

***A Comparative Analysis of the Experience of Sexual
Victimization between Persons with a Mental/Cognitive
Disability and Persons with No Reported Disability in New Mexico***



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EXECUTIVE SUMMARY

I. INTRODUCTION

Of the 320,775,014 civilian non-institutionalized population in the United States 12.7% live with one or more disabilities.²

In 2015, the rate of violent victimization against persons with disabilities in the United States (29.5 per 1000 persons age 12 or older) was 2.5 times higher than the rate for persons without disabilities (11.8 per 1000). By far, violent victimizations occurred most often among persons with a cognitive disability (57.9%).³

From 2011-2015, the average rate of rape/sexual assault among persons with disabilities in the United States (2.1 per 1000 persons age 12 and older) was 3.5 times higher than the average rate of rape/sexual assault among persons without disabilities (0.6 per 1000 persons age 12 and older).³

In New Mexico in 2016 – 2017, adults with a mental/cognitive disability (25.6%) were three times more likely to experience a completed or attempted rape in their lifetime than those without a mental/cognitive disability (9.2%).⁴

In New Mexico in 2018, 44% of rape victims who sought assistance at statewide sexual assault service provider agencies and 29% of rape patients at statewide SANE programs had a disability.⁵

Research regarding the similarities and differences in the experience of sexual violence between those survivors in New Mexico with a cognitive/mental disability and those without disability was conducted to illuminate specific service needs of survivors in New Mexico with a mental/cognitive disability and the challenges of accessing and obtaining services needed for effective recovery from their trauma.

A retrospective examination of statewide SANE data (2004-2018) and statewide sexual assault service provider data (2003-2017) was conducted to compare the experience of sexual victimization between survivors with a mental/cognitive disability and survivors with no reported disability.

II. FINDINGS

A fifteen-year retrospective examination of sexual assault data found that 23% (2,288) of SANE patients and 23.7% (3,586) of sexual assault survivors who sought therapeutic services from statewide sexual assault providers had a disability. Of these survivors with a disability, 61% (2,288) of SANE patients and 69% (3,586) of sexual assault survivors who sought services from statewide service providers had a mental/cognitive disability.

White (non-Hispanic) and Black survivors were significantly more represented among SANE patients with a mental/cognitive disability, while Hispanic survivors were significantly more represented among SANE patients with no reported disability. Nationally, more Native Americans (American Indians and Alaska Natives) (17.3%) live with a disability, than Blacks (14%), White non-Hispanics (14%), Native Hawaiians and Other Pacific Islanders (10.3%), Asians (7.1%), Hispanics (9%), those of some other race (8%), or those of mixed (two or more) races (11.1%).

Analysis of SANE and service provider data found that male and female rape survivors with a mental cognitive disability were significantly older at the time of their first sexual assault, as well as at the time they presented for services than survivors with no reported disability.

While most assaults for SANE patients with a mental/cognitive disability and patients with no disability were perpetrated by adults, SANE patients with a mental/cognitive disability were more vulnerable to assault from an adolescent, stranger perpetrated-assault, and assault involving multiple offenders.

Sane patients with a mental/cognitive disability of all ages were more likely to be offended by a stranger or someone from a brief encounter. Of the SANE patients with a mental/cognitive disability, child SANE patients (<13) were slightly more likely to be offended by an acquaintance, while adult SANE patients (>17) were slightly more likely to be offended by a family member.

Service provider data revealed that survivors with a mental/cognitive disability compared to survivors with no reported disability were significantly more likely to have experienced a prior sexual assault and more likely to be victims of ongoing abuse, rather than an isolated assault.

More survivors with a mental/cognitive disability were victims of criminal sexual penetration (rape) compared to survivors with no reported disability. Conversely, more survivors with no reported disability were victims of criminal sexual contact compared to survivors with a mental/cognitive disability.

While significantly more survivors with no reported disability were victims of incest compared to survivors with a mental/cognitive disability, twice as many survivors with a mental/cognitive disability were victims of gang rape compared to survivors with no reported disability.

SANE patients with a mental/cognitive disability were significantly more likely to be coerced by verbal threats and a weapon, than patients with no reported disability. Conversely, SANE patients with no reported disability were significantly more likely to be coerced by alcohol/drugs and a person of authority.

Significantly more survivors with a mental/cognitive disability than survivors with no reported disability were more likely to have experienced domestic violence in their past, have used alcohol and drugs during their assault, have an offender who used alcohol or drugs, have contracted a sexually transmitted disease and sought medical treatment.

SANE patients with a mental/cognitive disability than patients with no reported disability were significantly more likely to be injured and more likely to be injured as a child or adolescent. Child (<13) SANE patients with a mental/cognitive disability compared to patients with no reported disability were three times more likely to experience rectal injuries.

Forensic evidence was collected in equal proportions among SANE sexual assault survivors with a mental/cognitive disability and survivors with no reported disability. However, significantly more SANE patients with a mental/cognitive disability had rape kit evidence and clothes collected than patients with no reported disability; and this disparity was true for all age groups, with the greatest disparity found among adolescents.

Assessment services were provided in similar proportions to SANE patients with a mental/cognitive disability and patients with no reported disability, but significant disparities were found in the provision

of individual assessment services in these two groups, by patient age. STD treatment was provided more frequently to child and adolescent patients with no reported disability than child and adolescent patients with a mental/cognitive disability. Significantly more child SANE patients with a mental/cognitive disability obtained pregnancy/contraceptive services compared to child patients with no reported disability. Almost twice as many adolescent and adult SANE patients with a mental/cognitive disability obtained psychological/suicide assessment as adolescent and adult patients with no reported disability.

A report about the sexual assault was made to law enforcement in similar proportions among SANE patients with a mental/cognitive disability and patients with no reported disability. However, significantly more sexual assaults among child SANE patients with no reported disability were reported to law enforcement compared to reported sexual assaults among child patients with a mental/cognitive disability.

A greater proportion of SANE patient referrals to other services was made among SANE patients with no reported disability compared to patients with a mental/cognitive disability. SANE patients with a mental/cognitive disability were slightly more likely to be referred to SANE follow-up services, rape crises centers, hospital/medical care providers, and other services. SANE patients with no reported disability were slightly more likely to be referred to law enforcement and victim advocates, and significantly more likely to be referred to crime victims reparation, a community mental health center, and CYFD.

III. CONCLUSION

Many vulnerabilities among persons with a mental/cognitive disability in New Mexico are illuminated in the findings of this retrospective examination of sexual assault data. They first beg the question, “How do we protect persons with a mental/cognitive disability?” How do we protect them from stranger assault, multiple offender assault, and gang rape? How do we protect them from injury, especially rectal injuries among children with a mental/cognitive disability? How do we make medical treatment for sexually transmitted disease, pregnancy prevention, and psychological assessment for suicide prevention as routine as it is for those without a mental/cognitive disability. The myriad vulnerabilities illuminated secondly beg the question, “How do we help enable them, especially because so many persons with mental/cognitive disability also suffer with other physical and behavioral disabilities? How do we educate them and all who work with them about healthy sexuality and appropriate relationship boundaries? How do we help them obtain more autonomy so they are free to remove themselves from potential harm or stop abuse and report abuse. How do we help them access needed services to protect themselves or to heal their trauma? How do we make more services available and geographically accessible to adequately address the specific challenges that persons with a mental/cognitive disability and their advocates face?

There are numerous reasons why persons with mental/cognitive disabilities are highly vulnerable to sexual victimization. Some of these reasons include the lack of: a) sexuality education tailored to persons with mental/cognitive disability; b) autonomy to leave their environments and caregivers or report abuse; c) legislative policies that give persons with mental/cognitive disability more autonomy; d) available, accessible services to accommodate their specific needs; e) research or evidence-based policies or practices specifically for the prevention of sexual victimization among persons with a mental/cognitive

disability; f) training for advocates, healthcare providers, and law enforcement to appropriately respond to victims with mental/cognitive disability; and g) collaboration among “helping” systems.

In a 2019 report on sexual violence among New Mexicans living with intellectual/development disabilities, several initiatives needed to effectively achieve the prevention and reduction of sexual victimization specific to persons with intellectual/developmental disabilities are discussed.⁶ The goal is to establish “...a comprehensive approach to violence prevention that includes efforts to impart change at the individual, relationship, community and societal levels... .” To this end, several recommendations are offered, including but not limited to: “creating or strengthening legislative and organizational policies; providing direct education to people with intellectual/developmental disabilities, as well as service providers and caregivers; fostering critical collaboration” , “...address(ing) gaps in reporting of violence victimization” and utilize(ing) research to “...identify trends in victimization, inform interventions, and strengthen service delivery.” See the full report for specific details regarding each recommendation and the goal of creating a long-term strategic plan to protect and enable persons with mental/cognitive disability.⁶

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I. INTRODUCTION

Sexual violence has an impact on society like few other major crimes not only because of its prevalence, but because of the many challenges it poses and the resources required with respect to: treatment of victims, their families, and offenders; emotional, medical and social consequences of victimization; demands on the healthcare and criminal justice systems; and associated economic costs incurred by all involved parties, as well as their employers and the communities in which they reside. Additionally, the polarization observed between those advocating for and against policies and practices for the empowerment of sexual violence victims, cultural change, economic equality, gender equality, and criminal justice reforms regarding the prosecution and sentencing of offenders of sexual violence, is palpable in the United States today.

In the United States and New Mexico, the prevalence of sexual violence is devastating. One-third of U.S. women (36.3%) and New Mexico women (37.8%) experienced contact sexual violence, including rape and unwanted non-penetration sexual crimes.¹ One in five U.S. women (19.1%) and New Mexico women (20.4%) experienced a completed or attempted rape in their lifetime.

One in six U.S. men (17.1%) and New Mexico men (16.0%) experienced contact sexual violence in their lifetime.¹ While one in sixty-seven U.S. men (1.5%) experienced a completed or attempted rape in their lifetime, no estimate on the number of men who have experienced completed or attempted rape in New Mexico in their lifetime is currently available. However, given the similarity in the U.S. and New Mexico rates of contact sexual violence, one could assume a similar rate of completed or attempted rapes.

While the rates of sexual violence among the general population are disturbing, the rates among those with disabilities are alarming.

Of the 320,775,014 civilian non-institutionalized population in the United States, 12.7% (40,678,654) live with one or more disabilities.² The difference between females (12.8%) and males (12.6%) living with a disability in the United States is negligible.²

In 2015, the rate of violent victimization against persons with disabilities in the United States (29.5 per 1000 persons age 12 or older) was 2.5 times higher than the rate for persons without disabilities (11.8 per 1000).⁴ By far, violent victimizations occurred most often among persons with a cognitive disability (57.9%), followed by those with difficulty in independent living (30.8%), ambulatory disability (29.4%), vision disability (28.8%), self-care disability (25.9%), and hearing disability (15.7%).³

From 2011-2015, the average rate of rape/sexual assault among persons with disabilities in the United States (2.1 per 1000 persons age 12 and older) was 3.5 times higher than the average rate of rape/sexual assault among persons without disabilities (0.6 per 1000 persons age 12 and older).³

In New Mexico in 2016 – 2017, adults with a cognitive disability (25.6%) were three times more likely to experience a completed or attempted rape their lifetime than those without a cognitive disability (9.2%).⁴

Almost two-thirds (65.4%) of rape/sexual assaults against those with disabilities, were perpetrated against those with multiple disabilities, and one-third (34.6%) against those with a single disability. The rate of rape/sexual assault among persons with multiple disabilities (2.8 per 1000 persons age 12 and

older) was twice the rate of rape/sexual assault among persons with a single disability (1.4 per 1000 persons age 12 and older). Those with multiple disabilities reported the highest rate of having experienced a completed or attempted sexual assault in their lifetime (65.4%).⁴

In New Mexico in 2018, 44% of rape victims who sought assistance at statewide sexual assault service provider agencies and 29% of rape patients at statewide SANE programs had a disability.⁵ Because the lifetime and annual rates of sexual violence among persons with disability compared to those without disability are quite dramatic, research regarding the similarities and differences in the experience of sexual violence between those survivors in New Mexico with a cognitive/mental disability and those without disability may reveal the specific service needs of survivors in New Mexico with a mental/cognitive disability and the challenges of accessing and obtaining services needed for effective recovery from their trauma.

To this end, a retrospective review of statewide SANE data (2004-2018) and statewide sexual assault service provider data (2003-2017) was examined to compare the experience of sexual assault between survivors with a mental/cognitive disability and survivors with no reported disability.

In order to obtain a statistically large enough dataset of SANE patients with a mental/cognitive disability, 15 years of SANE data was analyzed, 2004-2018. There were 2,288 SANE patients with a mental/cognitive disability. The dataset examined for SANE patients with no reported disability covered a subset of five years, 2014-2018, as the size of the subset was sufficient to yield a statistically large sample. There were 4,250 SANE patients with no reported disability. All figures representing findings of the comparisons will state a time frame of 2004-2018.

Similarly, in order to obtain a statistically large enough dataset of service provider survivors with a mental/cognitive disability, 15 years of service provider data was analyzed, 2003-2017. There were 3,586 survivors with a mental/cognitive disability. The dataset examined for service provider survivors with no reported disability covered a subset of five years, 2013-2017 as the size of the subset was sufficient to yield a statistically large enough sample. There were 4,022 service provider survivors with no reported disability. All figures representing findings of the comparisons will state a time frame of 2003-2017.

II. SANE DATA FINDINGS

A. Survivor Gender

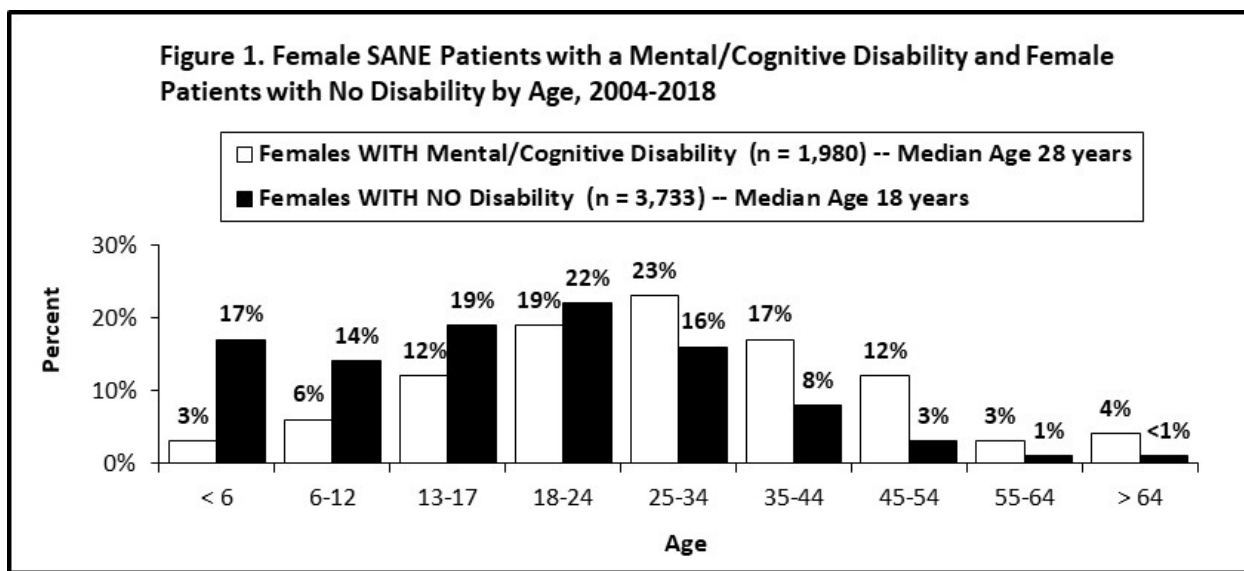
Survivor gender was examined among survivors with a mental/cognitive disability and survivors with no reported disability who were served by statewide SANE programs. The rate of victimization among female survivors with a mental/cognitive disability (88%) represents a negligible difference to the rate of victimization among females with no reported disability (86%).

B. Survivor Age

The median age of SANE patients with a mental/cognitive disability is 27 years old. The median age of SANE *female* patients with a mental/cognitive disability is 28 years old. The median age of SANE female patients with no reported disability is 18 years old. A significantly greater proportion of female SANE patients with no reported disability were victimized by age 24 (72%) than females with a mental/cognitive disability (40%). Nearly one-third (31%) of female SANE patients with no reported

disability were children (<13), compared to 9% of female SANE patients with a mental/cognitive disability. See **Figure 1**.

Conversely, a significantly greater proportion of female SANE patients with a mental/cognitive disability, were ages 25 and older, (60%) compared to females with no reported disability (28%). Four times as many female SANE patients with a mental/cognitive disability were ages 45-54 (12%), compared to females with no reported disability (3%). Refer to Figure 1.



The median age of SANE patients with no reported disability is 17 years old. The median age of SANE *male* SANE patients with no reported disability is 8 years old. The median age of SANE male patients with a mental/cognitive disability is 22 years old. A significantly greater proportion of male SANE patients with no reported disability were victimized by age 12 (62%) than males with a mental/cognitive disability (25%). More male SANE patients with a mental cognitive disability were adolescents (12%), compared to those with no reported disability (9%). Approximately twice as many male SANE patients with a mental/cognitive disability were ages 18-44 (53%), compared to those with no reported disability (27%). Three times as many male SANE patients with a mental/cognitive disability were ages 45-54 (6%), compared to males with no reported disability (2%). See **Figure 2**.

C. Survivor Race/Ethnicity

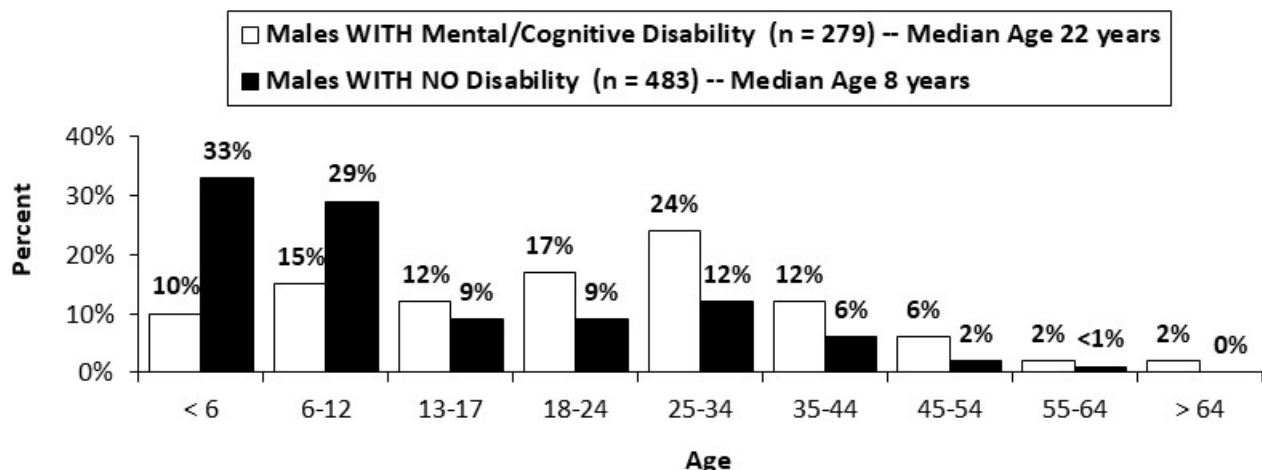
White (non-Hispanic) survivors (38%) and Black survivors (4%) are significantly more represented among patients with a mental/cognitive disability than patients with no reported disability, 27% and 2%, respectively. Conversely, Hispanic survivors are significantly more represented among patients with no reported disability (49%) than patients with a mental/cognitive disability (38%). See **Figure 3**.

D. Offender Gender and Age

While most offenders of SANE patients with a mental/cognitive disability and with no reported disability are male (97%, respectively), and adults (18 and older) (92% and 83%, respectively), more survivors with a mental/cognitive disability (12%) than those with no reported disability (7%), were victimized by an

adolescent offender. Additionally, while child offenders are few compared to adolescent and adult offenders, more survivors with no reported disability (5%) were victimized by a child offender, than survivors with a mental/cognitive disability (1%).

Figure 2. Male SANE Patients with a Mental/Cognitive Disability and Male Patients with No Disability by Age, 2004-2018



E. Survivor/Offender Relationship

Three-quarters (75%) of child SANE patients with no reported disability compared to two-thirds (65%) of child SANE patients with a mental/cognitive disability were assaulted by a family member. See **Figure 4**. Slightly more child (3%), adolescent (20%) and adult (29%) SANE patients with a mental/cognitive disability were assaulted by a stranger, than child (2%), adolescent (15%), and adult (25%) SANE patients with no reported disability. Refer to Figure 4. See **Figures 5 and 6**.

Figure 3. Survivor Race/Ethnicity Among SANE Patients with a Mental/Cognitive Disability and Among Patients with No Disability, 2004-2018

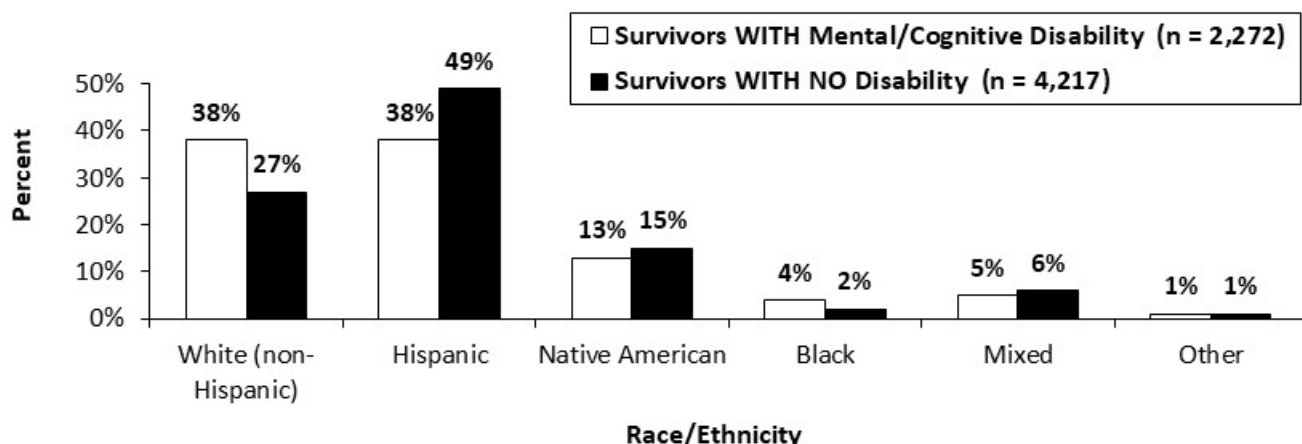


Figure 4. Victim/Offender Relationship Among Child (Age <13) SANE Patients with a Mental/Cognitive Disability and Child Patients with No Disability, 2004-2018

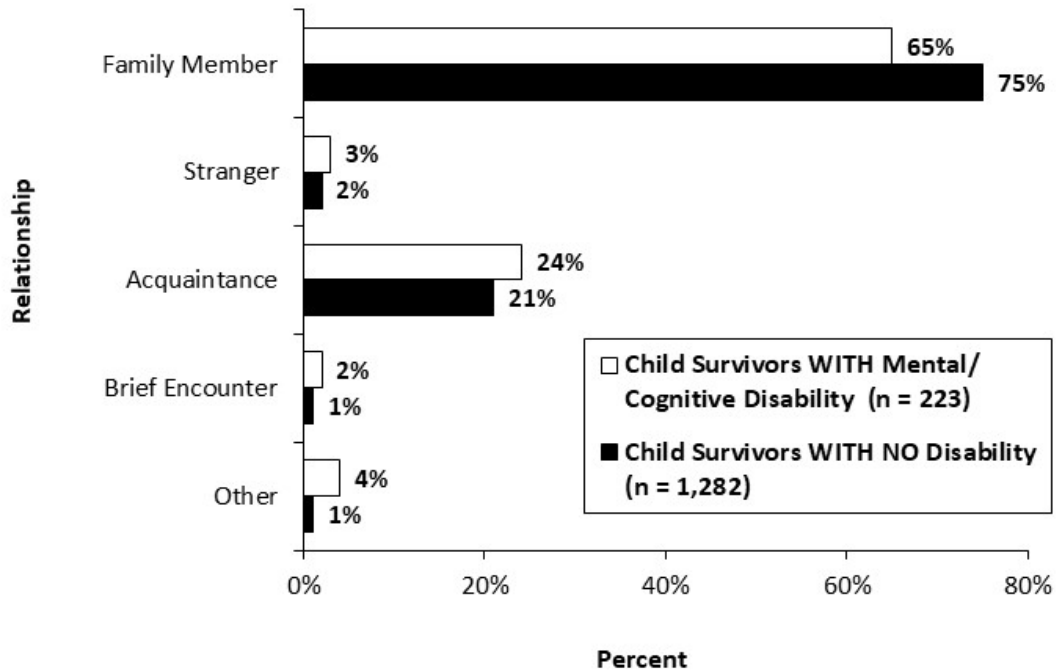


Figure 5. Victim/Offender Relationship Among Adolescent (Age 13-17) SANE Patients with a Mental/Cognitive Disability and Adolescent Patients with No Disability, 2004-2018

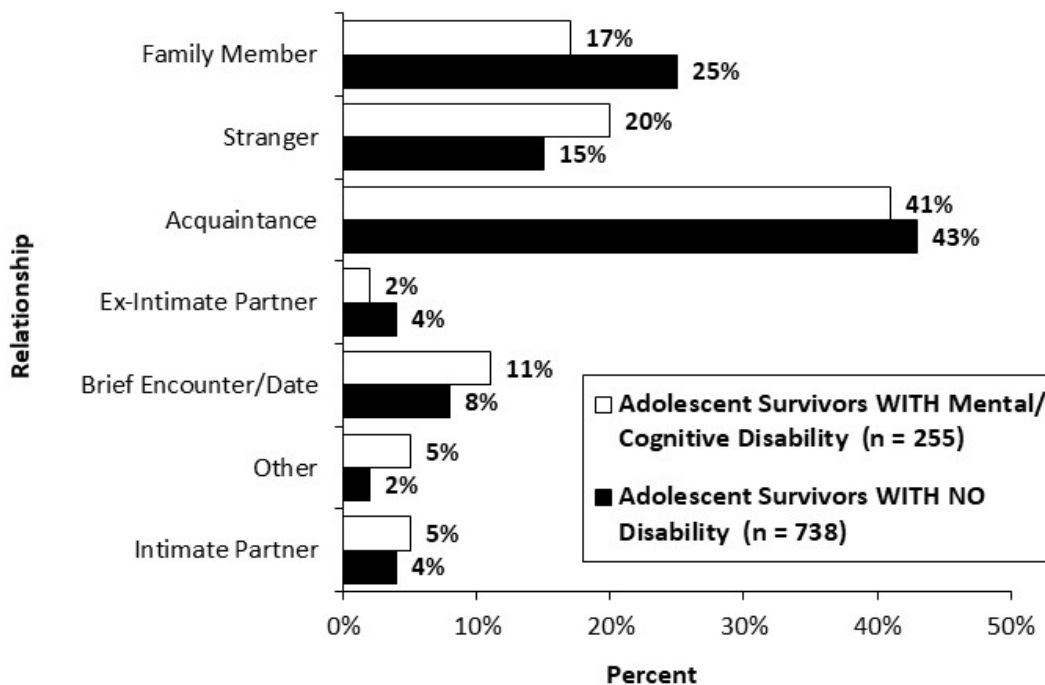
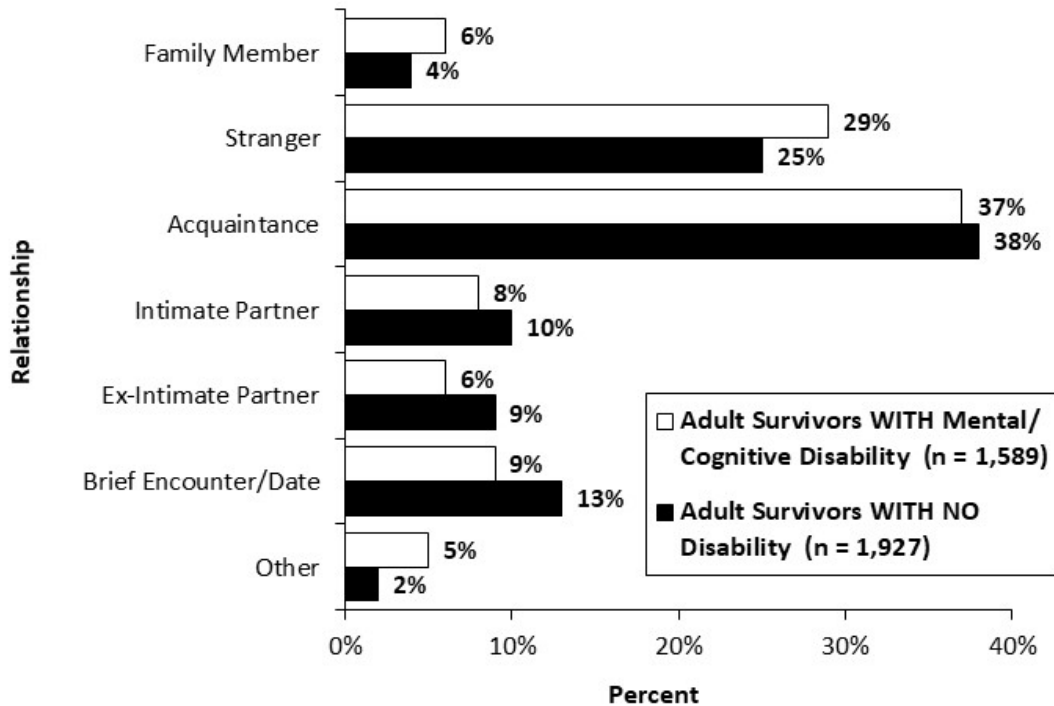


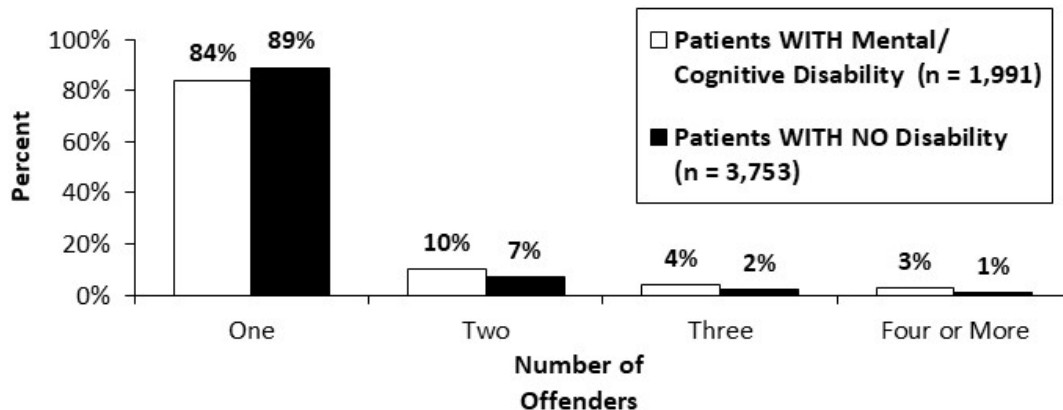
Figure 6. Victim/Offender Relationship Among Adult (Age >17) SANE Patients with a Mental/Cognitive Disability and Adult Patients with No Disability, 2004-2018



F. Number of Offenders

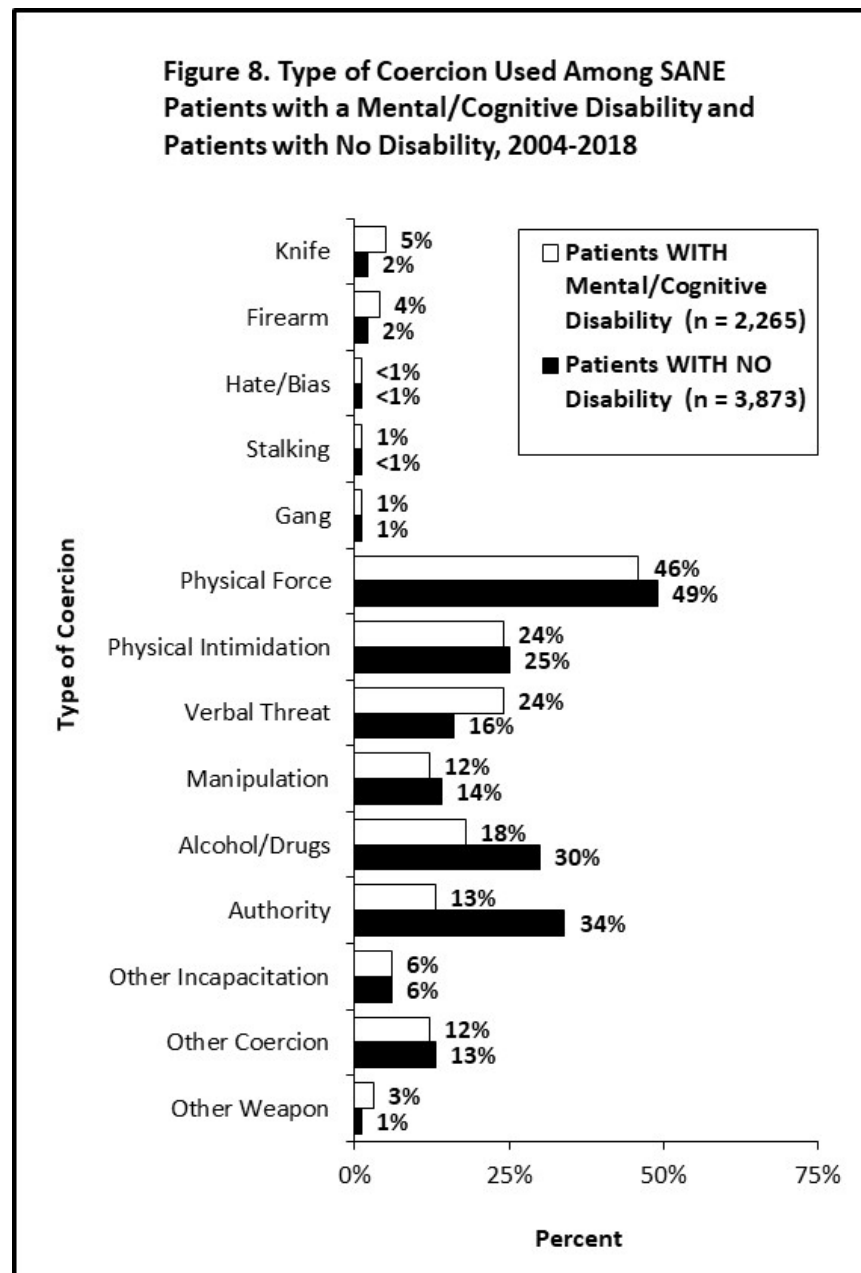
Of the SANE patients with a mental/cognitive disability, 17% were assaulted by multiple offenders compared to 10% of SANE patients with no reported disability. See **Figure 7**.

Figure 7. Number of Offenders Involved in Sexual Assault Offenses Among SANE Patients with a Mental/Cognitive Disability and Patients with No Disability, 2004-2018



G. Type of Coercion Used

Significantly more sexual assaults involving SANE patients with no reported disability involved the use of alcohol/drugs (30%) and a person of authority (34%) than patients with a mental/cognitive disability - alcohol/drugs (18%); person of authority (13%). Conversely, significantly more sexual assaults involving SANE patients with a mental/cognitive disability involved the use of verbal threats (24%) and a weapon (12%) than patients with no reported disability (16% and 5%, respectively). See **Figure 8**.



1. Type of Coercion by Survivor Age

When examined by age, significantly more child SANE patients with no reported disability (82%), than child patients with a mental/cognitive disability (72%) were coerced by a person in authority. See **Figure 9**. Similarly, significantly more adolescent SANE patients with no reported disability than adolescent patients with a mental/cognitive disability were coerced by alcohol/drugs (30% and 24%, respectively); and a person of authority (32% and 22%, respectively). Conversely, significantly more adolescent SANE patients with a mental/cognitive disability than adolescent patients with no reported disability were coerced by verbal threat (32% and 12%, respectively); physical intimidation (30% and 24%, respectively); and *other* means of coercion (20% and 11%, respectively). See **Figure 10**.

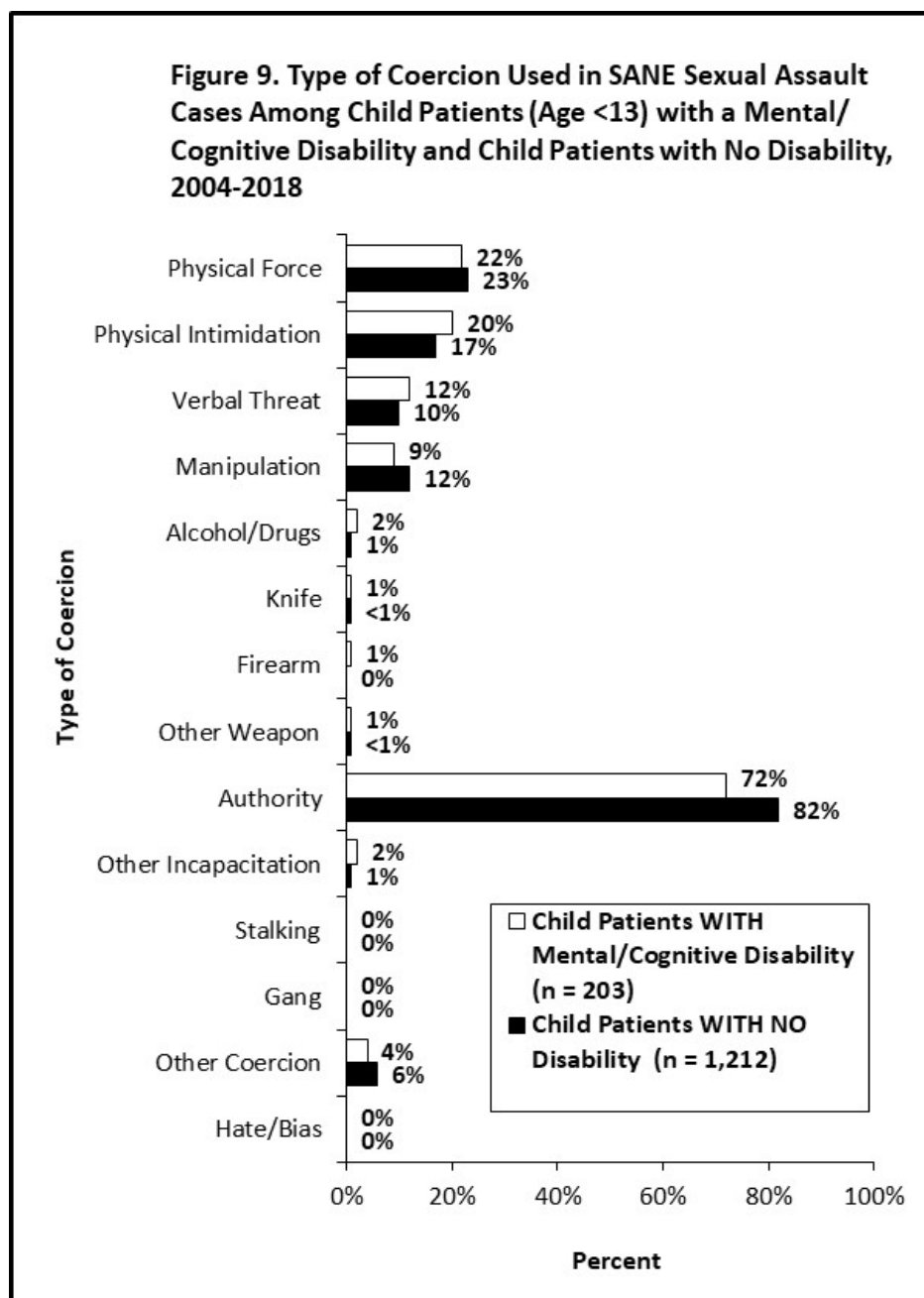
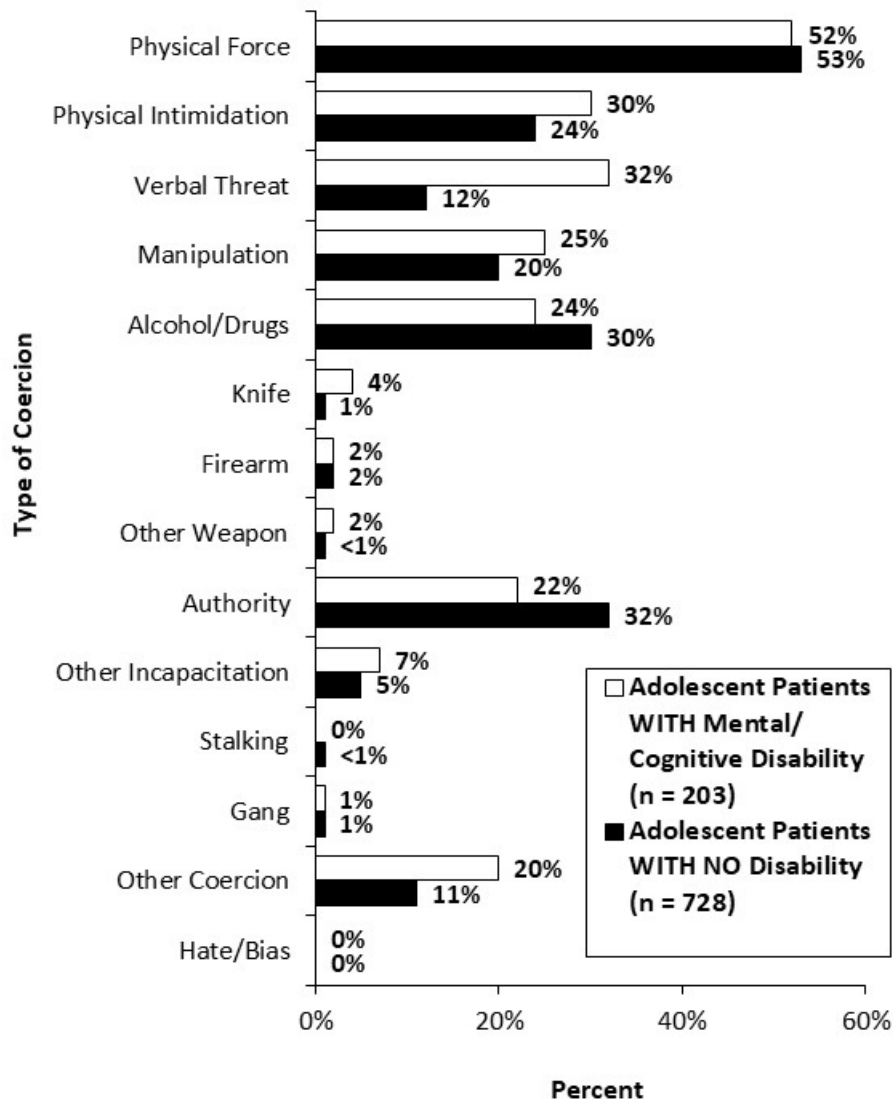
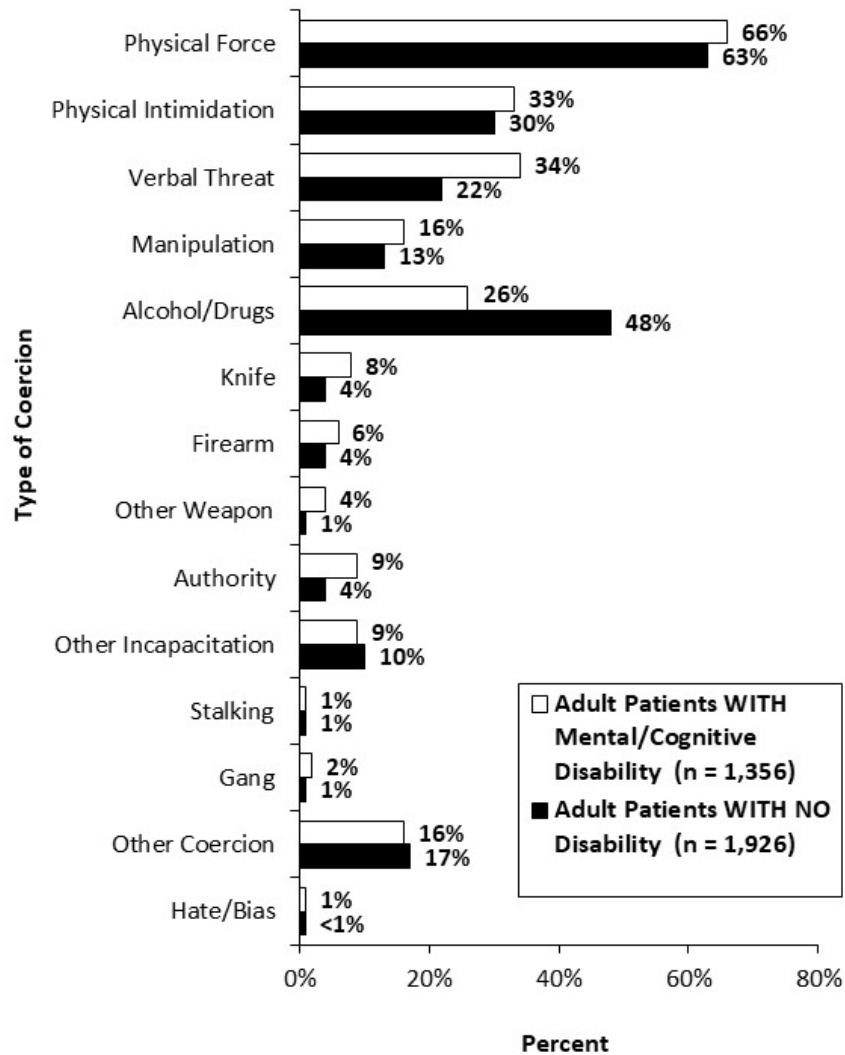


Figure 10. Type of Coercion Used in SANE Sexual Assault Cases Among Adolescent Patients (Age 13-17) with a Mental/Cognitive Disability and Adolescent Patients with No Disability, 2004-2018



Among adult SANE patients, twice as many survivors with a mental/cognitive disability were coerced with a knife (8%), as adult patients with no reported disability (4%). Similarly, significantly more adult patients with a mental/cognitive disability were coerced by verbal threat (34%) than adult patients with no reported disability (22%). Conversely, significantly more adult patients with no reported disability were coerced by alcohol/drugs (48%), than adult patients with a mental/cognitive disability (26%). See **Figure 11**.

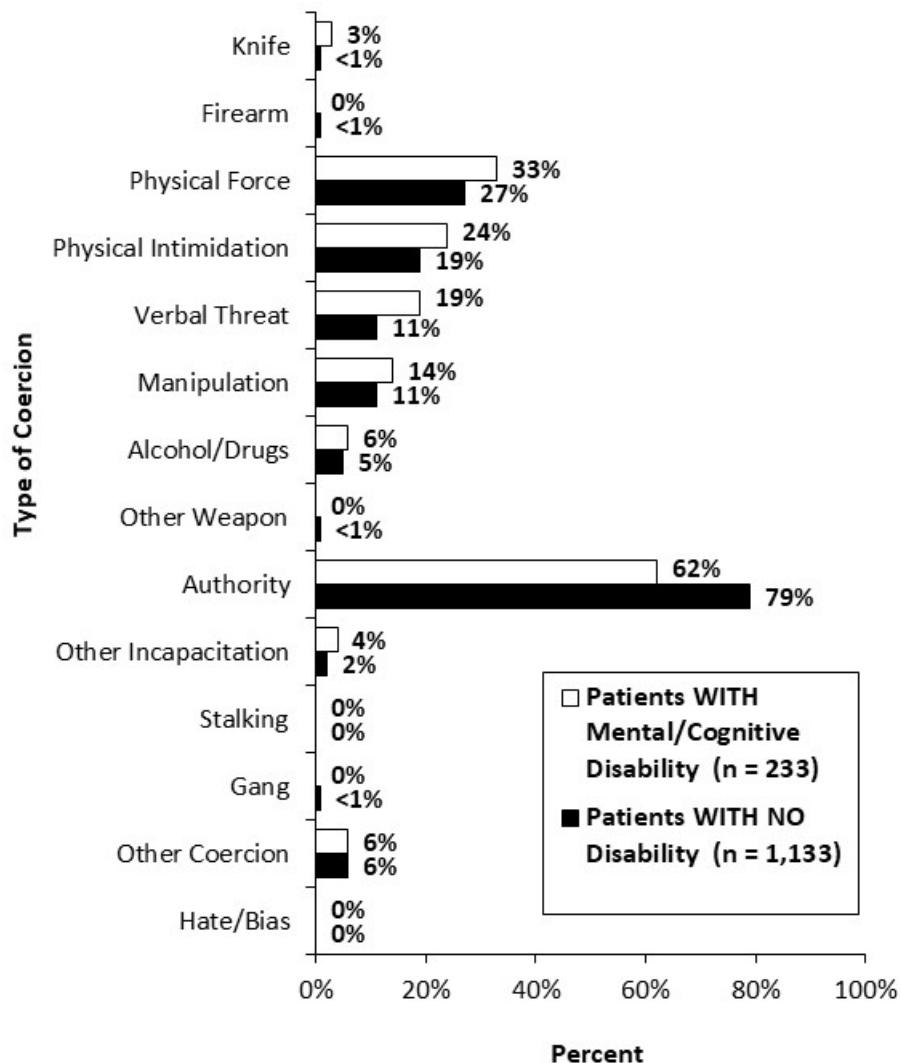
Figure 11. Type of Coercion Used in SANE Sexual Assault Cases Among Adult Patients (Age >17) with a Mental/Cognitive Disability and Adult Patients with No Disability, 2004-2018



2. Type of Coercion by Survivor/Offender Relationship

The type of coercion used most by *family-member* offenders was coercion from a *person of authority* among SANE patients with a mental/cognitive disability (62%) and patients and with no reported disability (79%). The type of coercion next most frequently used by a family-member offender was physical force. It was used in 33% of family member assaults on SANE patients with a mental/cognitive disability and 27% on SANE patients with no reported disability. Except for a *person in authority*, family-member offenders used all other types of coercion in greater proportions among SANE patients with a mental/cognitive disability than patients with no reported disability. See **Figure 12**.

Figure 12. Type of Coercion Used by a Family Member Offender Among SANE Patients with a Mental/Cognitive Disability and Patients with No Disability, 2004-2018



The type of coercion used most by *other-known* offenders was physical force among SANE patients with a mental/cognitive disability (63%) and patients with no reported disability (59%). Alcohol/drugs was used significantly more among SANE patients with no reported disability (37%) than patients with a mental/cognitive disability (25%). Similarly, other-known offenders used a *person of authority* slightly more among SANE patients with no reported disability (16%) than patients with a mental/cognitive disability (12%). Other-known offenders used manipulation equally among SANE patients with a mental/cognitive disability and with no reported disability (18%, respectively). Similarly, other-known offenders used *other unspecified types of incapacitation* equally among SANE patients with a mental/cognitive disability and with no reported disability (7%, respectively). Other-known offenders

used all other types of coercion in greater proportions among SANE patients with a mental/cognitive disability than patients with no reported disability. See **Figure 13**.

The type of coercion used most by *stranger* offenders was physical force among SANE patients with a mental/cognitive disability (71%) and patients with no reported disability (62%). Similarly, verbal threat (36%) and physical intimidation (35%) were used in significantly greater proportions in assaults among SANE patients with a mental/cognitive disability, than patients with no reported disability (22% and 27%, respectively). Stranger offenders were two times more likely to use a knife among patients with a mental/cognitive disability (12%) than with no reported disability (6%). Conversely, stranger offenders used alcohol/drugs significantly more in assaults among SANE patients with no reported disability (47%) than patients with a mental/cognitive disability (26%). See **Figure 14**.

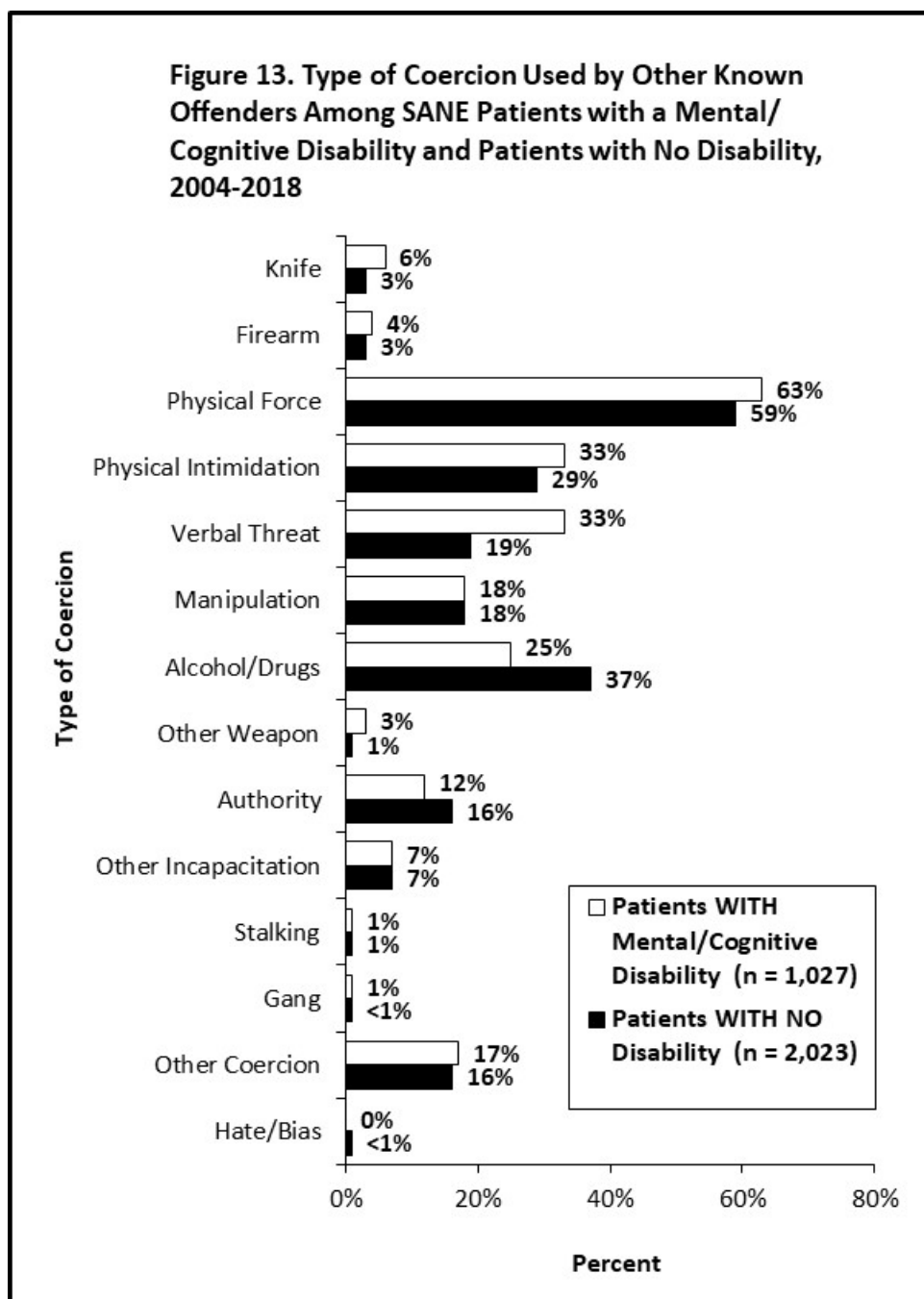
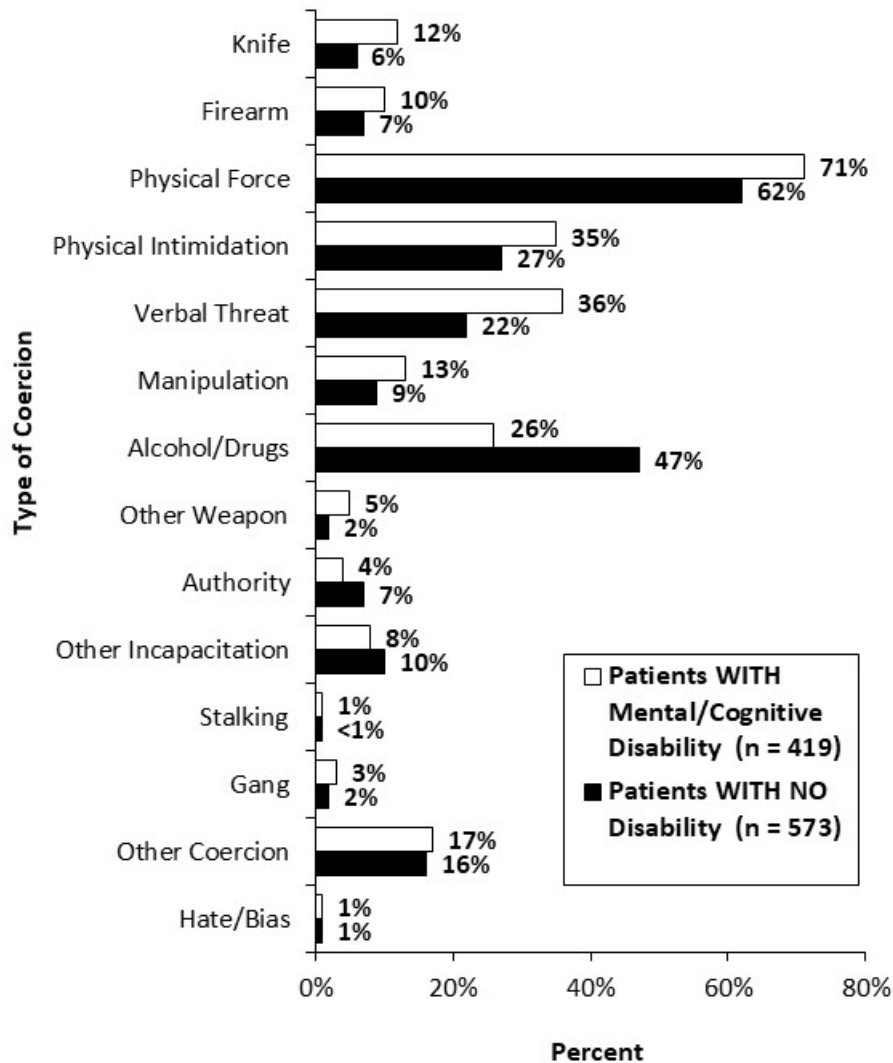


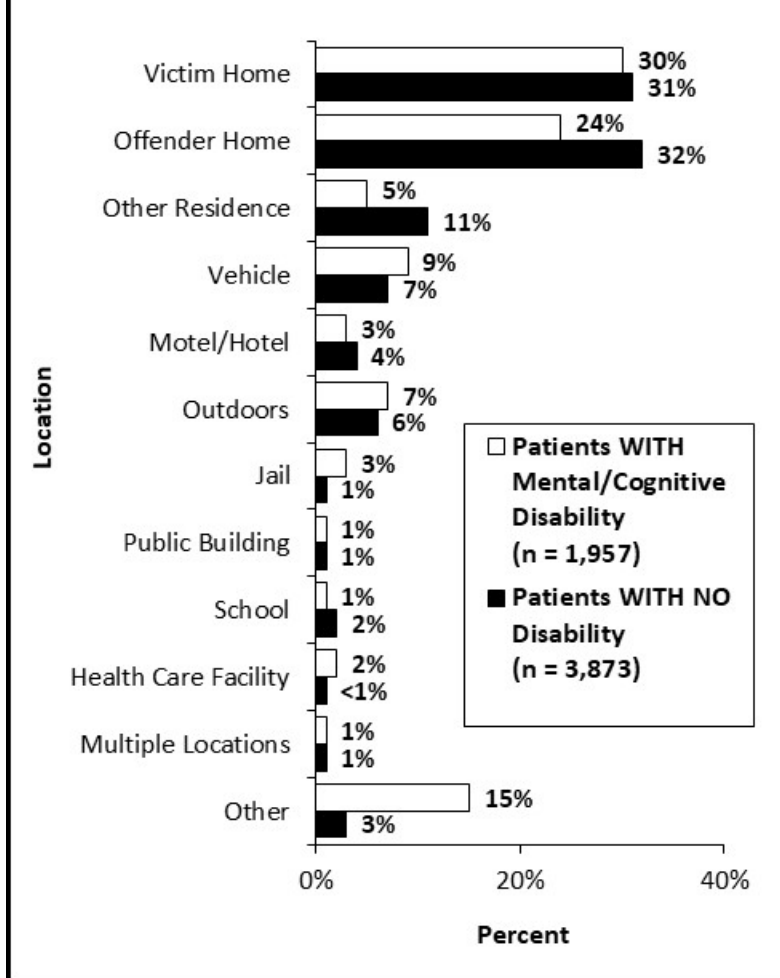
Figure 14. Type of Coercion Used by Stranger Offenders Among SANE Patients with a Mental/Cognitive Disability and Patients with No Disability, 2004-2018



H. Assault Location

SANE patients with a mental/cognitive disability were assaulted most frequently in their own homes (30%), followed by the offender's home (24%), and a vehicle (9%). SANE patients with no reported disability were assaulted most frequently in the offender's home (32%), followed closely by the victim's home (31%), and other residence (11%). See **Figure 15**.

Figure 15. Location of Sexual Offenses Among SANE Patients with a Mental/Cognitive Disability and Patients with No Disability, 2004-2018



I. Injury

Injuries were observed significantly more among SANE patients with a mental/cognitive disability (78%) than patients with no reported disability (63%). Injuries occurred significantly more in adolescent (75%) and child (38%) SANE patients with a mental/cognitive disability, than adolescent (62%) and child (30%) SANE patients with no reported disability. See **Figure 16**.

Over three times as many child SANE patients (age <13) with a mental/cognitive disability incurred rectal injuries (33%), as child patients with no reported disability (10%). Conversely, over three times as many child SANE patients with no reported disability incurred strangulation injuries (7%), oral injuries (4%), and other unspecified injuries (27%), as child SANE patients with a mental/cognitive disability (2%, 1%, and 8% respectively). Almost three times as many child SANE patients with no reported disability incurred head/neck injuries (21%), as child patients with a mental/cognitive disability (8%). See **Figure 17**.

Figure 16. Injury Among SANE Patients with a Mental/Cognitive Disability and Patients with No Disability, by Age, 2004-2018

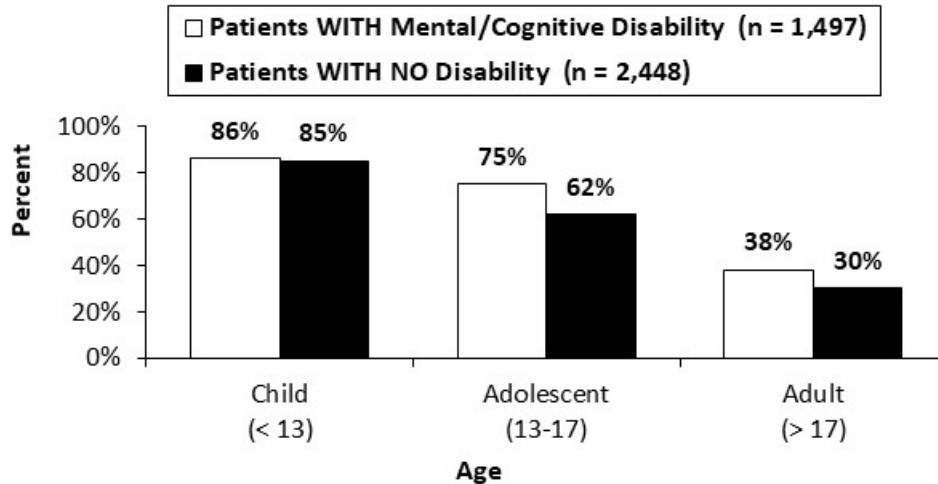
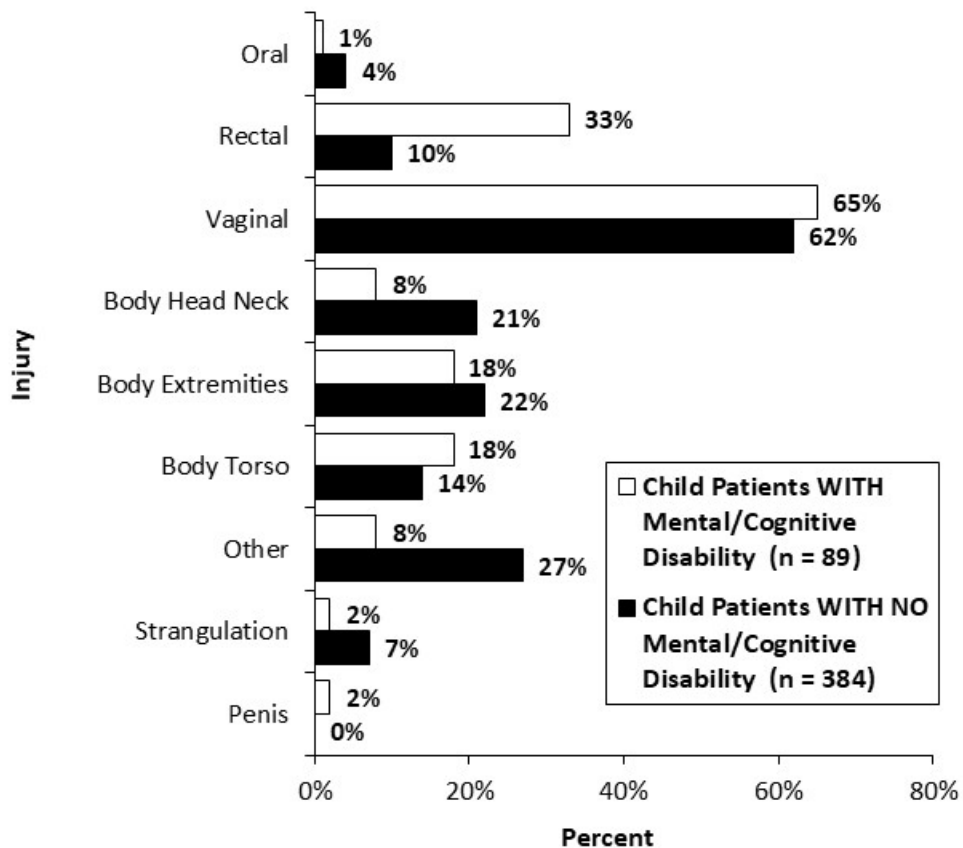
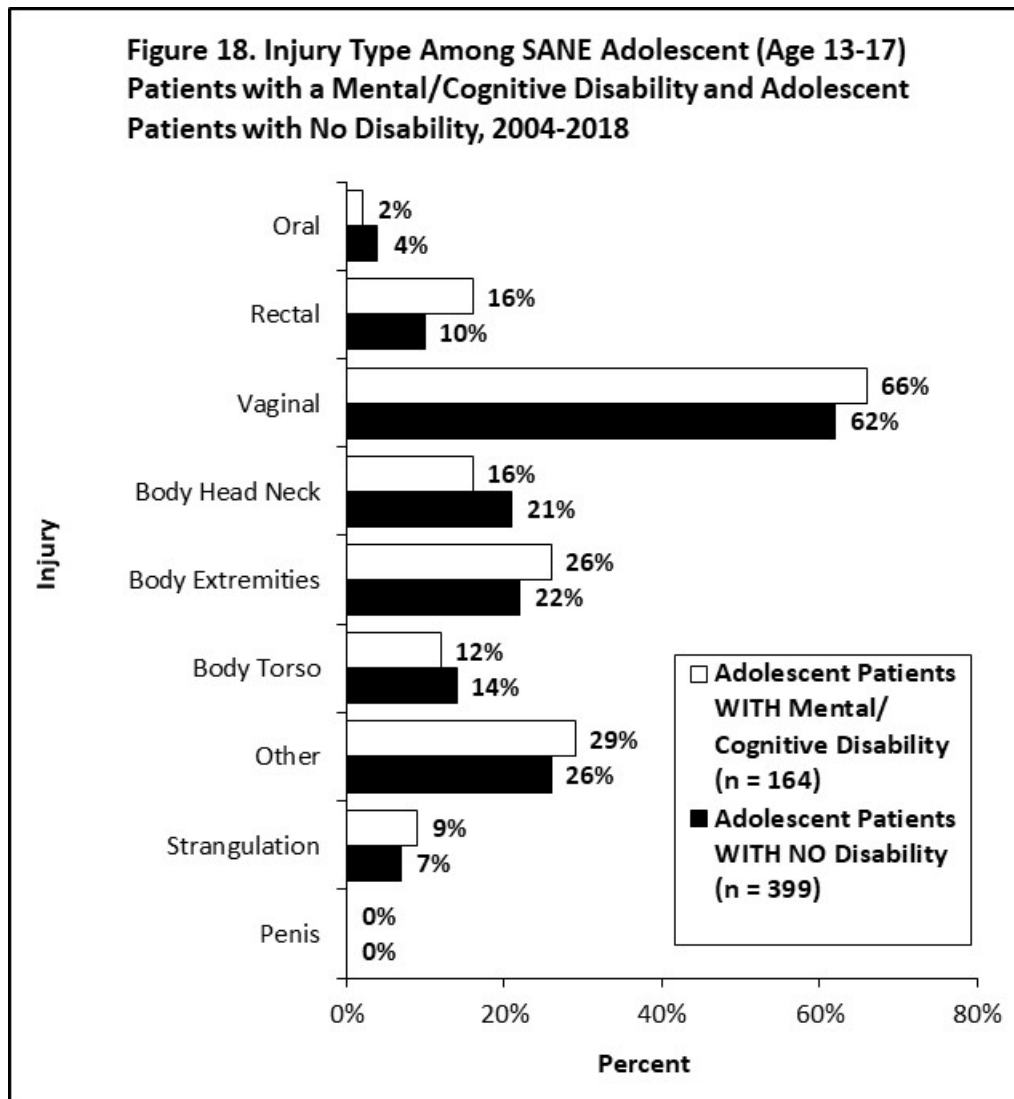


Figure 17. Injury Type Among SANE Child (Age <13) Patients with a Mental/Cognitive Disability and Child Patients with No Disability, 2004-2018

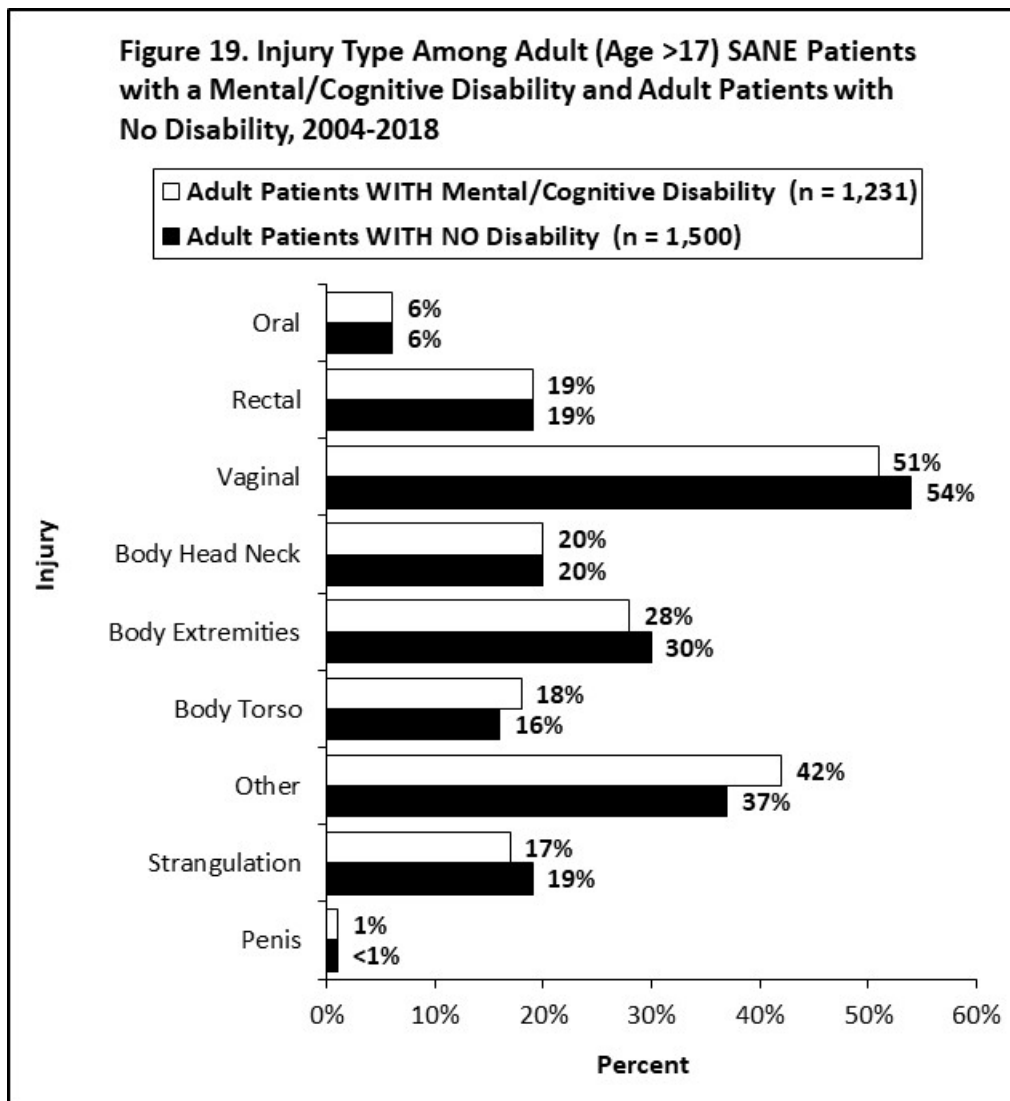


Slightly more adolescent patients (ages 13-17) with a mental/cognitive disability experienced rectal (16%), vaginal (66%), strangulation (9%), other unspecified injuries (29%), and injuries to their extremities (26%), than adolescent patients with no reported disability: rectal (10%), vaginal (62%), strangulation (7%), other unspecified injuries (26%) and extremities (22%). Conversely, more adolescent SANE patients with no reported disability experienced oral (4%), head/neck (21%), and injuries to their torso (14%), than adolescent patients with a mental/cognitive disability: oral (2%), head/neck (16%), and torso (12%). See **Figure 18**.



Adult (ages >17) SANE patients with a mental/cognitive disability and with no disability experienced oral injuries (6%, respectively), rectal injuries (19%, respectively), and head/neck injuries (20%, respectively) in equal proportions. Slightly more adult SANE patients with a mental/cognitive disability experienced injuries to the torso (18%) and other unspecified injuries (42%), than adult SANE patients with no

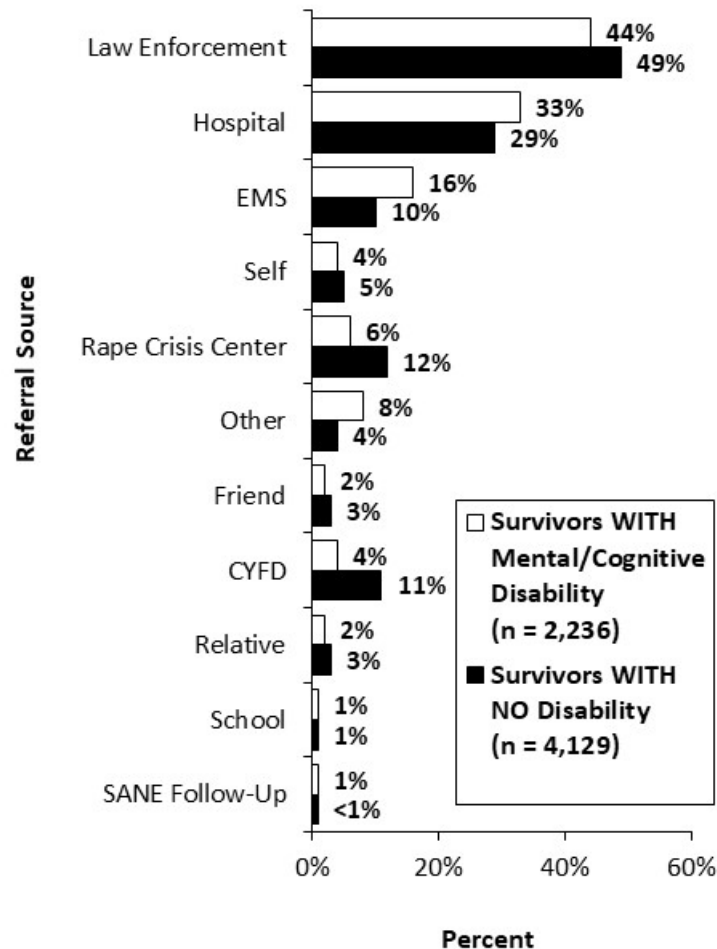
disability: torso (16%) and other unspecified injuries (37%). Conversely, adult SANE patients with no reported disability experienced slightly more vaginal injuries (54%), injuries to the extremities (30%) and strangulation injuries (19%) than adult patients with a mental/cognitive disability: vaginal (51%), extremities (28%), and strangulation (17%). See **Figure 19**.



J. Referrals to SANE

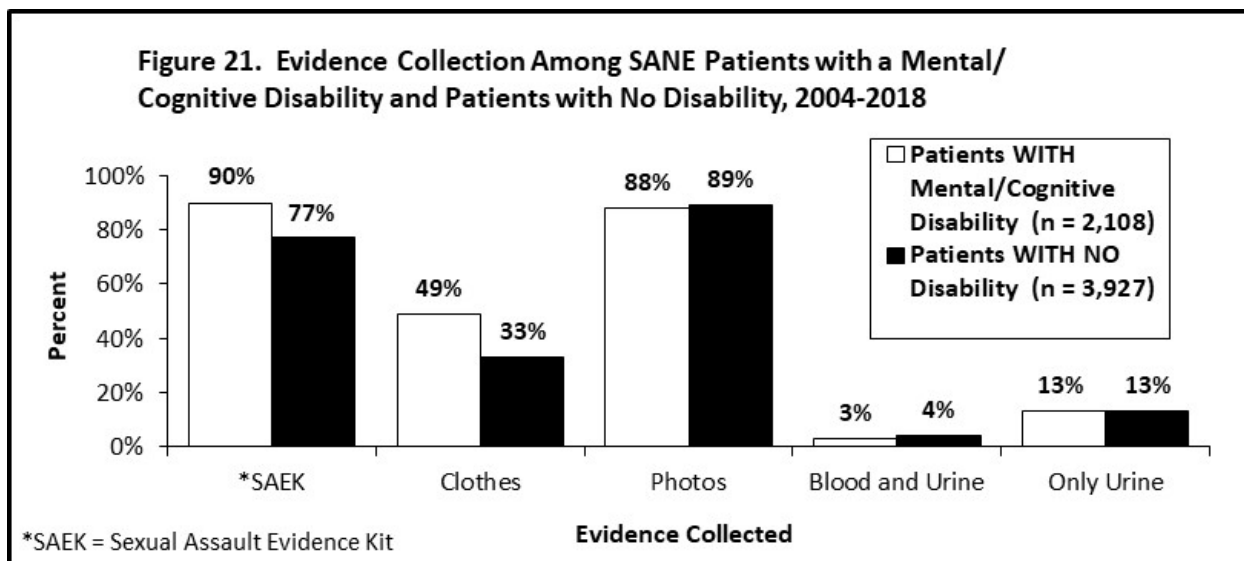
More sexual assault survivors with a mental/cognitive disability were referred to SANE from Hospitals (33%) and EMS (16%), than survivors with no reported disability (29% and 10%, respectively). Conversely, more sexual assault survivors with no reported disability were referred to SANE from law enforcement (49%), rape crisis centers (12%) and CYFD (11%), than survivors with a mental/cognitive disability: law enforcement (44%), rape crisis centers (6%), and CYFD (4%). See **Figure 20**.

Figure 20. Referral of Sexual Assault Survivors with a Mental/Cognitive Disability and Survivors with No Disability to SANE, 2004-2018

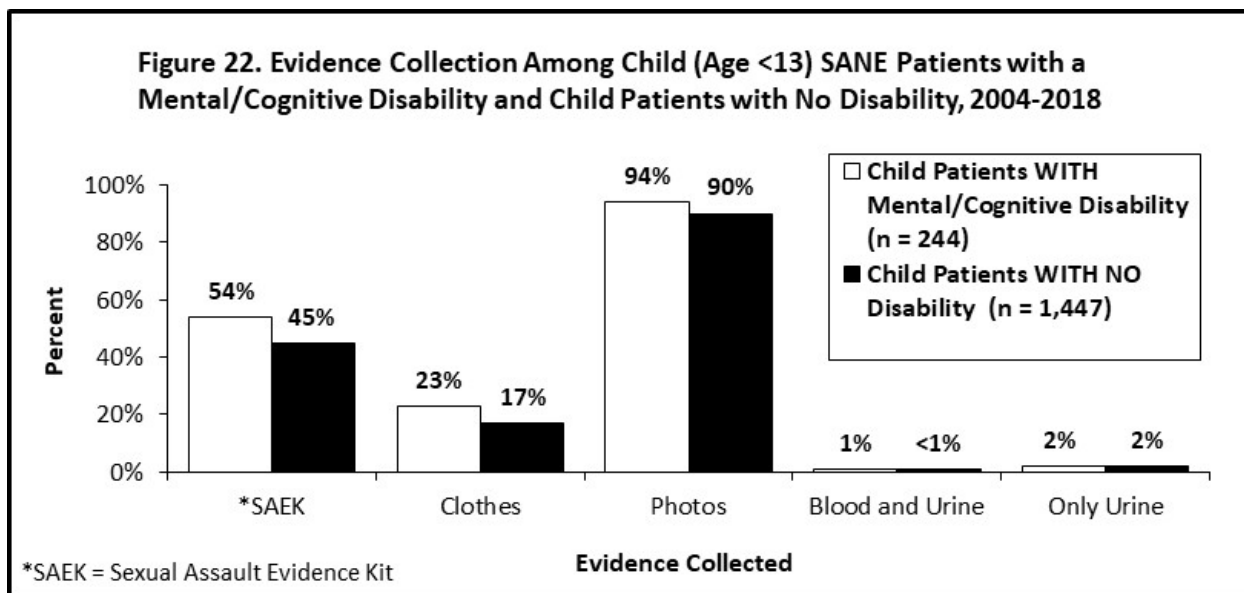


K. Forensic Evidence Collection

Forensic evidence was collected in equal proportions (92%, respectively) among SANE sexual assault survivors with a mental/cognitive disability and with no reported disability. Significantly more SANE patients with a mental/cognitive disability had rape kit evidence (90%) and clothes (49%) collected than patients with no reported disability (77% and 33%, respectively). See **Figure 21**. This disparity was true for all age groups: child, adolescent and adult patients, with the greatest disparity found among adolescents.

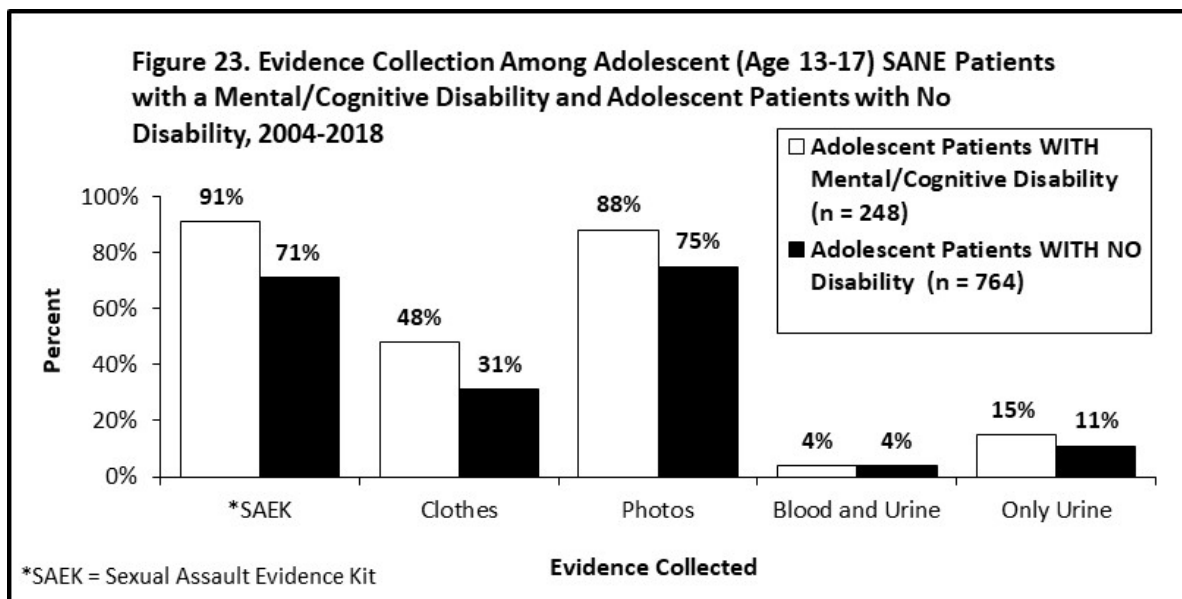


The largest disparity in evidence collection among child SANE patients was found in the collection of rape kit evidence. Significantly more child patients with a mental/cognitive disability (54%) had rape kit evidence collected than child patients with no reported disability (45%). See **Figure 22**.

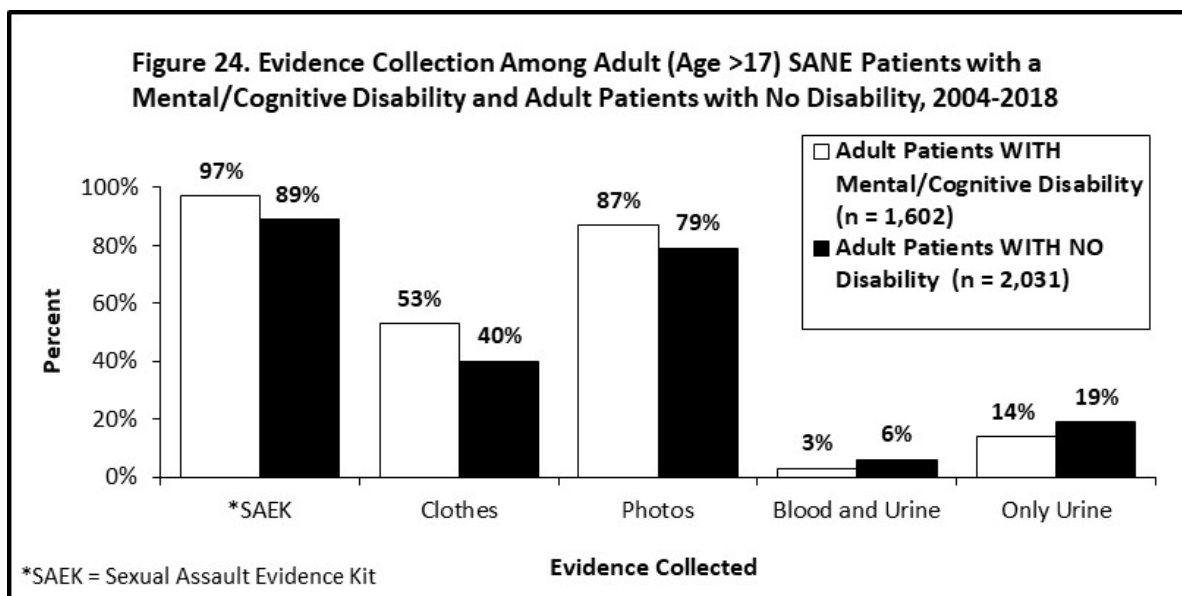


Among adolescent and adult SANE patients, there was significant disparity found in the collection of rape kit evidence, clothes, and photos taken. The greatest disparity in evidence collection among adolescent SANE patients was found in the collection of rape kit evidence. Significantly more adolescent patients with a mental/cognitive disability (91%) had rape kit evidence collected than adolescent patients with no reported disability (71%). A significant disparity was also found in the collection of clothes among adolescent SANE patients. Almost half (48%) of adolescent SANE patients with a

mental/cognitive disability had their clothes collected compared to one-third (31%) of adolescent SANE patients with no reported disability. Additionally, photos were taken among 88% of adolescent SANE patients with a mental/cognitive disability compared to 75% with no reported disability. See **Figure 23**.

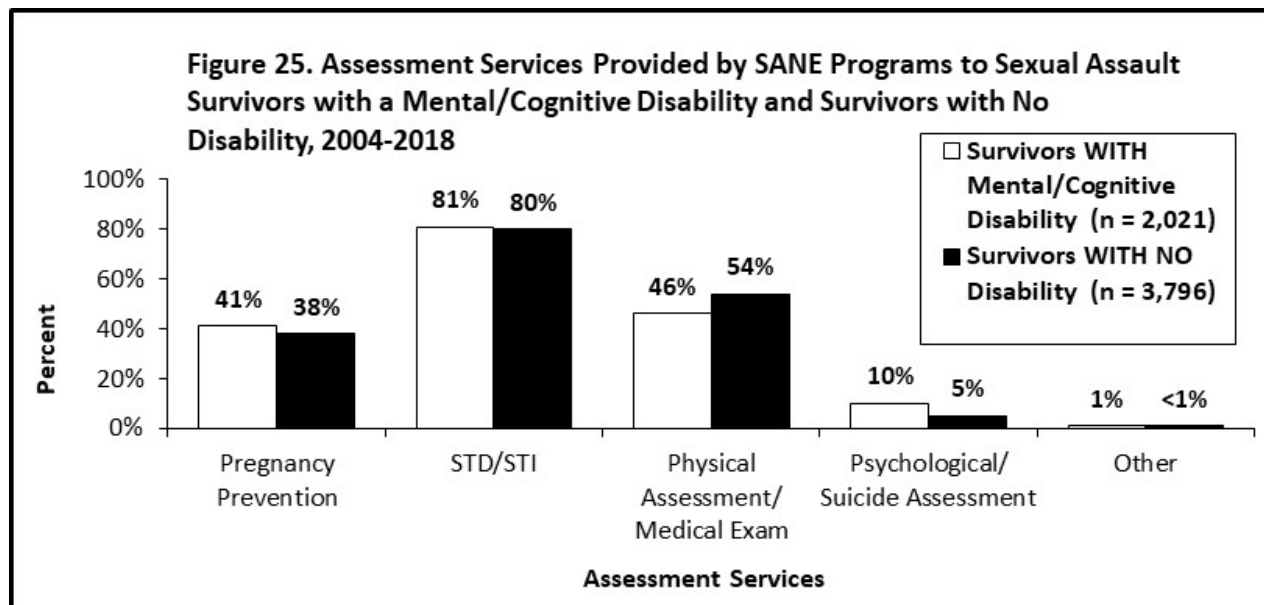


Significantly more adult SANE patients with a mental/cognitive disability had clothes collected (53%), rape kit evidence (97%) and photos (87%) than adult SANE patients with no reported disability: clothes (40%), rape kit evidence (89%) and photos (79%). See **Figure 24**.



L. Assessment Services Provided

Assessment services were provided to 89% of SANE patients with no reported disability and 88% of patients with a mental/cognitive disability. However, twice as many SANE patients with a mental/cognitive disability (10%) as patients with no reported disability (5%) obtained psychological/suicide assessment. Conversely, more patients with no reported disability (54%) compared to patients with a mental/cognitive disability (46%), obtained a physical exam/medical assessment. See **Figure 25**.



When assessment services were examined by patient age, child (56%), adolescent (93%), and adult (92%) SANE patients with no reported disability were significantly more likely to receive treatment for sexually transmitted diseases compared to child (42%), adolescent (83%), and adult (87%) SANE patients with a mental/cognitive disability. See **Figures 26, 27 and 28**.

Understandably, pregnancy prevention/contraception services for child SANE patients are provided less frequently compared to adolescent and adult patients. However, significantly more child SANE patients with a mental/cognitive disability (5%) obtained this service compared to child patients with no reported disability (1%). Refer to Figure 26. Almost twice as many adolescent (13%) and adult (11%) SANE patients with a mental/cognitive disability obtained psychological/suicide assessment than adolescent (7%) and adult (6%) patients with no reported disability. Refer to Figures 27 and 28.

Figure 26. Assessment Services Provided to Child (Age <13) SANE Patients with a Mental/Cognitive Disability and Child Patients with No Disability, 2004-2018

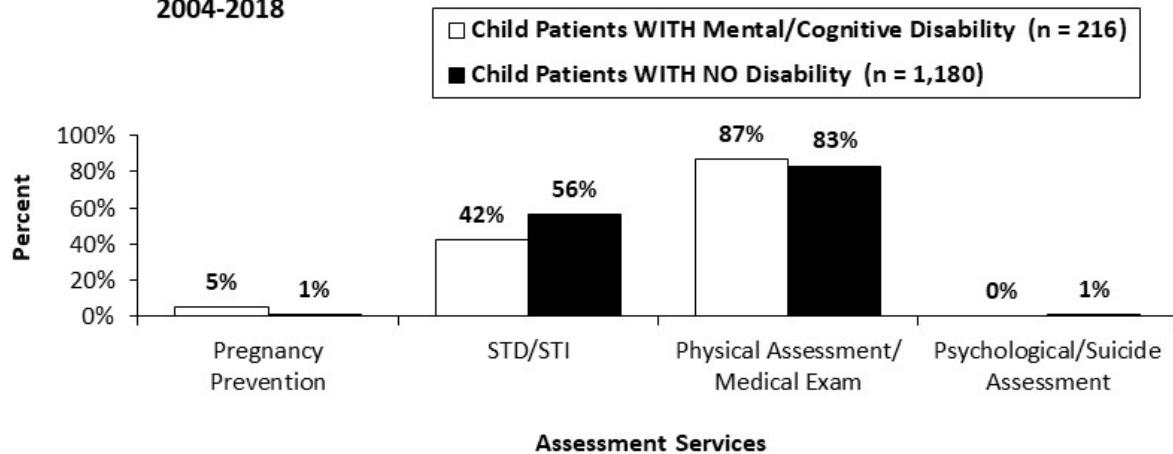


Figure 27. Assessment Services Provided to Adolescent (Age 13-17) SANE Patients with a Mental/Cognitive Disability and Adolescent Patients with No Disability, 2004-2018

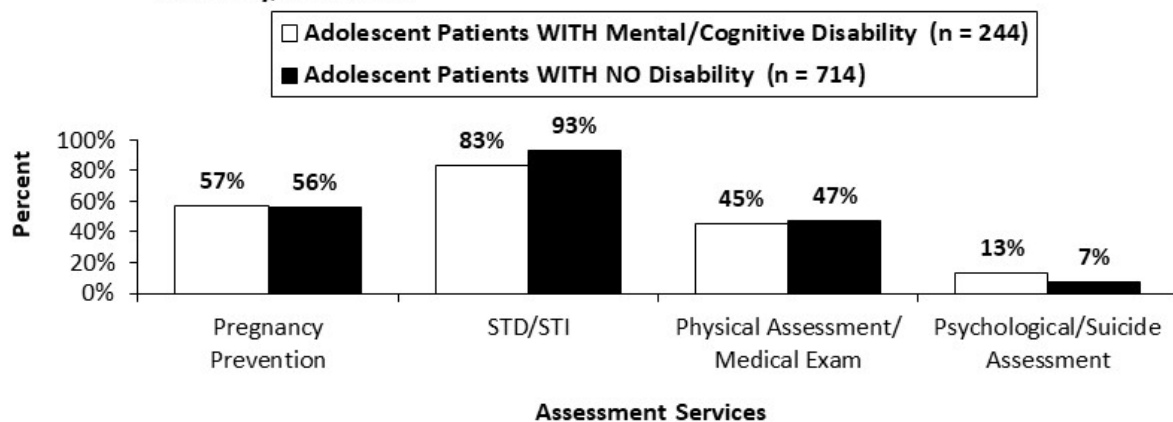
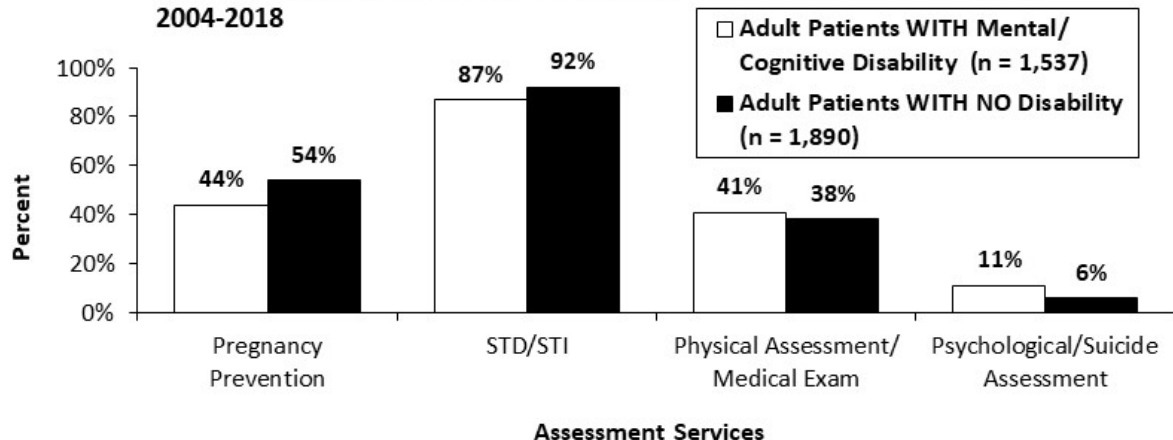
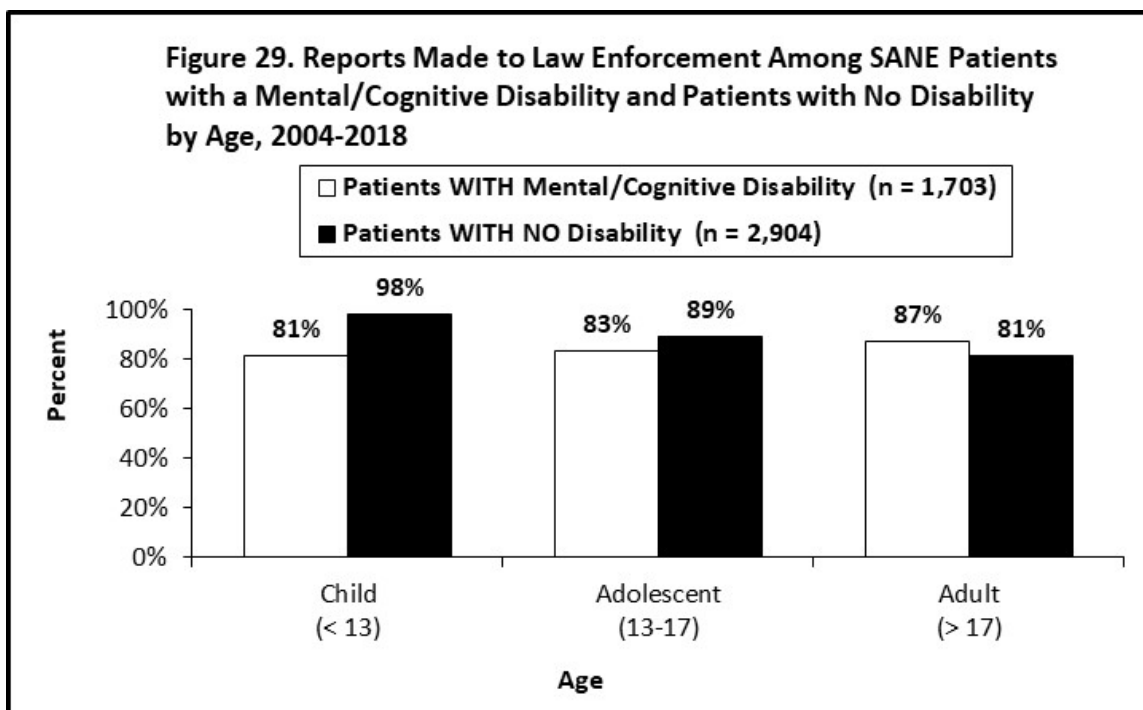


Figure 28. Assessment Services Provided to Adult (Age >17) SANE Patients with a Mental/Cognitive Disability and Adult Patients with No Disability, 2004-2018



M. Reports to Law Enforcement

A report about the sexual assault was made to law enforcement in similar proportions among SANE patients with a mental/cognitive disability (86%) and with no reported disability (85%). However, significantly more sexual assaults among child SANE patients with no reported disability (98%) were reported to law enforcement compared to sexual assault among child patients with a mental/cognitive disability (81%). See **Figure 29**.

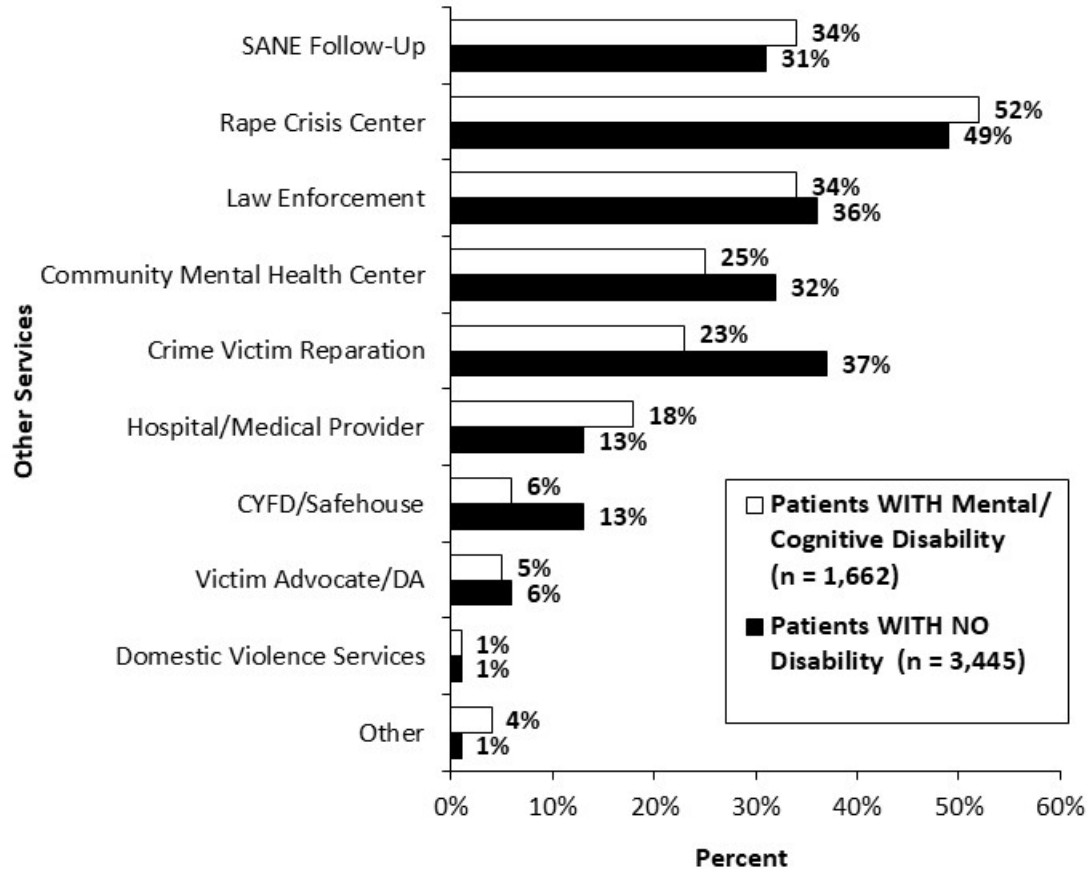


N. SANE Referrals to Other Services

Among SANE patients with no reported disability, 81% were referred to other services compared to patients with a mental cognitive disability (73%).

SANE patients with a mental/cognitive disability compared to patients with no reported disability were slightly more likely to be referred to SANE follow-up services (34% and 31%, respectively); rape crises centers (52% and 49%, respectively); hospital/medical care providers (18% and 13%, respectively); and other services (4% and 1%, respectively). SANE patients with no reported disability compared to patients with a mental/cognitive disability were slightly more likely to be referred to law enforcement (36% to 34%, respectively), and a victim advocate (6% and 5%, respectively), and significantly more likely to be referred to crime victims reparation (37% and 23%, respectively), a community mental health center (32% and 25%, respectively) and CYFD (13% and 6%, respectively). See **Figure 30**.

Figure 30. SANE Patient Referrals to Other Services Among Patients with a Mental/Cognitive Disability and Patients with No Disability, 2004-2018



III. SEXUAL ASSAULT SERVICE PROVIDER DATA FINDINGS

An examination of Sexual Assault Service Provider data was conducted to compare selective sexual assault experiences of survivors with a mental/cognitive disability and survivors with no reported disability who sought therapeutic services. These experiences include the age of survivor at time of presenting assault, age of survivor at time of therapy, time lapse between time of assault and time of presenting for therapy, history of prior sexual abuse, history of domestic violence, type of sexual offense, survivor use of alcohol/drugs, offender use of alcohol/drugs, contraction of sexually transmitted disease, and medical treatment.

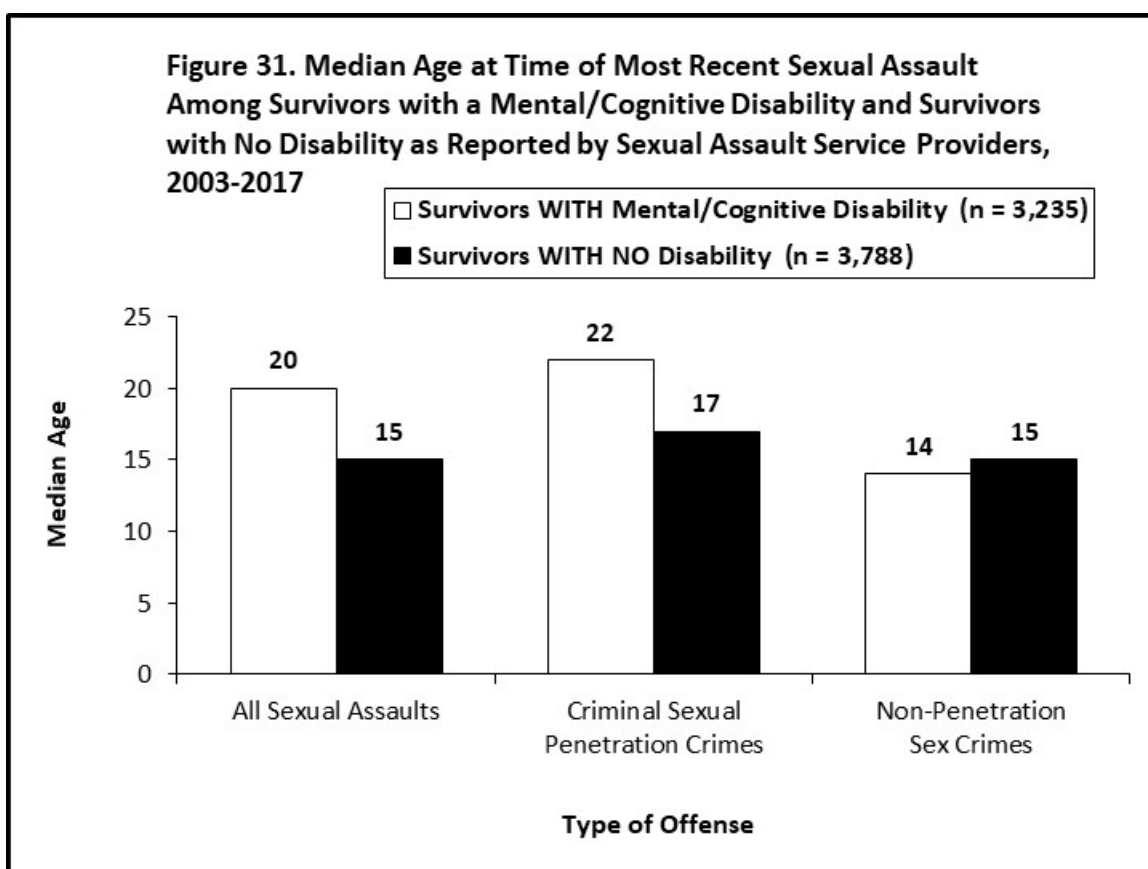
A. Survivor Age at Time of Incident

Of sexual assault survivors who sought therapeutic services, the median age of criminal sexual penetration (rape) victims with a mental/cognitive disability at the time of the assault, was 22 years compared to 17 years among rape victims with no reported disability. There was a negligible difference in the median age of victims of non-penetration sex crimes at the time of the sexual assault among

survivors with a mental/cognitive disability (14) and survivors with no reported disability (15). See **Figure 31**.

More female survivors with no reported disability (60%) than female survivors with a mental/cognitive disability (52%) sought therapeutic services within the first year of their sexual assault. Similarly, more male survivors with no reported disability (53%) than male survivors with a disability (43%) sought therapeutic services within the first year of their sexual assault.

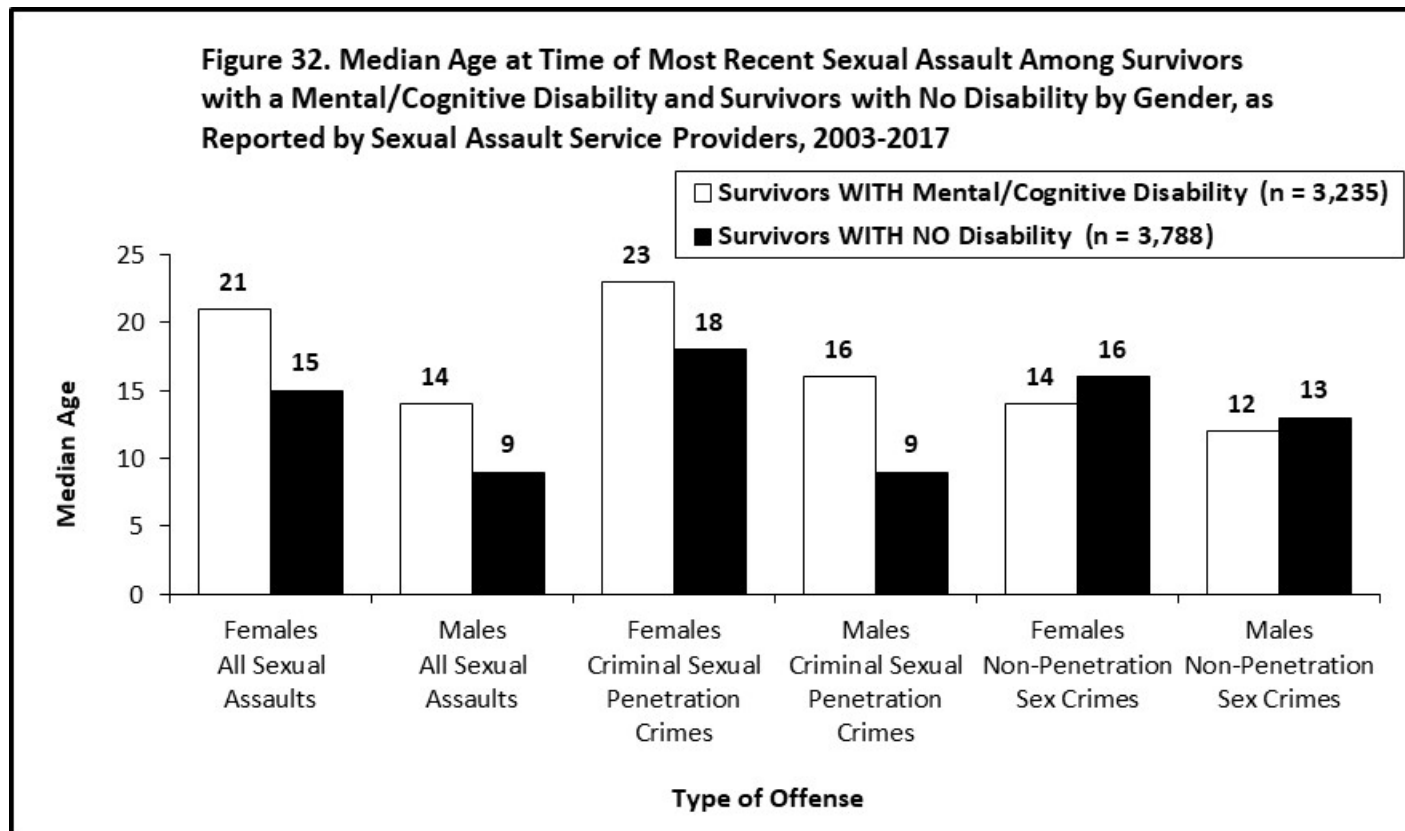
Of the survivors who waited to seek services beyond the first year following their sexual assault, females with a mental/cognitive disability waited an average 11.7 years compared to females with no reported disability (8.4 years). Similarly, of the survivors who waited to seek services beyond the first year following their sexual assault, males with a mental/cognitive disability waited an average 7.7 years compared to males with no reported disability (5.6 years).



The median age of female criminal sexual penetration (rape) survivors with a mental/cognitive disability was 23 years compared to 18 years for rape survivors with no reported disability. Conversely, the median age for female survivors of a non-penetration sex crimes, was 14 years for those with a mental/cognitive disability and 16 years for female survivors with no reported disability. See **Figure 32**.

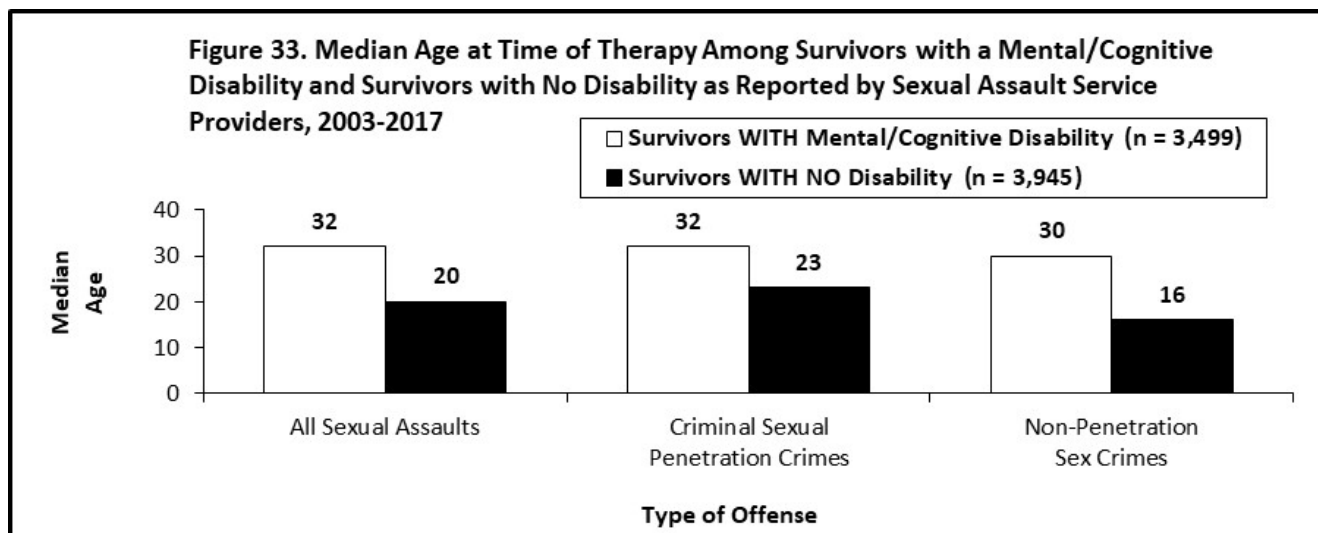
The median age of male criminal sexual penetration (rape) survivors with a mental/cognitive disability was 16 years compared to 9 years for male rape survivors with no reported disability. Conversely, the median age for male survivors of a non-penetration sex crime, was 12 years for those with a

mental/cognitive disability and 13 years for male survivors with no reported disability. Refer to Figure 32.



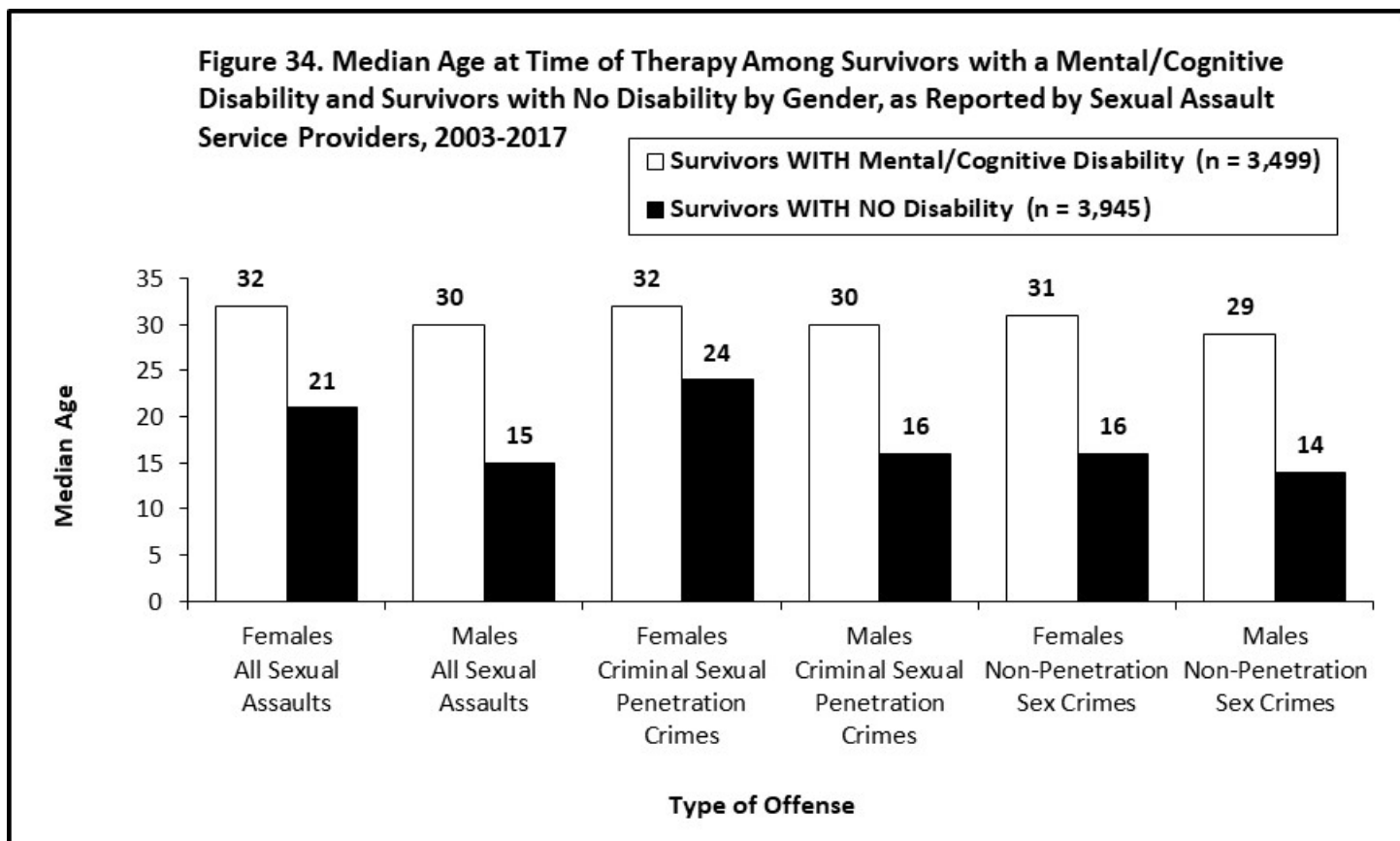
B. Survivor Age at Time of Therapy

Survivors of any type of sexual offense with a mental/cognitive disability who sought therapeutic services, had a median age at time of therapy of 32 years, significantly older than the median age of those with no reported disability (20 years). This is true for survivors of criminal sexual penetration (32 years and 23 years, respectively), and non-penetration sex crimes (30 years and 16 years, respectively). See Figure 33.



There were significant differences in the median age of survivors with a mental/cognitive disability and survivors with no reported disability at the time they sought therapeutic services for both female and male survivors. The median age for female criminal sexual penetration (rape) survivors at time of therapy was 32 years compared to 24 years for female rape survivors with no reported disability. The median age of female survivors of non-penetration crimes at the time they sought therapeutic services was 31 years among those with a mental/cognitive disability compared to 16 years among female survivors of non-penetration sex crimes with no reported disability. See **Figure 34**.

The median age for male criminal sexual penetration (rape) survivors at time of therapy was 30 years compared to 16 years for male rape survivors with no reported disability. The median age of male survivors of non-penetration crimes at the time they sought therapeutic services was 29 years among those with a mental/cognitive disability compared to 14 years among male survivors of non-penetration sex crimes with no reported disability. Refer to Figure 34.

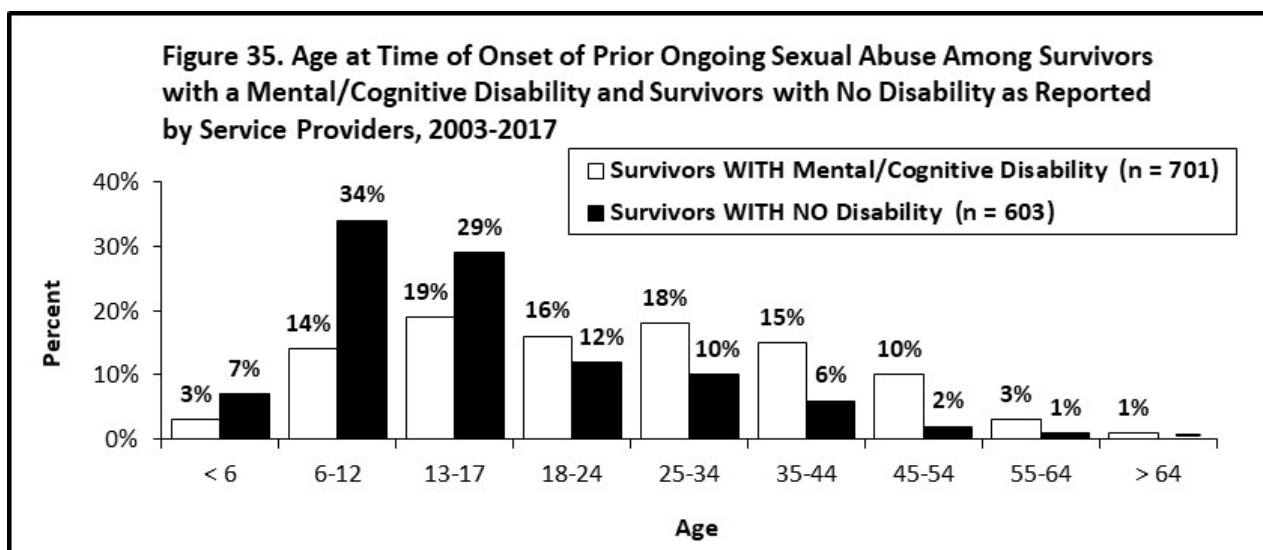


C. Prior Assault

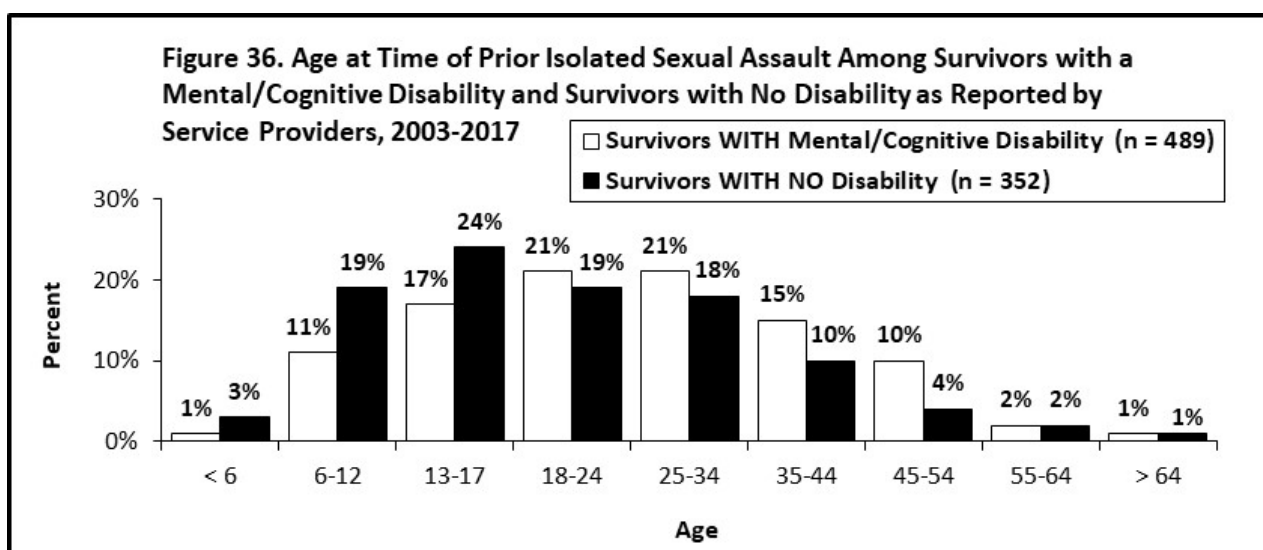
Prior sexual assault was reported for two-thirds (64%) of sexual assault survivors with a mental/cognitive disability compared to half (48%) of survivors with no reported disability.

Almost two-thirds (61%) of survivors who were victims of a prior sexual assault, were victims of ongoing abuse; 39% were victims of a prior isolated sexual assault.

Significantly more survivors with no reported disability who experienced ongoing abuse, were first victimized as a child (ages <13) (41%) compared to survivors with a mental/cognitive disability who first experienced ongoing abuse as a child (17%). Similarly more survivors with no reported disability who experienced ongoing abuse, were first victimized as an adolescent (ages 13-17) (29%) compared to survivors with a mental/cognitive disability who experienced ongoing abuse first as an adolescent (19%). See **Figure 35**.

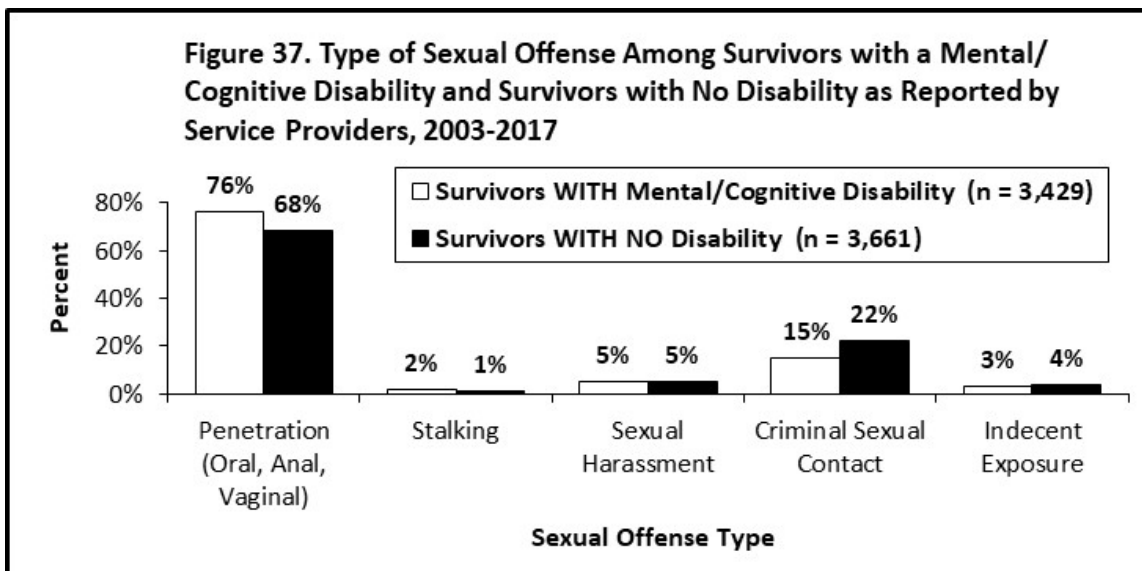


Significantly more survivors of an isolated prior sexual assault with no reported disability, were assaulted by age 17 (46%) than survivors of a prior assault with a mental/cognitive disability (29%). See **Figure 36**.

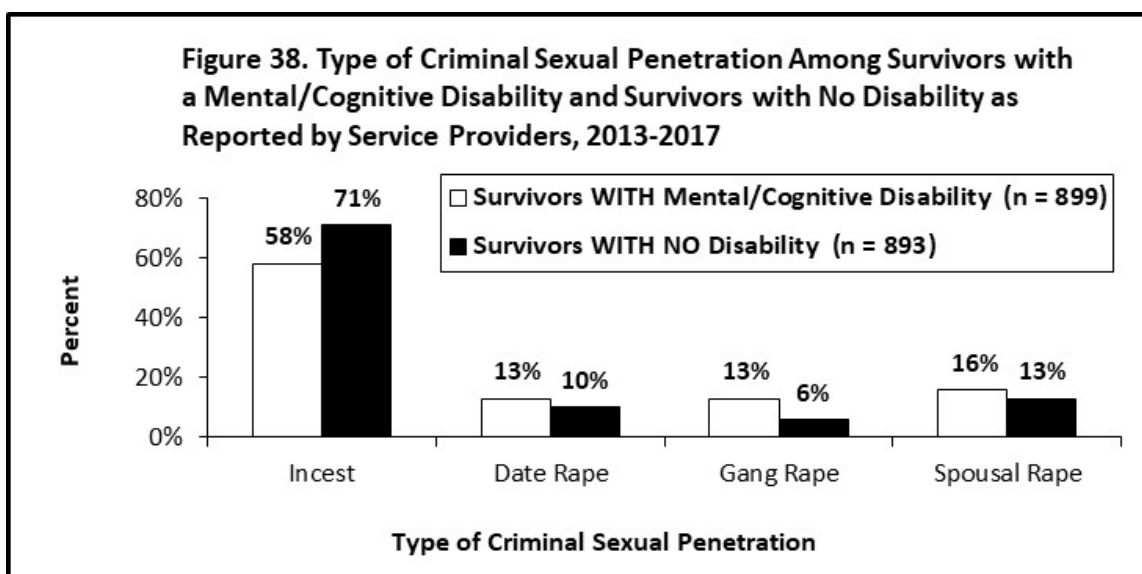


D. Type of Sexual Assault

More survivors with a mental/cognitive disability were victims of criminal sexual penetration (rape) (76%) compared to survivors with no reported disability (68%). Conversely, more survivors with no reported disability were victims of criminal sexual contact (22%) compared to survivors with a mental/cognitive disability (15%). See **Figure 37**.

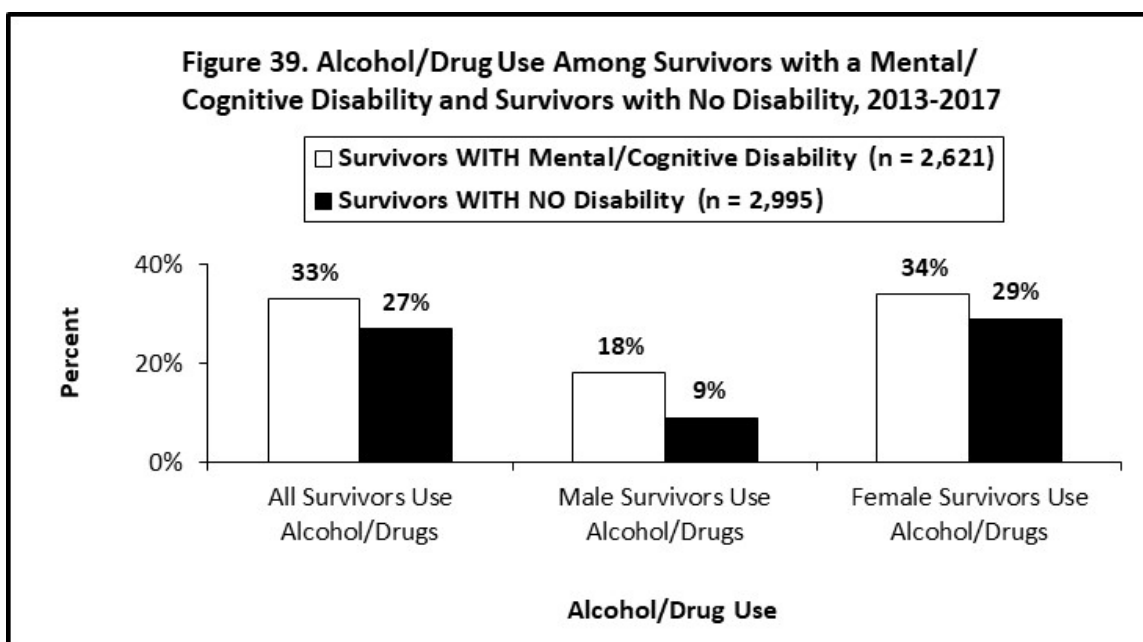


Significantly more survivors with no reported disability were victims of incest (71%) compared to survivors with a mental/cognitive disability (58%). Conversely, significantly more survivors with a mental/cognitive disability were victims of gang rape (13%) compared to survivors with no reported disability (6%). See **Figure 38**.



E. Alcohol/Drug Use

More survivors with a mental/cognitive disability used alcohol/drugs during their assault (33%), than survivors with no reported disability (27%). Twice as many male survivors with a mental/cognitive disability (18%) as male survivors with no reported disability (9%) used alcohol/drugs during their assault. More female survivors with a mental/cognitive disability used alcohol/drugs during their assault (34%), than female survivors with no reported disability (29%). See **Figure 39**.



More offenders in sexual assaults among survivors with a mental/cognitive disability used alcohol/drugs during the assault (71%) than offenders in sexual assaults among survivors with no reported disability (64%).

F. Domestic Violence History

Significantly more survivors with a mental/cognitive disability had a history of domestic violence (64%) compared to survivors with no reported disability (45%).

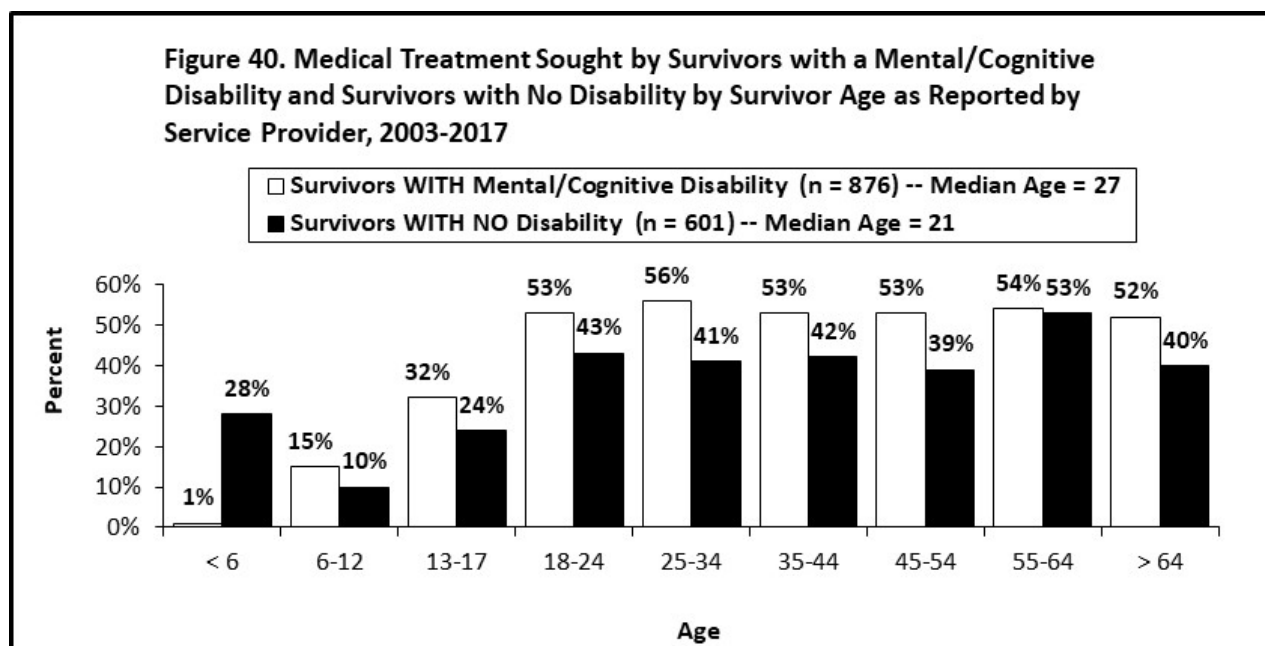
G. Sexual Transmitted Disease

Survivors with a mental/cognitive disability were two times (2.3) more likely to contract a sexually transmitted disease (7%) than survivors with no reported disability (3%).

Significantly more survivors with a mental/cognitive disability sought medical treatment (41%) compared to survivors with no reported disability (28%). When examined by gender, significantly more female survivors (44%) with a mental/cognitive disability sought medical treatment compared to female survivors (29%) with no reported disability. Slightly more male survivors with a mental/cognitive disability (25%) sought medical treatment compared to male survivors with no reported disability (21%).

H. Medical Treatment

The median age of survivors with a mental cognitive disability who sought medical treatment was 27 years compared to the median age of survivors with no reported disability, 21 years. Dramatically more survivors with no reported disability (28%) than survivors with a mental/cognitive disability (1%) sought medical treatment by age 5. In all other age groups, more survivors with a mental/cognitive disability sought treatment than survivors with no reported disability. See **Figure 40**.



IV. CONCLUSION

Many vulnerabilities among persons with a mental/cognitive disability in New Mexico are illuminated in the findings of this retrospective examination of sexual assault data. They first beg the question, “How do we protect persons with a mental/cognitive disability?” How do we protect them from stranger assault, multiple offender assault, and gang rape? How do we protect them from injury, especially rectal injuries among children with a mental/cognitive disability? How do we make medical treatment for sexually transmitted disease, pregnancy prevention, and psychological assessment for suicide prevention as routine as it is for those without a mental/cognitive disability. The myriad of vulnerabilities illuminated secondly beg the question, “How do we help enable them, especially because so many persons with mental/cognitive disability also suffer with other physical and behavioral disabilities? How do we educate them and all who work with them about healthy sexuality and appropriate relationship boundaries? How do we help them obtain more autonomy so they are free to remove themselves from potential harm or stop abuse and report abuse. How do we help them access needed services to protect themselves or to heal their trauma? How do we make more services available and geographically accessible to adequately address the specific challenges that persons with a mental/cognitive disability and their advocates face?

There are numerous reasons why persons with mental/cognitive disabilities are highly vulnerable to sexual victimization. Some of these reasons include the lack of: a) sexuality education tailored to persons with mental/cognitive disability; b) autonomy to leave their environments and caregivers or report abuse; c) legislative policies that give persons with mental/cognitive disability more autonomy; d) available, accessible services to accommodate their specific needs; e) research or evidence-based policies or practices specifically for the prevention of sexual victimization among persons with a mental/cognitive disability; f) training for advocates, healthcare providers, and law enforcement to appropriately respond to victims with mental/cognitive disability; and g) collaboration among “helping” systems.

In a 2019 report on sexual violence among New Mexicans living with intellectual/developmental disabilities, several initiatives needed to effectively achieve the prevention and reduction of sexual victimization specific to persons with intellectual/developmental disabilities are discussed.⁶ The goal is to establish “...a comprehensive approach to violence prevention that includes efforts to impart change at the individual, relationship, community and societal levels... .” To this end, several recommendations are offered, including but not limited to: “creating or strengthening legislative and organizational policies; providing direct education to people with intellectual/developmental disabilities, as well as service providers and caregivers; fostering critical collaboration” , “...address(ing) gaps in reporting of violence victimization” and utilize(ing) research to “...identify trends in victimization, inform interventions, and strengthen service delivery.” See the full report for specific details regarding each recommendation and the goal of creating a long-term strategic plan to protect and enable persons with mental/cognitive disability.⁶

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