal attitudes have not caught up with the reality that regardless of the type of crime, the victim does not carry responsibility and should not be stigmatized. However, we are not there yet, and many victims of sexual crimes are treated disrespectfully by their friends, neighbors, professional contacts, religious leaders and even members of the criminal justice system. At this point, both for these reasons and one's own right to privacy, it is recommended that the fact of the crime be revealed only to those with a "need to know" to support the victim and convict the perpetrator.

We are still struggling, in the sexual assault field, with naming sexual crimes. Since the majority are committed against acquaintances without the use of weapons, and "rape" is generally perceived as a stranger jumping out of a bush with a knife, it is important to develop a term of reference that identifies that act as a crime that includes force either physical or psychological and involves sexual contact. At present Date Rape, Acquaintance Rape and Non Stranger Sexual Assault are used. It is likely that in the near future other terms will be developed that the public can more easily understand and relate to that distinguishes these crimes from stranger sexual assault.

Changes in one's ability to think, remember, concentrate and learn are significantly effected by a traumatic event. This should be taken into consideration for the victim, both in terms of managing normal daily routines (which may be impaired) and for adapting to new activities, particularly those involving the criminal justice system, such as learning new words, concepts and participating in new activities. Multiple interviews, meeting people in uniforms with guns,
going to court, facing the perpetrator are all new experiences. Although the crime victim may have seen portrayals of such events on TV, it is quite different when one is the victim herself. Patience, repetition, and use of materials that are written for individuals with learning disabilities go a long way to facilitating the victim’s learning and adaptation psychologically to survivor sequella.

Changes in the victim’s personality can be expected, usually for the worse. The individual can be expected to withdraw socially, to become irritable, perhaps initiate the use of profanity or sexually related words or phrases. She can become obstinate, stubborn, demanding, non-compliant, and have a “don’t care” attitude. Or she may simply withdraw and refuse to speak to anyone or participate in any social activity. Many of these changes can be viewed as positive adaptations to a world of danger. However, it is likely that the application of these changes with those wishing to help rather than those wishing evil is not welcomed. It is highly likely that these changes will not be validated in the sense that, properly used, can be identified as excellent survival strategies, Appropriate application and utilization can be taught. It may take up to 2-5 years to see if these personality changes are permanent. The damage caused by crime victimization is powerful, and the victim cannot and should not be blamed for undergoing a permanent personality change. Some become Survivor Advocates, and wish to work in situations where they can “tell their story” and thus help others to understand both that these things happen, and that the impact of such crimes is powerful and permanent. Additionally, they may wish to make changes for the future from how the criminal justice system responded in their case, and make presentations to Law Enforcement Agencies for this purpose.
Social Impact

The social impact of these issues, although great, is unrecognized for the most part, as the victims of assault who have disabilities remain an under served and infrequently identified population. The costs to society in terms of lack of contribution as a result of the trauma, and payment for resulting injuries play a part in the overall societal price for crimes against persons.

Failure to apply serious penalties upon conviction of perpetrators continues a pattern of “allowing” perpetrators of crimes against those who are undervalued to get away with the crime. This not only encourages perpetrators to seek out victims for whom they are unlikely to serve a sentence or a serious sentence, but the word gets out, and experienced perpetrators teach untrained perpetrators the tricks to avoiding prosecution and/or lengthy sentences. This pattern is similar to that which occurred in crimes against women, children, and people in poverty.

Costs for additional disabilities including PTSD (Post Traumatic Stress Disorder), depression, anxiety, behavior changes should be factored in when considering social impact. Although therapy for many victims of crime with developmental disability never happens, or happens years after the trauma, the appropriate psychological and psychiatric evaluations and treatment interventions may be more intensive than for the generic victim of abuse. Overall, although the duration of the treatment may be similar, the treatment plan is likely to involve many other agencies and individuals, and therefore will be more costly in time and money to assure consistency of treatment approaches. Further, the individual may require an interpreter, and this cost should be factored in. Since the ADA (Americans with Disabilities Act) requires that the
provider of service provide the interpreter (the person and the fee), this may be a hidden cost as it is not likely to be included in standard cost analyses.

While the individual with a developmental disability may only have a diagnosis of a cognitive impairment, there is the possibility that the person may also have other disabilities either pre-existing or as a direct result of the assault. These include: Physical disabilities (mobility impairments), sensory impairments (hearing impairments, vision impairments), neurological impairments or psychiatric disabilities. If the disability is a result of the trauma, the treatment will demand attention to the issues of grief, loss, rage, and accommodation to the new disability.

Techniques that help abuse victims

Psychological treatment and psychiatric treatment are critical to the healing process for any victim, and thus of course for the crime victim with a disability. In many cases individual treatment is provided for a time, followed by group treatment. Although this is useful for many, it is not useful for everyone, and an individual clinical decision would be made. In many cases there is neither a qualified practitioner available for individual or group treatment for victims with disabilities. Involvement of the family members in the treatment is a critical aspect to working with crime victims with developmental disabilities. The support of the family in attending sessions is extremely important, as well as providing a service to them directly.

There are specific considerations that must be made in the case of assault victims with disabilities. For example, allowing time and response of the victim to dictate when and how
quickly to return to daily activities of school or work. In most cases, the victim of assault has ideas and feelings about returning to usual daily activities following an assault, and should be allowed as much time as the victim wishes to get ready to re-engage in the daily routine. If the perpetrator will be at a location in which the victim has normal routine activities all efforts should be made to have the perpetrator moved to another program. If the perpetrator is staff, he should be charged with the crime and fired. The parent/guardian should not disallow the client to return if she wishes.

Usually, if the place of the crime was her workplace, this is also where she has a great deal of her social life, friendships, and regular sense of belonging. This should not be ripped away from her in an effort to protect her. This should be her decision. Many other factors of daily living should be available for the victim to decide if she wishes, and if not, be allowed to be helped in these decisions.

How to increase practice nationwide has been an area of great concern for many years on the part of this author. Although information and training programs have been made available, very few mental health practitioners demonstrate an interest. Some have expressed an interest, but the interest is short lived. An exploration into motivation is needed.

Why mental health providers do not acquire training is believed to be a function of the general societal lack of interest in individuals with disabilities. Most people agree that the majority of individuals involved in issues of disability regardless of the field of endeavor have taken an interest due to a personal experience. I believe that this is a primary issue. The next issue of
probably equal importance is that training courses, or even class material in generic courses, do not mention much less focus on individuals with disabilities. If a psychologist or other mental health practitioner graduates from any college today, it is likely that they have received one hour or less on treating individuals with disabilities.

Services for crime victims

Victim’s Assistance Programs provide funding for psychological counseling for crime victims in every state. In addition, funding for treatment for secondary victims is also provided. When the mental health practitioner does not accept Medicare or Medicaid, this funding source can cover the fee. This program is considered “last dollar”, so that any insurance the patient has must be billed first, then the balance will be paid by the program. The Victim’s Assistance Program has criteria for qualified providers as well as treatment plans.

Generic utilization statistics show that approximately 10% of crime victims ever request psychological assistance through this program. It may be that potential mental health clients are never informed of this option by the law enforcement office with whom they have their case. It is the responsibility of the LEA to inform each crime victim of this program. Access to the program is through local non-profit or county or city governmental agencies.

Information on utilization for people with a developmental disability & accessibility is unknown. Since relatively few crime victims access the Victim’s of Crime Program, it is likely that the pattern of underutilization by individuals with developmental disabilities continues into this
arena. However, no statistics have ever been developed to determine utilization.

Specialized units or services for people with developmental disabilities exist in scattered agencies throughout the nation. It is not widely advertised, however, and in many cases these units are not institutionalized, but rather a function present due to the interest and dedication of one person. When that person leaves, the programs wither and terminate.

Specialized services for victims with disabilities, or generic services that include individuals with disabilities may be provided by any of the following, yet there is no data on either the presence of a program or utilization at: Rape Treatment Centers, National Advocacy Centers, government sponsored child abuse counseling programs, or government sponsored domestic violence programs.

Vertical Prosecution Units would be enormously supportive to individuals with disabilities. However, these are few and far between. There is resistance to their development. And, there is no research to tell us how many such Units there are across the country. Where there are such units, it has been noted that there is an increase in convictions and appropriate sentencing.

As is true for other victims, participation in the case through victim impact statements, and utilization of victim advocate programs has been enormously supportive and facilitates re-empowerment and thus psychological health. However, the extent of such participation in these programs is less than ideal. Advocacy to help victims learn about the Victim’s Assistance program would be an excellent first step to increasing both services for victims with disabilities.
as well as training and experience for Victim’s Advocates who may not have worked with someone with a disability before.

Barriers

Barriers to receiving services are many, beginning with the fact that many agencies, organizations and even courts are not fully accessible to individuals with disabilities. Such lack of attention to the needs of the whole community should have been repaired years ago, at least by July of 1994 which was the final date for accessibility compliance. Yet, following this date court houses and other facilities for the public have been built without using universal standards. In addition to the physical site being accessible, services, materials, and communication must be available to individuals with disabilities. In this arena as well, compliance is more the exception than the rule. It seems that this may not be due to anything beyond “benign neglect”, but the neglect is anything but benign as it excludes at least 12% of the public from receiving public services.

Among the services that are, for the most part, not accessible, are mental health treatment for the victim or the secondary victim; outreach efforts including public education seminars, and written materials for victims of crime who have disabilities.

Shelters for battered women with disabilities are few. Although most receive governmental funding, the funding agency does not require compliance with ADA (Americans with Disabilities Act) to receive funding. This falls under the category, “If you don’t have to do it, don’t”. While
compliance is not demanded, it is unlikely that things will change. There currently are no surveys that document the number or percentage of shelters that are in compliance with ADA.

Community services such as informational brochures, flyers, programs, advertisements, PSA's (public service announcements) lectures and presentations are outreach activities in which most agencies engage. However, most do not specifically state that their programs are for individuals with disabilities, individuals with disabilities are not included in their illustrations, and there is no “tag line” stating that the agency is fully accessible. Thus, individuals with disabilities are not likely to think that the agency has services for them. It is unusual for such agencies to go to service delivery organizations or agencies that serve children and adults with disabilities, further decreasing the possibility that people with disabilities will be aware of or contact the agency for assistance.

Risk Reduction Training Programs rather than “prevention programs” are likewise few. In many cases, where a “Prevention Program” has been instituted, it is too convoluted for the student (using abstract thinking tasks for concrete thinkers), it is administered only once (where practiced and practical techniques are required). Worse, those in the community who wish to protect their children (minors and adults) then are left with a conviction that their child now has the information and skills to evade or manage an attempted assault when in fact they have not.

In the case particularly of stranger danger (1% of the cases), Self Defense - Martial Arts training specialized for people with developmental disabilities has been developed. For those who have taken the training, parents report an increase in self esteem and self empowerment. These are
important psychological factors that increase the individuals' overall mental health, and may serve to avoid an attempted assault. However, in my opinion it would be wise to spend more energy addressing 99% of the problem, assault by acquaintences.

Barriers and facilitators for service delivery include the following at the very least. Additional items should be developed and utilized for program development. Barriers for service delivery include: lack of knowledge of the problem; lack of interest in the problem; lack of information on resources to gain skills; fear of additional administrative and fiscal responsibility; the agency is already overwhelmed with it's workload and is reluctant to add time-intensive tasks if such can be avoided; a lack of understanding of the extent and impact of the problem.

Facilitators of service delivery include: free training to become ADA compliant is available; grants are available if needed to make physical changes in the facility for accessibility; additional financial revenues are available when adding new populations to the client census; the opportunity to provide unique training and internship programs offer the agency a way to distinguish itself from the other agencies, thus become a "gatekeeper" referral source.

Providers of mental health services to individuals with disabilities who are trained and experienced report a rich experience they would not trade. Each new client provides a new learning experience as well as an opportunity to serve others. There is some frustration in that there are so few individuals and agencies specializing with work with individuals with disabilities, yet gatherings of these practitioners expose their enthusiasm for the work, for learning from each other, and sharing their knowledge with others.
Abuse Awareness Educational Programs & “Personal Safety” Programs

There is an inherent danger of using euphemisms that imply criminal activity can be eliminated. Although most people would like to see a violence-free world, this is unlikely to occur. In comparing problem issues of violence with health concerns, the problem becomes apparent. When vaccines for polio were discovered, mass vaccinations were conducted. They goal was to “prevent” new cases of polio. This was the result in a majority of the cases, and the epidemic of polio in the United States was ended. When we wish to eradicate violence, the approach is not so simple. There is no vaccine. Yet, when educational programs billed as “Prevention Programs” are offered, there is a psychological response that the result will be like the polio prevention program, and one no longer needs to worry about crime victimization for the student who completes the program. “Prevention”, a public health term, utilizes an approach of primary (informing the entire public), secondary (informing and treating persons potentially impacted by the problem) and tertiary (treating those who have acquired the problem) methods. When used in a lay fashion the concept can be misconstrued, leading to increased rather than decreased vulnerability. Using the term “Risk Reduction” forces the mind to stay focused on ongoing risk, and reduces the possibility that when the Risk Reduction formal program has been completed that either the student or the parent will assume the danger has been eliminated.

Abuse Awareness Educational Programs have been instituted, again, only in a few agencies and may be administered due to the interest and motivation of one person, rather than the efforts of an ongoing organization or unit of the organization. Some community resistance has been
encountered. This is based on fears of parents and other care providers. Some believe that discussing crimes will induce untoward fear in the students which is unnecessary. Others believe that discussion of sexual crimes will lead to sexual interest and thus to sexual activity, and the resultant “problems” this will engender. Therefore, it is strongly believed by many community members that it is best not to conduct such educational programs. For this and other educational endeavors, a listing of facilitators and barriers is helpful to work with these community concerns to arrive at an accord that allows for the educational program to be conducted in a manner that is culturally sensitive to the community.

Both children and adults with a developmental disability, as well as their parents or care providers should be provided information about abuse and criminal victimization. The curriculum should be adapted to the particular needs of the community and the audience. There are a number of curricula available, and most agencies use a variety of curricula to modify into one that works for them. It is best if the curriculum includes at minimum: A protocol for planned repeated presentations; pre/post testing to evaluate effectiveness of learning; the inclusion of an IRP (Individualized Response Plan); feedback from the community and program participants; a measure of effectiveness, and endorsement from local officials.

Best Practices

To make recommendations for best practices, an multidisciplinary advisory group of experienced clinicians should be convened. The resulting recommendations could be considered for incorporation into the standards of practice for each of the several professional therapist
organizations such as the American Psychological Association, American Psychiatric Association, National Association of Social Workers, and the American Association of Marriage and Family Therapists, among others.

These “Best Practice” recommendations should include qualification of the therapist, basic training for the therapist, experience with individuals with disabilities, crime victims, trauma, grief and bereavement, cross cultural training, child development, developmental disabilities, and supervision and consultation practices.

Summary

The exposure to violence by individuals with disabilities is extraordinarily high, yet disclosure, reporting and adequate response by the legal and therapy communities is less than for the generic population. Increased information about the seriousness not to mention existence of this as an epidemic, needs to be made. Public officials who can authorize funding for programs that are ear-marked for individuals with disabilities should be encouraged to do so.

With the current wave of interest, it is hoped that this is a permanent change rather than a fad that will soon disappear. A great many people have been working in their own communities doing what they can with meager funding and support of the community. If this can change into wide support and excellent funding, the experience of individuals with disabilities who become crime victims will change radically. Further, if educational risk reduction programs are instituted, it is possible that families and individuals can resist and report assaults better. And finally, with funding of programs, there is potential for the interest of mental health practitioners to grow so
that communities can serve all members of the public, not just those who do not have disabilities.

Research is the next great effort that is needed to support requests for funding for programs. As indicated above, there are many areas where our knowledge is lacking in response to crime victimization. While this information is needed, at the same time action must be taken now to effectively and sensitively respond to the crime victims currently in need of services.

If the recommendations contained within this article are implemented, the legal and mental health service delivery systems can effectively serve crime victims with developmental disabilities.

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