Disparities in Prevalence, Access to Services and Outcomes for Sexual and Domestic Violence Survivors from Five Underserved Populations

Gay, Lesbian, Bisexual and Transgender

Immigrant

People with Disabilities

Rural

Elder

October 2013 (revised October 2014)
Disparities in Prevalence, Access to Services and Outcomes for Sexual and Domestic Violence Survivors from Five Underserved Populations

Gay, Lesbian, Bisexual and Transgender Immigrant People with Disabilities Rural Elder

Services Accessibility Working Group Governor's Council to Address Sexual and Domestic Violence

Council Co-Chairs
Secretary Andrea Cabral, Executive Office of Public Safety
Secretary John Polanowicz, Executive Office of Health and Human Services

October 2013
(revised October 2014)

Acknowledgements:

Services Accessibility Working Group Members:
Courtney Allen, Austin Bay, Joyce Boyd, Linda Brown, Quynh Dang, Iain Gill, Sheridan Haines, Robert Haynor, Whitney Henderson, Sandy Hovey, Kate Lawson, Joshua Lubbers, Sharon MacLean, Janice Mirabassi, Monique Nguyen, Laura Rauscher, Curt Rogers, Hema Sarang-Sieminski, Wayne Thomas, Marie A. Turley, Amy Waldman

The Working Group would like to thank the following state agencies, community organizations and individuals for their contributions to this report:

- Ad-Hoc Committee on Disabilities, Stephanie DeCandia, City of Boston, Ethos
- GLBT Domestic Violence Coalition, Massachusetts Department of Children and Families, Massachusetts Department of Public Health, Massachusetts Disabled Persons Protection Commission, Massachusetts Executive Office of Elder Affairs, Massachusetts Executive Office of Public Safety, Massachusetts Governor’s Council to Address Sexual and Domestic Violence, Massachusetts Commission for the Deaf and Hard of Hearing, Massachusetts Office of Victim Assistance, Cathleen McElligott, Vera Mouradian, Refugee and Immigrant Safety and Empowerment Programs (RISE), Rural Domestic and Sexual Violence Project, Jessamyn Smyth, Stop Abuse Gain Empowerment (SAGE)
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>Gay, Lesbian, Bisexual, and Transgender Disparities Report</td>
<td>7</td>
</tr>
<tr>
<td>Immigrants Disparities Report</td>
<td>23</td>
</tr>
<tr>
<td>Disparities Report for People with Disabilities</td>
<td>33</td>
</tr>
<tr>
<td>Rural Disparities Report</td>
<td>47</td>
</tr>
<tr>
<td>Elder Disparities Report</td>
<td>59</td>
</tr>
<tr>
<td>Financial Analysis</td>
<td>69</td>
</tr>
<tr>
<td>References</td>
<td>73</td>
</tr>
</tbody>
</table>

This document was originally formatted for publication as a double-sided and bound document. The blank pages in the original version, which typically appeared at the end of a section to allow the next section to begin on a facing page, have been removed for this digital PDF version. As a result, there is an occasional gap in pagination. The content is identical and, for citation purposes, page numbers remains consistent with the original bound version.
Executive Summary

Introduction

The Services Accessibility Working Group of the Governor’s Council to Address Sexual and Domestic Violence was established to address accessibility issues for underserved populations. The working group was designed to leverage population-specific collaborations/coalitions and to serve as a liaison between the Council and these groups. The populations represented on the working group were determined by existing population-specific collaborations/coalitions, as well as the lack of representation in mainstream sexual and domestic violence agencies. The collaborations/coalitions initially on the working group included:

- Gay, Lesbian, Bisexual and Transgender Domestic Violence Coalition (GLBT DVC)
- The Friends of RISE
- Ad Hoc Committee on Disabilities
- Massachusetts Rural Domestic & Sexual Violence Project (MRDSVP)
- Stop Abuse Gain Empowerment (SAGE)

The following research explores prevalence, key concerns, barriers to accessing services and commonalities amongst the following populations:

- people who identify as gay, lesbian, bisexual, or transgender (GLBT)
- immigrants
- people with disabilities
- people who live in rural regions
- elders

Terminology

For this report, the Services Accessibility Working Group of the Governor’s Council to Address Sexual and Domestic Violence understands sexual and domestic violence as follows:

Domestic Violence

Domestic violence is a pattern of coercive behavior that one person uses to systematically gain and maintain power and control over another in a close personal relationship. Abuse can happen in both romantic and non-romantic relationships. Forms of abuse may include physical, emotional/psychological, sexual, financial, legal, cultural/identity and stalking.

It is important to recognize that domestic violence occurs within a psycho-social context; hence definitions may vary across populations. Some populations in this report experience domestic violence that involves multiple abusers, such as extended family or crime networks. Domestic violence may occur outside the context of a romantic relationship, such as abuse by caregivers. For some populations, their experience of abuse involves intentional neglect.
Sexual Violence

Sexual violence is any nonconsensual sexual contact or penetration, intentional touching, trafficking, and non-contact acts of a sexual nature such as voyeurism and verbal or behavioral sexual harassment by one person toward another. These activities are considered sexual violence whether they are attempted or completed acts. Consent or non-consent is recognized as approval or disagreement given without force or coercion. One’s ability to consent is impacted by age, ability, language, and self-induced or forced intoxication of alcohol or drugs. Sexual violence includes the following:

- Rape, defined as forced or non-consensual sexual penetration of any body part by an object and/or individual. A person is forced into sexual intercourse through threats, physical restraint, and/or violence.
- Sexual assault, which includes unwanted behaviors that are attempted or completed against one’s will or when one is unable to consent. This includes, but is not limited to, actual or threatened physical force, use of weapons, coercion, intimidation, and sexually offensive touching.
- Sexual harassment/exploitation includes, but is not limited to, sexual advances, requests for sexual favors, inappropriate sexual comments, exhibitionism, undesired exposure to pornography, sexually explicit stalking, incessant telephoning, taking nude photographs of a sexual nature of another person without their consent, online solicitation of minors, unwelcome online solicitation of adults, and any hostile environment where sexual joking is present without consent.

Methodology

The working group reviewed Massachusetts and Federal data and existing studies on sexual and domestic violence in order to understand prevalence, barriers to accessing services, and key concerns per population. The Service Accessibility Working Group also assessed existing state funding of sexual and domestic violence agencies in order to determine current funding resources allocated for the five specific populations. The findings from this analysis are summarized below by the common themes, key findings per population and recommendations.

Common Themes

The five populations represented in this report were all found to experience sexual and domestic violence differently than the general population, including disparities in prevalence of sexual and domestic violence, access to support and services, and a greater impact on the health and well-being of victims and survivors within these specific communities.

1. These five populations experience sexual and domestic violence at rates equal to or greater than the general population.
2. Less data is available about these populations. Systemic barriers in data collection systems dis-allow for a full understanding of the prevalence and dynamics of sexual and domestic violence experienced by these populations.
3. These populations confront systemic and cultural barriers to accessing victim and survivor services including outright denial of services or not being able to access services due to geographic inaccessibility, linguistic barriers, lack of physical access to facilities, mistrust of law enforcement and/or lack of culturally sensitive services.

4. The severity of sexual and domestic violence is minimized and unrecognized within the populations themselves and among the services and systems that are designed to respond.

5. Services for these populations receive less funding relative to domestic violence services provided for the general population, which already operate with little funding.

6. Individuals who identified with two or more underserved populations faced increased and compounding barriers to accessing services.

**Key Findings**

- **GLBT**
  - People who identify as gay, lesbian, bisexual or transgender experience sexual assault at a rate more than double that of heterosexuals. According to the Massachusetts Behavioral Risk Factor Surveillance System for 2001-2006, 13% of heterosexual adults in Massachusetts (age 18-64) reported unwanted sexual contact at some time in their lives, while the prevalence rate was 26% for gay/lesbian adults and 37% for bisexual adults.\(^1\)
  - A 2000 U.S. Department of Justice’s National Violence Against Women Survey found that same-sex cohabitants reported significantly more intimate partner violence than did opposite-sex cohabitants. 39.2% of women in same-sex cohabitating relationships reported being victimized by an intimate partner at some time in their lifetime compared to 21.7% of women in opposite-sex cohabiting relationships. Among men, the figures are 23.1% and 7.4% respectively.\(^2\)

- **Immigrant**
  - In Massachusetts, between 1993 and 2009, immigrants were twice as likely to be killed due to domestic violence as non-immigrants. Immigrants accounted for 14% of the state population yet comprised 28% of the domestic violence homicide victims.
  - Hispanic women were 38% more likely than non-Hispanic women to report that a current or former intimate partner raped them at some time in their lifetime. Approximately 7.9% of Hispanic women will be raped by a male spouse, boyfriend or ex-boyfriend during their lifetime.

- **Rural**
  - Rural survivors of intimate partner violence are twice as likely to have severe physical injuries as their urban counterparts. In 2005, a Department of Justice study found that 18% of all homicides in rural areas involved an intimate partner compared to 6% in larger cities.
The rate of issuance of restraining orders in predominantly rural Berkshire, Franklin and Northwest Worcester counties are 37%, 36%, and 53% higher, respectively, than the state rate.

Survivors in rural areas of Massachusetts reported rapes to area rape crisis centers at a rate twice as high as the state rate.

- People with Disabilities
  - The U.S. Center for Disease Control and Prevention reports that people with disabilities were more likely (28.5%) than people without disabilities (15.4%) to experience threats of violence, or experience acts of violence such as hitting, slapping, pushing, and/or kicking by an intimate partner.
  - Women and men with a disability are significantly more likely to report experiencing lifetime sexual violence victimization than those who do not have a disability. From the Massachusetts Behavioral Risk Factor Surveillance System 2005-2009, 26.6% of women and 13.9% of men with a disability reported lifetime sexual violence victimization compared to 12.4% of women and 3.7% of men without disabilities.

- Elder
  - Between 2000 and 2010, reports of elder abuse to the MA Executive Office of Elder Affairs increased from 9,385 reports in 2000 to 15,935 reports filed in 2010, an increase of 70%.
  - According to the National Center for Elder Abuse, abuse by intimate partners accounts for 11.3% of abuse reports, adult children account for 32.6% and other family members account for 21.5%. Most of these cases meet criteria for sexual and domestic violence.
Recommendations

Due to the disparities in prevalence and access to services amongst the selected populations, a number of population-specific recommendations are provided in each section of the report. Below are common cross-population recommendations that emerged from the report:

- **Increase interagency communication** on marginalized high-risk populations via the creation of a standing committee of the Governor's Council to Address Sexual and Domestic Violence. The committee would include top officials from Dept. of Children and Families, Dept. of Public Health, MA Office of Victim Assistance, Executive Office of Public Safety, Executive Office of Elder Affairs, Disabled Persons’ Protection Commission, MA Commission for the Deaf and Hard of Hearing, Dept. of Developmental Services, Office of Refugees and Immigrants, MA Commission for the Deaf and Hard of Hearing, Dept. of Mental Health, Dept. of Transitional Assistance and the co-chairs of the Services Accessibility Working Group. The goal of the Committee would be to increase access, capacity and culturally appropriate responses and decrease duplicated efforts through cross-agency education and expertise sharing with the end result of breaking down of the 'silos' approach to sexual and domestic violence that occurs with the current lack of coordination between State agencies.

- **Initiate a pilot population-specific liaison project** to increase access to services for underserved populations at sexual and domestic violence programs. The project would compensate programs for a part time population-specific liaison who would create and implement an action plan to increase cultural competency and accessibility at the host program. The pilot project would require minimal funding; all liaisons would be coordinated on a state level; and participating programs would be given priority points in future RFRs. Where primary services are provided at programs that do not specialize in sexual and domestic violence (such as elder services) the liaison would be sexual and domestic violence specific rather than population-specific.

- **Increase access to services** by increasing population-specific services and further integrating culturally appropriate population-specific responses at mainstream programs. The decision of whether to pursue either or both strategies should be led by the needs of the population with the understanding that providing culturally competent and accessible services for marginalized high risk populations, in either strategy, is more expensive than providing services for mainstream survivors and that it is both acceptable and appropriate to expend more resources to ensure quality services are available to all citizens in the Commonwealth.
Disparities in Prevalence, Access to Services and Outcomes for GLBT Survivors of Sexual and Domestic Violence
Introduction

The acronym GLBT stands for gay, lesbian, bisexual and transgender, populations that are defined by their gender identity and sexual orientation. Gay refers to men who are attracted to other men. Lesbian refers to women who are attracted to other women. Bisexual refers to people who are attracted to both men and women. Transgender is an umbrella term that is used by a group of people whose gender identity, and how it is expressed, is different than the sex they were assigned at birth. Cisgender refers to people whose gender identity and gender expression align with their assigned sex at birth. FTM refers to a person who transitions from “female-to-male,” meaning a person who was assigned female at birth, but identifies and lives as a male. MTF refers to a person who transitions from “male-to-female,” meaning a person who was assigned male at birth, but identifies and lives as a female.

Sexual and domestic violence is experienced at higher rates by GLB men and women than their heterosexual male or female counterparts and sexual violence is experienced by transgender people at higher rates than GLB or heterosexual cisgender people. The characteristics of sexual and domestic violence for GLBT individuals and heterosexuals are similar in many respects, including high rates of prevalence, types of abuse, and the underlying dynamics of power and control. The primary differences are GLBT victims’/survivors’ experiences in attempting to access support and services and GLBT culturally-specific control tactics used by abusers. Barriers to service for both survivors and abusers include systemic barriers (denial of service, re-victimizing or victimizing responses from mainstream service providers, insufficient culturally-specific services, and insufficient research on transgender populations) and internal barriers for the individual (a survivor’s real or perceived barriers based on the their gender and/or sexual orientation). The report primarily recommends increasing victim/survivor and perpetrator access to GLBT culturally-specific services and increasing access for GLBT survivors to services provided by organizations that serve the general population.

Demographics

Until recently, demographic data for GLBT communities has relied on convenience sampling and has varied widely depending on whether researchers measure attraction, behavior or identity. In the past decade, government-administered population based surveys have begun to collect GLBT demographics. While the population based surveys are more statistically rigorous, the findings show a low GLBT population count which many advocates and institutions in the GLBT community believe under-represent the population. Research with the GLBT population is challenging due to the historic and current bias, violence and discrimination experienced by GLBT individuals.

The Williams Institute review of six government-administered population based surveys has found that the U.S. population that identifies as gay, lesbian or bisexual converges around 3.5% and the transgender population is at 0.3%. Another survey, National Intimate Partner and Sexual Violence Survey 2010 found that 2% of male respondents identified as gay and 1.2% as bisexual. Among women the responses were 1.3% lesbian and 2.2% bisexual. The percentage is similar in Massachusetts. The Massachusetts Behavioral Risk Factor Surveillance System 2001-2006
found that 1.9% of the state’s population self-identified as gay, lesbian or homosexual, and 1% identified as bisexual$^\text{11}$, and 0.5% identified as transgender$^\text{12}$ for a total of 3.4%. In all these population based surveys, many more women identified as bisexual than men. These studies represent conservative estimates of the GLBT population. Even so, these percentages mean that there are almost 11 million people in the US who identify as GLB and 700,000 people who identify as transgender.

The collection of demographic data for people who identify as lesbian, gay, bisexual, and transgender vary for a number of reasons.$^\text{13}$ In measuring sexual orientation, the variations may be due to different definitions that are used, such as self-identification as gay, lesbian or bisexual, or whether criteria based on same sex sexual behavior or attraction is also included. Some individuals, especially from communities of color, immigrant communities and faith communities, may have same sex attraction and behavior but not identify with the terminology of gay, lesbian, bisexual or transgender, and thus not be counted in the research. In collecting demographics on the transgender population, definitions vary with regard to gender identity, gender expression and gender non-conformity.

Data also varies due to survey methods, which involve telephone or door-to-door interviews, which may be affected by the willingness of respondents to respond to these sensitive questions. Stigmatization is still an important factor in the lives of GLBT people and for GLBT research. As a result, many GLBT individuals are reluctant to reveal information about their sexual orientation or gender identity to surveyors.$^\text{14}$ Thus depending on the way that data is collected, there can be large variations. For example, when asking about same sex behavior, one study using convenience sampling found that 25% of respondents reported having attraction for someone of the same sex and 10% of them reported at least one same sex encounter. However, when the same study asked respondents to identify as lesbian, gay or bisexual, the percentage dropped to 3-4%.$^\text{15}$ In 2010, the National Gay and Lesbian Task Force Policy Institute convened leading national GLBT researchers, advocates and community leaders, reviewed existing research, discussed disparities in GLBT demographic data and concluded the population percentage to be in the 4-10% range.$^\text{16}$

According to the 2010 Census, Massachusetts ranks third in the country with the highest concentration of same-sex couple households (8 per 1000)$^\text{17}$ with Suffolk County ranking fourth highest in the country for county concentration of same-sex couple households (3.55%).$^\text{18}$ Massachusetts leads the nation with the percentage of same sex partners who are married (44%). Four cities in MA have high concentrations of same-sex households: Provincetown (14.80%), Northampton (4.03%), Boston (1.47%) and Cambridge (1.44%).$^\text{19}$
Prevalence

Due to the inability to obtain accurate population numbers for the GLBT Communities, the below data points reflect percentages and not prevalence.

Domestic Violence

Representative surveys of domestic violence in the US population have found that gay, lesbian and bisexual men and women experience higher rates of domestic violence compared to their heterosexual male or female counterparts. At the time of this report, there were no known population based studies of intimate partner violence against transgender people, however data may be extrapolated from the broader category of violence in the home.

- The 2010 National Intimate Partner and Sexual Violence Survey (NIPSVS) survey reported that 34% of lesbians and 57% of bisexual women experienced rape, physical violence and/or stalking by an intimate partner compared to 28% of heterosexual women. Gay men experienced these forms of violence at a rate of 11% and heterosexual men at 10%. There was insufficient data on bisexual men.

- A 2000 U.S. Department of Justice’s National Violence Against Women Survey found that same-sex cohabitants reported significantly more intimate partner violence than did opposite-sex cohabitants. 39.2% of women in same-sex cohabitating relationships reported being victimized by an intimate partner at some time in their lifetime compared to 21.7% of women in opposite-sex cohabiting relationships. Among men, the figures are 23.1% and 7.4% respectively.

- A Massachusetts Department of Public Health survey of 1,598 GLBT individuals using convenience sampling found that 14% of gay men and lesbians, 18.4% of bisexuals and 34% of transgender individuals self-reported that they had been threatened in the past with physical violence by an intimate partner. Rates of domestic violence that include other forms of abuse would be expected to be higher.

- Two population based studies asked transgender people their experience of violence in the home, which includes intimate partner violence. One of the studies found 56% and the other 66% of transgender people experienced violence at home, with more MTFs (67%) than FTMs (38.7%) reporting abuse. Of the perpetrators, 8% were current spouse/partner and 8% former spouse/partner. While there is sparse domestic violence prevalence data for transgender individuals, data show that this population experiences higher rates of violence in general than the rest of the GLBT communities and more severe violence.

- Between 2007 and 2010, 1% or fewer clients in Massachusetts certified batterer intervention programs identified as GLBT.
Sexual Violence

Evidence indicates that lesbian, gay and bisexual populations experience a higher prevalence of rape or sexual violence other than rape than the heterosexual population.\textsuperscript{30,31,32} Bisexual women experience higher rates of rape and other forms of sexual violence than lesbian or heterosexual women, and men of any sexual orientation.\textsuperscript{33} Prevalence data from randomized studies were not available for transgender populations, however, studies using convenience sampling indicate greater rates of sexual violence victimization of transgender individuals than gay, lesbian, bisexual or heterosexual people.\textsuperscript{34}

- A review of the studies of violence against transgender people found that transgender people experience high levels of violence from strangers and people known to them, experience the violence from an early age, and experience violence throughout their lifetime. The most comprehensive study is the Virginia Transgender Health Initiative Survey conducted by a state health department, and the FORGE study, conducted by a transgender peer advocacy group.

- The percentage of transgender people who had experienced rape or unwanted sexual activity varied across studies, with most studies converging around 50\%.\textsuperscript{35,36} The FORGE report had the highest rate (66\%) while other studies found lower rates (10-15\%).\textsuperscript{37}

- Studies vary as to whether they found that MTFs or FTMs experienced greater forced sex.\textsuperscript{38} First rapes occurred young, with the median age of 14 for FTMs and 15 for MTFs.\textsuperscript{39}

- Most transgender victims/survivors had perpetrators who were male (90\%), female (30\%) and transgender (12\%) (numbers total greater than 100 because there was often multiple incidences or more than one perpetrator).\textsuperscript{40} The largest categories of perpetrators were acquaintances (48\%), strangers (26\%), father or stepfather (16\%), former spouse or partner (14\%), ex-spouse or partner (12\%), or sibling (12\%).\textsuperscript{41} Over half (57\%) of transgender victims/survivors believed that the assaults were motivated by transphobia.\textsuperscript{42}

- Transgender survivors are particularly unlikely to report sexual or domestic violence to law enforcement or social services, perhaps because of a history of revictimization or victimization from these sources.\textsuperscript{43} Indeed, the FORGE study found that 4.9\% of incidences of sexual violence were perpetrated by police, and 5.9\% by a health care or social service provider.\textsuperscript{44} Police constituted 14\% of the perpetrators of physical abuse.\textsuperscript{45}

- The 2010 National Intimate Partner and Sexual Violence Survey (NIPSVS) found that 13\% of lesbians and 46\% of bisexual women had been raped in their lifetime, compared to 17\% of heterosexual women. The rate of rape of gay and bisexual men was too small to estimate.\textsuperscript{46}
• The NIPSVS found that gay and bisexual men are more likely to experience forms of sexual assault other than rape at higher rates than heterosexual men (40% of gay men and 47% of bisexual men vs. 20% heterosexual men). Lesbian women experienced sexual assault other than rape at a rate of 46%, bisexual women at 75% and heterosexual women at 43%.47

• The majority of perpetrators of sexual violence, other than rape, against lesbian, bisexual and heterosexual women were males (85%, 87%, and 95%). Perpetrators against gay and bisexual men were majority male (79% and 66%) and perpetrators against heterosexual men were majority female (55%).48

• According to the Massachusetts Behavioral Risk Factor Surveillance System for 2001-2006, 13% of heterosexual adults in Massachusetts (age 18-64) reported unwanted sexual contact at some time in their lives, while the prevalence rate was 26% for gay/lesbian adults and 37% for bisexual adults.49

• A 2011 meta-analysis of 75 studies on sexual assault victimization of GLB individuals showed that that lifetime sexual assault for gay and bisexual males averaged 30% and for lesbians and bisexual females averaged 43%.50

• This study also found differences in the type of sexual violence that was experienced. Lesbian and bisexual women reported greater childhood and adult sexual assault, lifetime sexual assault, and intimate partner sexual assault than did gay or bisexual men. Gay men and bisexual males were more likely to report sexual assault related to hate crimes than lesbian or bisexual women.51

• GLB youth also face high rates of sexual assault. The 2005 Massachusetts Youth Risk Behavior Survey reports that 34% of GLB students reported sexual violence victimization as compared to 9% of heterosexual students.52

GLBT Dynamics of Sexual and Domestic Violence

GLBT individuals experience significant poly-victimization, including victimization due to their sexual orientation and/or gender identity which can compound their cumulative experience of trauma and require additional resources for services providers to provide appropriate support.53,54,55,56,57

Most characteristics of domestic violence (power and control, types of abuse, barriers to leaving) are similar for GLBT and heterosexual victims and perpetrators. The primary differences are in the tactics of abuse that are relevant to a victim's GLBT identity and their experiences in accessing support. GLBT culturally-specific abuse can include: reinforcing fears that no one will
help the victim because of their GLBT identity, telling their partner that they "deserve" the abuse due to their GLBT identity or that “this is what happens in GLBT relationships,” justifying abuse with the accusation that the victim is not "really" GLBT, and/or that the violence is an expression of masculinity or some other "desirable" trait. Some GLBT-specific abusive tactics come from a couple’s shared gender, such as identity theft being more easily executed or portraying the violence as mutual or even consensual, especially if the victim attempted to defend themselves. Within the transgender community, an abuser can block access to or hide hormones, or simply interfere with someone’s recovery from transition-related surgeries.

Additionally, predominant feminist theory on domestic violence emphasizes the ways in which gender inequalities produce power imbalances in society and intimate relationships and focuses on the way in which men and women are socialized to act masculine and women to act feminine. Socially constructed masculinity/femininity in the United States means that men are expected to be aggressive and violent and women to be passive and nonviolent. This framework does not reflect the reality that women can be abusers and men can be victims -- a reality highlighted in GLBT relationships. Although this theoretical framework has been fundamental in developing mainstream domestic violence services, it fails to take into account the full experience of domestic violence as experienced by GLBT individuals. A broader oppression framework is needed to reduce the emphasis on gender and include an understanding of how homophobia, biphobia, and transphobia shape survivors’ experiences.

As with domestic violence, many of the characteristics of sexual assault are similar for GLBT and heterosexual individuals. The primary differences for GLBT individuals are sexual assaults that are linked to the individual’s GLBT identity and GLBT individuals’ experiences in attempting to access support and services. Sexual assault of a GLBT individual can be a hate crime, whether it is youth(s) assaulting a GLBT youth who has just ‘come out’ or an assault of a transgender adult who is targeted for their gender identity/transition. GLB individuals have also been sexually assaulted by heterosexuals of the opposite sex in attempts to force them to "be" heterosexual. In addition, sexual assault may lead to increased harassment and bullying within insular communities such as a high school. The harassment can occur in person in the school or via Facebook, text, etc., and usually involves derogatory words to describe the victim because of their participation in the assault. The harassment may also lead to additional sexual violence.

**Barriers to Accessing Support and Services**
(Barriers outlined below were documented in a 2005 MA State House Public Hearing Report)\(^{58}\)

**Systemic Barriers**

- **Denial of Service**
  Some state-funded Massachusetts domestic violence programs have exclusive policies that limit service availability to women.
• **Poor Responses from Service Providers**
  
  o **Inadequate or Inconsistent Response from Criminal Justice System**

  While some providers and police departments have collaborated with culturally-specific GLBT organizations to improve policies and practices, many survivors continue to report challenges in accessing help, such as:
  
  ▪ Limited involvement by police to reported scenes of GLBT sexual and domestic violence
  
  ▪ Inappropriate responses by police personnel to victim reports of abuse:
    
    ➢ Homophobia: fear and negative attitudes, feelings, stereotypes and behaviors against people who are attracted to people of the same gender.
    
    ➢ Biphobia: fear and negative attitudes, feelings, stereotypes and behaviors against people who are attracted to people of the same and opposite gender.
    
    ➢ Transphobia: fear and negative attitudes, feelings, attitudes, stereotypes and behaviors against people who transgress social expectations of gender conformity.

  "I had called the police ... just to ask about what would happen if I wanted to have him arrested for the hitting, I was almost laughed at. I was told that I needed to ‘straighten out my lifestyle and then I would be all set.’ That was it for me. I stayed with him and lived with the abuse, I drank a lot every day and I even started to do some drugs to deal with it, so I wouldn’t feel anything. I was also hoping that I would OD and then it would be all over.”

  Anonymous gay male survivor

  ▪ Police not following up on GLBT sexual and domestic violence reports.
  
  ▪ Barriers to GLBT victims obtaining restraining orders.

  o **Lack of GLBT Cultural Competence among Service Providers**

  ▪ Lack of knowledge of and competence with GLBT issues, including culturally incompetent gender identity and/or sexual orientation language.

  "I once worked with a woman who was transgender, and whose partner had almost killed her. She had finally made the decision to leave the relationship and she went to a shelter in Massachusetts. When she got there, the counselors were confused about her gender even though she had previously explained to them that she was transgender, and what that meant. The shelter staff asked her a set of intensive and grueling questions about her body including, ‘What is between your legs?’ … after this humiliating treatment, they told her that she could not be housed there because they decided that she was really a man. After being denied shelter, this woman went back to her batterer because she had no family, no friends and nowhere else to go.”

  GLBT-specific domestic violence advocate

  ▪ Lack of recognition and appropriate response to GLBT sexual and domestic violence
  
  ▪ Lack of appropriate victim/perpetrator domestic violence screening.
  
  ▪ Telling survivors to hide their GLBT-identifying characteristics.
  
  ▪ Telling survivors that GLBT status is the cause of the abuse or sexual assault.

  “My whole life people have felt entitled to hurt me because I make them feel uncomfortable because I “act gay”. I am used to taking the blame so I wasn’t surprised when the hospital staff doing the rape kit told me I should try to act tougher so no one would bother me next time.”

  Anonymous gay male survivor
- Failure to physically protect GLBT individuals in domestic violence shelters.
- Rude and patronizing approach to GLBT victims.
- Inability/refusal to address homo/bi/trans-phobia.

**Institutional and Individual Discrimination**

- Homo/bi/trans-phobia (fear of, hatred of, or discrimination against gay men, lesbians, bisexuals or transgender individuals)
  - Discriminatory organizational policies and practices.
  - Tolerating discriminatory behavior by other program participants.

> “I was grateful for a place to hide but it was one of the most uncomfortable situations I have been in. Instead of being able to deal with my current situation, I had to deal with the other women’s issues about my sexuality. I was asked not to be gay in front of one woman’s child. I couldn’t talk about my situation as everyone else at the house had trouble understanding how I could be battered by another woman.”

- Discriminatory actions by individual providers.
- GLBT victimization trivialized or discounted.

- Heterosexism (favoritism toward opposite-sex relationships) and heteronormativity (the presumption that everyone is or should be heterosexual).
  - Heteronormative responses once victims’ gender is known/presumed.
  - Heterosexist policies, including assumptions about appropriate gender of staff/volunteers and rules in residential settings.
  - Heterosexist outreach/marketing of sexual and domestic violence services.
  - Heterosexist prevention campaigns.

- Gender-bias (presumptions or discrimination based on gender): Early activists developed a framework for delivering domestic violence services for women who experienced abuse by male abusers; however, it did not address the experiences of people of all genders. While heterosexual women are significantly impacted by domestic violence, GLBT people experience domestic violence at equal or greater rates. The early bias of providing services exclusively for women created barriers to GLBT people accessing services, as service providers often believe men and people who identify as transgender cannot be survivors, violence is less severe in GLBT relationships, and domestic violence in a same-sex partnership is mutual battering.

- Perceived homo/bi/trans-phobia, heterosexism and/or gender-bias: Even though a service provider program – including criminal justice – may have undergone intensive cultural competence trainings and be prepared to offer culturally competent services and support, without aggressive outreach to the GLBT community, GLBT individuals can still perceive the institution to be unwelcoming to GLBT victims and not access services.
  - Less than 2% of gay men consider the police or DA’s office to be a resource for a gay male victim of domestic violence.
  - GLBT individuals fear they won’t be believed by systems that are designed to serve women who are victimized by men.
  - GLBT individuals fear having to ‘out’ themselves to receive services.
• **Insufficient Culturally-Specific Services**
  o In Massachusetts, only three small programs (GLBTQ Domestic Violence Project, The Network/La Red and the Violence Recovery Program) offer culturally-specific domestic violence services with only five GLBT-specific safe home beds.
  o Although the GLBTQ Domestic Violence Project has a GLBT-specific Sexual Assault Case Manager and the Violence Recovery Program offers a sexual assault support group and counseling/advocacy for sexual assault victims, there is a need for more culturally-specific sexual assault prevention and expanded culturally-specific access/service options for GLBT victims.
  o Due to the small/insular nature of the GLBT community, if the perpetrator is GLBT, they may falsely present as the victim and monopolize scarce GLBT culturally-specific services.

• **Insufficient GLBT-Focused Research**
  o Due to heterosexist theories of sexual and domestic violence as well as the difficulties of researching the GLBT communities, GLBT victims and perpetrators of sexual and domestic violence were largely ignored in the past by researchers, authors, and publishers, which has meant that knowledge about sexual assault and IPV in the GLBT community is sparser and in a more nascent state than knowledge about sexual assault and IPV in the heterosexual population.
  o Information about GLBT people in Massachusetts is largely incomplete due to barriers built into statistical gathering systems. The Weapons-Related Injury Surveillance System (WRISS), the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS) and the Massachusetts Youth Risk Behavior Survey (YRBS) are the primary statistical mechanisms for gathering relevant health information regarding GLBT people. Although improvements have been made to BRFSS and YRBS to include sexual orientation and gender identity, WRISS does not capture the information. The lack of consistency across reporting mechanisms creates barriers to documenting the prevalence of sexual and domestic violence for people who identify as GLBT in Massachusetts.
  o Lack of research contributes to the pervasive institutional marginalization of GLBT victims and further reinforces the invisibility of GLBT victims, leading to increased lack of self-identification of sexual and domestic violence. The Massachusetts Sexual Violence Prevention Plan (DPH, 2010) calls for increased research partnerships to address the problem of insufficient contextual data regarding the documented higher rates of sexual violence against GLBT populations.
Internal Barriers

- Survivor’s potential inability to self-identify due to lack of visibility of GLBT sexual and domestic violence in general literature and the general consciousness.
- Survivor’s potential lack of awareness of resources for GLBT victims.
- Survivors’ potential personal fear, embarrassment, internalized homo/bi/trans-phobia.
- Survivors’ potential self-doubt and/or self-blame.
- Survivor’s potential fear of seeking services/support as it may mean coming ‘out’ as GLBT to a provider, friend or family.
- Survivor’s potential fear that providers, friends or family will believe that victimization is due in part to their GLBT identity – especially if family/friends have not been supportive of GLBT identity.

“My parents and family told me that they would “accept” my being gay as long as I didn’t talk to them about it. So when I was raped by someone I had met at a bar, I didn’t tell them. I just said that my broken nose was due to a fall and left it at that. I was so afraid they would think I deserved to be raped.”

Anonymous lesbian survivor

- Survivor’s potential fear of re-victimization by non-inclusive support services.
- Survivor’s potential isolation from friends and family support from coming ‘out’ as GLBT.
- Survivor’s potential isolation and/or inability to access GLBT community support due to the small, insular nature of the GLBT community.
- Survivor’s potential fear of harming the GLBT community if the perpetrator is GLBT.

Funding Trends

Massachusetts has funded GLBT-specific domestic violence services for the past 20+ years, beginning with the Massachusetts Office of Victim Assistance and the Executive Office of Public Safety in the 1990s. The Department of Public Health and the Department of Children and Families have been funding GLBT-specific domestic violence services for the past 14 years. Currently, the Commonwealth of Massachusetts does not fund any GLBT-specific sexual assault services.

Although domestic violence funding for this specific population has been in place for a number of years, the amount of funding is small ($905,326 in FY12, only 2.5% of the State's sexual and domestic program allocation) and fails to meet the needs of the GLBT community. A 2005 State House Public Hearing Report on GLBT Domestic Violence Shelter/Housing Needs documented the gap between survivors’ needs and the services available, and the report clearly identified a primary recommendation of improving and expanding shelter options for GLBT victims statewide. Research indicates that the GLBT population experiences higher rates of sexual and domestic violence than the general population. However, despite the State House Public Hearing Report and disproportionate prevalence rates, funding levels remain inadequate.
**Current Efforts**

Massachusetts has three GLBT-specific domestic violence programs: The Violence Recovery Program at Fenway Health, the GLBTQ Domestic Violence Project and The Network/La Red. Cumulatively, these programs have five safe home beds and offer a range of community based services, including a dedicated GLBT legal program, community engagement initiatives and supportive technical assistance to mainstream programs that want to transition to offering culturally competent inclusive services.

Massachusetts has limited GLBT-specific sexual assault services, primarily provided by the three programs mentioned above. Services include GLBT-support groups, a federally funded GLBT sexual assault case manager and limited individual counseling.

Massachusetts also has several mainstream programs with small GLBT-specific initiatives. These initiatives include outreach, direct service and training. Historically, GLBT initiatives at mainstream programs frequently have been reliant on either a key staff member who champions the issue or a time-limited funding source and, as such, many have lacked the additional support needed to become institutionalized and survive beyond the tenure of the key staff member or initial funding.

Massachusetts also has a vibrant collaboration of GLBT domestic violence service providers and allies that work to raise awareness and improve access to services for GLBT survivors. The GLBT Domestic Violence Coalition has been in existence for 20 years and authored a groundbreaking screening tool to help identify victims and perpetrators in abusive relationships. The Coalition has been training providers on the screening tool for 12 years and has institutionalized an annual two-day training that attracts service providers from across the country.

**Recommendations**

**Primary Recommendations**

1) Improve and expand GLBT culturally-specific community-based and shelter services.
   - Increase funding to expand GLBT culturally-specific domestic violence residential programs from safe homes to shelters.
   - Increase funding to expand GLBT culturally-specific sexual and domestic violence community-based and residential programs to appropriately serve the entire state, better ensure victim safety, and provide adequate support, counseling, case management and residential supervision.
2) Improve and expand mainstream service options for GLBT victims and perpetrators statewide.
   - Increase funding for the provision of GLBT culturally-specific technical assistance to mainstream providers to educate, mentor, and support mainstream programs as they transition to inclusive services and work with GLBT victims and perpetrators. Technical Assistance can/should include:
     - GLBT sexual and domestic violence intervention and prevention training
     - GLBT cultural competency
     - Training on GLBT victim/perpetrator domestic violence screening
     - Training on dismantling heterosexism and homophobia.
     - Incorporating gender identity and sexual orientation inclusive language throughout the program
   - Initiate a low-cost GLBT-specific advocate program for mainstream programs. Participating mainstream programs would receive a $5,000 increase to their State contract to appoint an advocate to this position, with the assumption that the majority of the increase would go to the advocate to compensate for the increased responsibility and travel. GLBT-specific advocates would assess the program's inclusivity, create and implement an improvement plan, and monitor/report on progress. A small amount of funding should also go to the GLBT Domestic Violence Coalition to coordinate efforts, and to provide support and ongoing technical assistance to the advocates.
   - Increase funding for mainstream programs to institutionalize current GLBT-specific programming that is reliant on a champion staff member and vulnerable to discontinuing if staff member departs.
   - Increase funding for the provision of GLBT culturally-appropriate certified batterer intervention services.
   - Further incorporate GLBT inclusivity into the scope of services for all state-funded contracts for sexual and domestic violence.
     - Require all state-funded sexual and domestic violence and certified batterer intervention programs to provide safe and culturally competent services for GLBT victims and perpetrators, and that GLBT victims and perpetrators have access to the full range of services the agency provides.
     - Require state funders to develop uniform means to monitor equal access to equal services for GLBT victims and hold deficient programs accountable.
     - Mandate that all education and outreach materials be gender identity and sexual orientation inclusive, unless they are specifically intended as gender-specific or sexual orientation specific materials.
   - Amend public accommodation law to specifically include residential domestic violence programs by editing Massachusetts General Laws Part IV, Title 1, Chapter 272, Subsection 92A, 2nd paragraph by inserting the text “safe home, transitional living program,” between “shelter,” and “roadhouse.”
Secondary Recommendations

1) Increase GLBT community awareness.
   - Increase funding for GLBT culturally-specific community education campaigns to increase awareness of GLBT sexual and domestic violence to allow survivors to self-identify and identify accessible resources.
   - Increase funding for GLBT culturally-specific prevention work to increase awareness of healthy relationships and sexuality and engage in violence prevention strategies.
   - Increase funding for mainstream providers with GLBT cultural competency to engage in proactively inclusive outreach campaigns to change the perception within segments of the GLBT community that mainstream services are solely for heterosexual women.

2) Fund the GLBT Domestic Violence Coalition’s annual Screening Tool Conference to educate domestic violence service professionals (including police, courts and mainstream service providers) on the skills and concepts needed to appropriately screen for victim/perpetrator in a relationship where domestic violence is present.

3) Expand the information gathered in state-funded service activities and in state-mandated reporting mechanisms to include information on domestic violence victimization where that is currently lacking, on perpetration of sexual and domestic violence where that information is currently lacking, to collect gender and sexual orientation information on perpetrators where that is currently lacking, and to collect information on gender identity (inclusive of transgender identities) where that is currently lacking.

4) Leverage state agencies’ regulatory powers to increase healthcare settings’ GLBT access, cultural competence and awareness of GLBT-specific resources for referral.

5) Increase funding for cross-agency collaborations that address the intersection of a survivors’ GLBT identity and their other marginalized identities, such as the four other populations included in this report.

6) Require GLBT sexual and domestic violence specific training for investigators/gatekeepers in the criminal justice system (law enforcement and ADAs) as well as for first responders (911 dispatchers, hospital personnel, and EMTs).
Disparities in Prevalence, Access to Services and Outcomes for Immigrant Survivors of Sexual and Domestic Violence
Introduction

Sexual and domestic violence are significant problems that may disproportionately affect immigrant populations. In Massachusetts, immigrants are two times more likely to be killed by an intimate partner than the general population, and immigrant girls are two times more likely to report recurring sexual assault than non-immigrant girls. Immigrant victims may be more vulnerable due to their social context as immigrants, and experience greater barriers to seeking help and safety. Batterer Intervention services for immigrant perpetrators of intimate partner violence (IPV) also remain scarce.

An immigrant is any person who leaves another country to settle in the US. Under this broad definition are numerous legal and public benefits categories of immigration statuses including refugees, naturalized US citizens, undocumented people, people with work visas, students, etc. Some people in these categories may not self-identify as immigrants. For the purposes of this report, the broadest definition of immigrant will be used.

Demographics

Massachusetts has the 7th largest immigrant population in the US, comprising 14.9% of the total Massachusetts population. According to the 2011 US Census Bureau, the foreign-born population grew by 27% between 2000 and 2011 to a total of 983,389. Of those individuals, 51% were naturalized citizens. One in five MA residents between the ages of 25-54 is an immigrant. One in four children in MA is a child of an immigrant. The foreign-born population hails from around the world with the top three regions being Latin America (35.7%), followed by Asia (29.3%), Europe (23.3%), and Africa (8.4%).

Prevalence

Domestic Violence

The prevalence of domestic violence is difficult to determine because of under-reporting due to lack of linguistic access, fear of government authorities, and real or perceived discrimination. Existing research suggests that the severity and prevalence of Intimate Partner Violence (IPV) or IPV related homicide and sexual assault may be higher among immigrant women and girls than among non-immigrants. There is a lack of data on immigrant men and boys. Data on immigrant domestic violence is also limited in that most studies are focused on specific ethnicities and do not account for immigration as a separate variable.

- Using data from the MA Department of Public Health, a Harvard School of Public Health report looked at homicides due to domestic violence in MA during the period 1993-2000. It found that people born outside the 50 US States were two times more likely to die of a domestic violence homicide than their US born counterparts. A follow-up Yale School of Public Health study spanning 1996-2009 also found that immigrants were twice as likely to be killed due to IPV as non-immigrants.
• Figures from a New York City Department of Health Study on female homicides from 1990-1997 reveal that immigrant women were over-represented in the statistics charting female victims of male-partner-perpetrated homicide. They found that 54% of intimate partner homicide victims were foreign-born women, although foreign-born women constituted just 28% of the female population. In a separate race analysis, they also found that Asian women were more likely to be killed by an intimate partner than by a non-intimate perpetrator when compared with other women.

• A multi-year 1995-2002 review of intimate partner homicides in New York City found that 57% of the victims were foreign born women. Immigrants’ vulnerability (i.e., isolation and economic insecurity due to their immigration status), culture, and legal status increase their susceptibility to abuse, and create barriers to seeking help.

• A 2003 study of South Asian women residing in the Greater Boston area found that 40.8% reported intimate partner violence in their current relationship. The majority of this sample (87.5%) was comprised of non-U.S. born women.

• The Washington State Coalition Against Domestic Violence 2006 fatality review found that immigrants were over-represented in the state domestic violence homicides. They found that immigrant victims sought help, but did not have adequate access. In one case, an immigrant hostage victim had to interpret between the police and her husband before her husband killed her.

• In a 2000 study of a sample of Latina immigrant women, 48% of Latinas reported that their partner’s violence against them had increased since they immigrated to the United States. 72% of the battered Latinas surveyed reported that their spouses never filed immigration petitions for them even though 51% of the victims would have qualified to have petitions filed on their behalf.

• Another study found that physically and sexually abused Latina immigrants experienced greater barriers to getting free from abuse than the general population of abused women. These barriers include lack of money (67% of immigrant women vs. 40% of abused women generally), lack of employment (32% vs. 20%), lack of English proficiency (26% vs. 18%), and lack a place to live if they were to leave (35% vs. 18%).

**Sexual Violence**

Immigrants may be subjected to sexual violence as a result of wartime conflict, human trafficking, labor and sexual exploitation, forced marriages, domestic violence, border migration, virginity examinations, and may have increased vulnerability to sexual predators due to legal and social status. Only one prevalence study of sexual violence against immigrants exists, and the remaining studies are ethnic or race specific. There are varied findings among the ethnic specific studies, with some studies reporting higher rates of sexual violence and others reporting lower rates. These varied findings may be due to the stigma of reporting and to inconsistency in translation and interpretation of surveys and interviews.
• A 2007 analysis of the population based Massachusetts Youth Behavior Risk Survey found that immigrant girls were twice as likely as non-immigrant girls to report recurring sexual assault (within past year and prior to past year).[^81]

• Married Hispanics/Latinas were less likely than other women to immediately define their experiences of forced sex as rape and to terminate their relationships; some viewed sex as a marital obligation.[^82][^83]

• A 2000 National Institute of Justice report found that Hispanic women were significantly less likely to report that they were raped at some point in their lives than non-Hispanic women.[^84]

• A Department of Justice report found that Hispanic women were more likely than non-Hispanic women to report that a current or former intimate partner raped them at some time in their lifetime (2.2% higher). Approximately 7.9% of Latinas will be raped by a spouse, boyfriend or ex-boyfriend during their lifetime.[^85]

• Asian and Pacific Islander (API) women tend to report lower rates of rape and other forms of sexual violence than do women and men from other minority backgrounds.[^86] This may be accounted for because Asian values may discourage them from disclosing such victimization, even in confidential settings. Similar to other women of color, API women are subjected to derogatory and demeaning stereotypes. Myths that API women are submissive, elusive, and/or sexually available, make API women vulnerable to pervasive sexual harassment in the workplace, religious institutions, in school, and by law enforcement.

• The Massachusetts Behavioral Risk Factors Surveillance Survey found that Hispanic/Latina women experience approximately the same rate of sexual violence as white women. The National Violence Against Women Survey (NVAWS) found that there was no significant difference between sexual assault of Hispanic women and non-Hispanic women (Hispanic: 21.2%, non-Hispanic: 22.1%).[^87]

[^81]: "A 2007 analysis of the population based Massachusetts Youth Behavior Risk Survey found that immigrant girls were twice as likely as non-immigrant girls to report recurring sexual assault (within past year and prior to past year)."

[^82]: "Married Hispanics/Latinas were less likely than other women to immediately define their experiences of forced sex as rape and to terminate their relationships; some viewed sex as a marital obligation."

[^83]: "Married Hispanics/Latinas were less likely than other women to immediately define their experiences of forced sex as rape and to terminate their relationships; some viewed sex as a marital obligation."

[^84]: "A 2000 National Institute of Justice report found that Hispanic women were significantly less likely to report that they were raped at some point in their lives than non-Hispanic women."

[^85]: "A Department of Justice report found that Hispanic women were more likely than non-Hispanic women to report that a current or former intimate partner raped them at some time in their lifetime (2.2% higher). Approximately 7.9% of Latinas will be raped by a spouse, boyfriend or ex-boyfriend during their lifetime."

[^86]: "Asian and Pacific Islander (API) women tend to report lower rates of rape and other forms of sexual violence than do women and men from other minority backgrounds. This may be accounted for because Asian values may discourage them from disclosing such victimization, even in confidential settings. Similar to other women of color, API women are subjected to derogatory and demeaning stereotypes. Myths that API women are submissive, elusive, and/or sexually available, make API women vulnerable to pervasive sexual harassment in the workplace, religious institutions, in school, and by law enforcement."

[^87]: "The Massachusetts Behavioral Risk Factors Surveillance Survey found that Hispanic/Latina women experience approximately the same rate of sexual violence as white women. The National Violence Against Women Survey (NVAWS) found that there was no significant difference between sexual assault of Hispanic women and non-Hispanic women (Hispanic: 21.2%, non-Hispanic: 22.1%)."
Barriers to Accessing Support and Services

In challenging sexual and domestic violence, service providers often hear and believe that violence is a part of the culture and that immigrants often will not seek help because of these beliefs. A fatality review conducted by the Washington State Coalition Against Domestic Violence challenged the commonly held belief that immigrant women do not want to seek help. It found that immigrant women did seek help, but that they lacked access to the services that were designed to help them and that there was lack of follow-up from the services that they contacted. Cultural beliefs were not a major factor in seeking help, but rather significant systems barriers existed for immigrant victims. Common barriers precluding the victim from seeking help include:

**Lack of linguistically accessible services:** Numerous national health utilization surveys and state benefits data indicate that immigrants under-utilize services relative to their proportion in the population. Much of this is due to the lack of bilingual staff capacity.

- Immigrants may not have access to bilingual shelters or medical care, financial assistance, or food. It is also unlikely that they will have the assistance of a certified interpreter in court, when reporting complaints to the police or a 911 operator, or even in acquiring information about their rights and the legal system.
- Immigrant men are overrepresented in certified batterer intervention programs in Massachusetts. The lack of linguistic court staff may increase the probability that certain immigrant men face harsher consequences to their criminal Intimate Partner Violence offenses than immigrants who speak English.
- Mexican American women are less likely than White women to access support systems such as legal, medical, and judicial systems following a rape.
- In one survey of Latina battered women, the overwhelming majority (75.6%) of participants spoke little or no English, and for those who spoke no English, the survey found that two-thirds of the time, the police who responded to the domestic violence calls did not speak Spanish to the victim or use an interpreter.
- Often abused immigrants must rely on family, neighbors or co-workers to translate for them, and often even their own children in order to seek core services.
- Police officers frequently end up gathering information on a dispute from the abuser, who frequently has greater proficiency in English.

“My partner hit me at a restaurant. I went outside to call the police. Because I cannot speak English, when the police arrived my partner reversed the situation by telling the police the opposite version of what had happened, and I was the one in trouble.” – Maria, Brazilian
Immigration status/fear of deportation: Abusers often use their victim’s immigration status as a tool of control. They may threaten deportation as a means of keeping the victim in the relationship or never apply for adjustment of status that their spouse is entitled to pursue.

- A study of battered Latina immigrant women in the D.C. area found that 21.7% were fearful of being reported to immigration authorities, citing this as their primary reason for remaining in an abusive relationship.\textsuperscript{95}
- Threats to report a victim/survivor to authorities is an indicator of high risk for domestic violence lethality in the Danger Assessment – Immigrant Version.\textsuperscript{96}
- If immigrant victims believe that they are dependent on their abuser for legal status, they are unlikely to report abuse.\textsuperscript{97} This applies in the case when intimate partners and employers sponsor the immigrants’ papers.
- Securing legal status is not accessible for all abused immigrants. VAWA petitions are available only for federally recognized marriages to citizens or Legal Permanent Residents. Although immigration relief, in the form of U visas, are technically available for gay and lesbian victims of sexual or sexual violence, none have yet been granted.
- Fear of the abuser being jailed or deported is also prevalent among victims. If the victim is later deported to her home country, the abuser can be waiting in the home country to retaliate.\textsuperscript{98}

Distrust of the justice system: Many immigrants come from homelands where authorities were repressive. Immigrants are often afraid of seeking help from law enforcement or other government institutions based on these experiences with government institutions in their home country.\textsuperscript{99} In the US, they may be unaware of their rights and of how the United States justice system works or they have experienced or witnessed racial and ethnic profiling and have developed a reasonable fear of authorities.

Shame and taboo: The experience of living in the US is often an isolating one for many immigrants, who are cut off from family members, friends, and the systems and ways of doing things that are familiar. This experience can heighten the reliance on the community and the pressure to maintain the relationship and not to “rock the boat”. Victims may decide not to seek out services, for fear of further oppressing or defaming their own minority community or out of concern that they will be ostracized from the community. It is helpful to understand these concerns and be able to assure victims of their right to confidentiality. Shame also impacts help seeking among immigrants, as survivors who feel shame may not ask for help. Finally, shame about the perpetrator’s behavior has been found to be a high risk indicator for domestic violence lethality for immigrant women.\textsuperscript{100}

\begin{quote}
“In my country, domestic violence is not seen as a social problem. When I seek help, people say that I should go back with my husband and tell me my children cannot grow up without a father.” – Pilar, Mexican
\end{quote}
Lack of economic resources: Immigrant victims may lack economic means to self-sufficiency. Many immigrants with legal immigration status and undocumented immigrants are not permitted to work under rigid immigration laws. Some visas are linked to the employer’s sponsorship, trapping immigrants with employers who may be abusing or coercing them. Immigrants who lack proof of status are not eligible for federal safety-net benefits such as Transitional Aid to Families with Dependent Children (TAFDC) cash assistance, food stamps and non-emergency MassHealth. For battered immigrants who appear federally eligible, there are additional hurdles. Immigrants who meet the federal criteria for benefits –including immigrants who have Legal Permanent Residency status or who self-petition under VAWA - must wait for five years to elapse before qualifying for benefits in most programs. And, as noted above, battered immigrants who cannot apply under VAWA despite the severity of their plight are simply ineligible for most safety-net benefits.

“I was living in an emergency shelter after I fled my abuser. I went to the local welfare office to get some help for my family. When I showed them my documents, they said I had to wait five years from the month my VAWA petition was filed. I cannot wait five years!”
Carmen, reported to Western Mass domestic violence shelter.

“Where, what are you going to buy. You just got paid, give me your check. It is my money. You do not have anything here. Everything belongs to me.” Emilia, client of the Boston Area Rape Crisis Center, reporting her abuser’s comments to her before she left him.

Funding Trends

Immigrants throughout Massachusetts remain an underserved community. Immigrants pay more in taxes than they use in services and may be ineligible to receive the benefits and services that a citizen can receive. For example, one study found that immigrants contributed $115 billion dollars more to the Medicare Trust Fund than they accessed in Medicare services.¹⁰¹

Survivors of sexual and domestic violence rely on a safety net of programs, entitlements and rights in order to attain safety. For immigrants, there has been a steady erosion of these programs and rights, leaving immigrant victims/survivors of sexual and domestic violence without the resources that they need. Examples of programs and rights to which US citizen victims/survivors have access, and to which immigrant victims/survivors have restricted or no access include: cash assistance and food stamps, public housing, health insurance, drivers licenses, educational scholarships and loans, being able to call the police for help without fear of deportation, etc.

The Refugee and Immigrant Safety and Empowerment (RISE) Programs were funded specifically to serve the needs of this vulnerable population. In FY2013, the RISE programs were funded at the level of $1,068,842.38, a drop from the FY2009 level of $1,319,853.96. In FY2014, funding was partially restored, but is lower than FY2009 levels.


**Current Efforts**

The MA Department of Public Health funds the Refugee and Immigrant Safety and Empowerment Programs (RISE) to provide sexual and domestic violence services and community organizing for immigrants. These 21 programs provide crisis intervention, safety planning, advocacy for safety net resources, and immigration counsel and representation in over 15 languages. In addition, some of these programs organize immigrant communities to change social norms and increase immigrant communities’ capacity to recognize, respond and/or refer victims/survivors and perpetrators.

A working group comprised of RISE Programs, legal services programs, a nurse scientist, and the MA Department of Public Health have held focus groups to explore high risk factors for immigrant domestic violence related re-assault and homicide. The risk factors for immigrants, such as shame and acculturation, are significantly different than the risk factors for non-immigrants, which include firearms and unemployment. The working group is exploring possibilities for further study of the risk factors with local and national researchers. Increased knowledge of risk factors can inform the risk assessments that are conducted by domestic violence programs and high risk teams.

Jane Doe, Inc has an Immigrant and Refugee working group comprised of advocates from member programs that meet quarterly to address issues related to working with victims and survivors from immigrant and refugee communities across the Commonwealth.

MA Immigrant and Refugee Advocacy (MIRA) Coalition has a 3-year collaboration with the Massachusetts Early Education and Care (EEC) Office, Office of Refugees and Immigrants (ORI), the Multicultural Action Council, and staff from Wheelock College to offer trainings for EEC providers, social service agencies, and other stakeholders to increase awareness of the needs of immigrant and refugee children and bridge gaps in school readiness. The trainings included a focus on domestic violence and human trafficking issues as they impact immigrant communities, especially undocumented immigrants given Secure Communities, with an emphasis on the avenues of accessing T Visas and U Visas.

UU Mass Action has been working with a broad coalition of organizations to mitigate some of the harmful impacts of the federal Secure Communities Program. Secure Communities is a deportation program requiring local law enforcement to share data directly with federal Immigration and Customs Enforcement. This program has spread fear and has negatively impacted the relationships of local law enforcement agencies with immigrant communities and immigrant sexual and domestic violence survivors.

A broad coalition of organizations has been working to defend access to public safety net programs for certain vulnerable categories of immigrants, in response to certain state legislative proposals. They are currently working to preserve access to public housing for immigrant U visa holders, which include victims of sexual and domestic violence and human trafficking. Similar efforts successfully defeated a proposal to deny certain immigrant statuses access to a health care programs. This broad coalition includes victims/survivors, REACH Beyond Domestic Violence, MIRA Coalition, Jane Doe Inc., churches, immigrant advocates, housing and workers’ rights organizations and legal advocacy groups.
**Recommendations**

1) Increase bilingual/bicultural advocacy and counseling services to assist victims’ access to social service, educational, medical, legal, and housing systems.

2) Increase legal counseling and representation to assist victims in filing for immigration relief. Access to immigration relief may enable victims to be able to work and to access federal safety net programs.

3) Expand and enhance interpreter services and increase bilingual/bicultural staff at all levels – in courts, health systems, law enforcement, social service systems, etc.

4) Increase understanding of the high risk factors that are specific to immigrants, rather than simply applying a general model of high risk to this population. Develop high risk responses that factor in immigrant victims'/survivors’ needs to be safe from deportation and safety plan around threats to family members in their countries of origin.

5) Increase linguistically and culturally appropriate community organizing in immigrant communities so that social norms condoning sexual and domestic violence can be changed and so immigrant communities know their rights and know of resources.

6) Increase the linguistic capacity of Certified Batterer Intervention Programs to provide services to immigrant perpetrators in their first language; and increase the capacity of Certified Batterer Intervention Programs to provide culturally-informed services so that they can more effectively address cultural belief systems while applying the power and control framework.
Disparities in Prevalence, Access to Services and Outcomes for Survivors of Sexual and Domestic Violence with Disabilities
Introduction

People who have disabilities are more likely than those who are not disabled to be victims of many types of crime, including sexual and domestic violence. People with disabilities are not “exempt” from sexual and domestic violence: people with disabilities experience relationships, and encounter the potential of being victimized by partner violence in the same ways as every other population in childhood, adolescence and adulthood.

Acts of domestic and sexual violence are committed at a higher rate against disabled individuals and people who are deaf. Furthermore, specific types of abusive or controlling acts are more readily committed against people with disabilities whose physical or cognitive limitations grant them less control over their environment. It is essential to note that the intersection between violence and disability may be quite overt: some people initially acquired their disability as a direct or indirect result of experiencing sexual or domestic violence.

We acknowledge that as people age, there is a much greater likelihood that they will acquire a disability, thus there is much overlap regarding violence perpetrated against elders and people who have disabilities; we also acknowledge that “people with disabilities” are part of every population - including every underserved group discussed in this report.

Ableism, or discrimination and social prejudice directed toward people living with disabilities, plays a unique role in the experience of sexual and domestic violence for this population. For example, survivors with disabilities may experience systemic barriers from service providers, such as inaccessible community-based and shelter services, lack of sexual and domestic violence training for disability service providers, and inadequate responses from sexual and domestic violence organizations.

Despite advances in disability services and regulations following the Americans with Disabilities Act (ADA) of 1990, substantial societal limitations remain for some people with disabilities. The independent living movement, which advocates that people with disabilities should be at the forefront of designing services since they are the best experts on their needs, suggests that “structural barriers in society, from a lack of wheelchair ramps to a lack of attendant services and stereotyp[ing] attitudes…are the fundamental problems faced by people with disabilities.” This suggests that a cultural shift is necessary to foster an environment in which people with disabilities are able to live healthy, safe lives.

The scope of this report includes people in the Commonwealth of Massachusetts with disabilities, as defined by the ADA – the civil rights laws that prohibit discrimination based on disability status. The ADA defines disability as, “a physical or mental impairment that substantially limits one or more of [a person’s] major life activities.”
The Individuals with Disabilities Education Act (IDEA) recognizes the following categories of disabilities, which will be covered in this report.

- Intellectual or Developmental Disabilities: “When a person has certain limitations in mental functioning and in skills such as communicating, taking care of him or herself, and social skills.”

- Mental Health Disabilities: “Refers to disorders generally characterized by dysregulation of mood, thought, and/or behavior. Mood disorders are amongst the most pervasive and include major depression.”

- Mobility Disabilities: “A condition limiting physical ability; generally considered to include lack of or decreased movement due to disease, amputation, paralysis, injury, or development condition; or limitation of movement due to cardiovascular or other disease. Conditions can range in severity from limitations of stamina to total paralysis.”

- Sensory Disabilities: “A term that refers to a disability that may involve one or more of the five senses, including hearing, vision, or both hearing and vision. Sensory disabilities affect access to visual and/or auditory information.”

- Other Disabilities: Additional disabilities, which limit daily functioning, may include conditions such as HIV/AIDS, epilepsy, cancer, diabetes, and recovering from dependence on alcohol and/or drugs.

It is important to recognize that disabilities can be temporary or chronic and may present at birth or be acquired later in life and are especially common among people who are elderly. The environment in which people live has a significant impact on empowering or disempowering people with disabilities. The World Health Organization illustrates the connection between environment and disabilities by stating that “a disability is a complex phenomenon, reflecting an interaction between features of a person’s body and features of the society in which the person lives.”

Deafness is classified by the ADA as a sensory disability, which provides civil rights protections to people who are D/deaf. It is important to recognize that people may identify as Deaf, emphasizing the uppercase D as a cultural and linguistic identity rather than a disability. A significant portion of people who are deaf or hard of hearing do identify with Deaf culture and may not identify as deaf or hard of hearing. For the purposes of this report, and as supported by the Massachusetts Commission for the Deaf & Hard of Hearing, we have included people who are D/deaf or hard of hearing in our definition of people with disabilities.
Demographics

In 2010, the United States Census gathered data from the Survey of Income and Program Participation (SIPP) in order to measure the national population of people with disabilities. It is important to note that the demographic information does not include people who are living in institutions, such as correctional facilities and nursing homes. It is estimated that if the survey included people who were institutionalized, the number of people with disabilities represented in the Survey report would be greater.110

Despite this limitation, the national report shows that approximately 56.7 million people (18.7%) of the 303.9 million in the civilian non-institutionalized U.S. population had a disability in 2010. About 8.3 million people (12.6%) had a severe disability, or a disability that impacts daily functioning, of which 4.4% needed assistance with one or more activities of daily living or essential activities of daily living.111

There is a significant intersection between those who are elderly and people with disabilities. The U.S. Census Bureau reports that “people in the oldest age group (people 80 years and older) were about 8 times as likely to have a disability as people in the youngest age group (children less than 15 years old).”112

The Massachusetts Behavioral Risk Factor Surveillance System (MA-BRFSS) shows percentages within the Commonwealth of Massachusetts. In 2010, 18.7% of the population in Massachusetts identified as having a disability. The table below shows the population of people who reported having a disability in the MA-BRFSS surveys between 2000 and 2010, which remained relatively stable over time.113 Note that people who are Deaf would not have been included in this phone-based survey.

<table>
<thead>
<tr>
<th>MA BRFSS Data 2000 – 2010 on People with Disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with disability</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>% needing help with activities</td>
</tr>
</tbody>
</table>

Disparities Report for People with Disabilities 37
Prevalence

Domestic Violence

Due to the diversity encompassed by the term “disability”, it is difficult to generalize about the incidence and prevalence of violence in the entire disability community. Most of the data presented herein are derived from survivors who have self-disclosed a disability.

The following data present a broad overview of the many populations of survivors with disabilities. Domestic violence statistics include abuse from intimate partners, family members, and personal care attendants, as well as other individuals who support the health and wellbeing of the individual. Additional research is needed for specific subpopulations within the greater disability community in order to gain more knowledge of the unique experiences of these diverse survivors. The following prevalence rates overwhelmingly represent survivors of domestic violence who are women with disabilities. Additional research is needed to understand prevalence rates among survivors who are men and people who identify as transgender who are living with disabilities.

- 62% of a national sample of women with physical disabilities reported having experienced emotional, physical, or sexual abuse.\textsuperscript{114}
- People with disabilities were more likely (19.7%) than people without disabilities (8.2%) to experience a history of nonconsensual sex by an intimate partner.\textsuperscript{115}
- People with intellectual or developmental disabilities experience victimization from a known and trusted individual at a rate of 97-99%, of which 32% of the offenders are family members or acquaintances and 44% are persons who had a relationship with the survivor specifically related to the person’s disabilities (i.e., residential care staff, transportation provider, or personal care attendant).\textsuperscript{116}
- Women with disabilities experience more severe and longer-lasting violence involving a greater number of abusers compared to women without disabilities.\textsuperscript{117}
- A comparative study of abuse among women with and without disabilities found that women with disabilities who lacked appropriate victim services experienced more severe, longer-lasting violence.\textsuperscript{118}

The U.S. Center for Disease Control and Prevention analyzed data collected from the 2006 U.S. Behavioral Risk Factor Surveillance System (US-BRFSS), which reports that:

- People with disabilities were more likely (28.5%) than people without disabilities (15.4%) to experience threats of violence, or experience acts of violence such as hitting, slapping, pushing, and/or kicking by an intimate partner.
- Women with a disability were significantly more likely (37.3%) than women without a disability (20.6%) to experience intimate partner violence in their lifetime.

Limited data exists for statewide information with regard to domestic violence experienced by people with disabilities. The Commonwealth of Massachusetts Disabled Persons Protection Commission (DPPC) is an independent state agency responsible for the investigation and remediation of instances of abuse committed against persons with disabilities in the
Commonwealth. The jurisdiction of DPPC includes adults with disabilities between the ages of 18 and 59, who are either in state care or in any private setting, and who experience serious physical and/or emotional injury through the act and/or omission of their caregivers. The DPPC is a state-mandated program, requiring certain professionals (such as teachers, social workers, police, RNs, MDs, EMTs, etc.) to report incidences of physical abuse, emotional abuse, sexual abuse, financial exploitation or neglect of people with disabilities in the above age group. Please see the chart below on domestic violence and sexual abuse reports filed with the DPPC.

### Allegations Made to DPPC by Fiscal Year for Domestic Violence and Sexual Abuse

<table>
<thead>
<tr>
<th>Fiscal Years</th>
<th>Abuse Reports</th>
<th>Domestic Violence</th>
<th>Sexual Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>6,898</td>
<td>319</td>
<td>652</td>
</tr>
<tr>
<td>2011</td>
<td>7,061</td>
<td>236</td>
<td>563</td>
</tr>
<tr>
<td>2012</td>
<td>7,732</td>
<td>256</td>
<td>565</td>
</tr>
<tr>
<td>2013</td>
<td>7,986</td>
<td>233</td>
<td>587</td>
</tr>
<tr>
<td>2014</td>
<td>9,018</td>
<td>322</td>
<td>706</td>
</tr>
</tbody>
</table>

### Sexual Violence

- A 1994 study found that 80% of women and 30% of men with intellectual disabilities have been sexually assaulted; of those women, 50% have been assaulted more than ten times.  
  
- If the victim or survivor of sexual violence has a disability, between 88% and 98% of abusers are known to the victim.

- Only 3% of sexual abuse cases involving people with disabilities are reported.

- A Canadian study predicted that 83% of women with disabilities would be sexually assaulted in their lifetime.

- Men with a disability are twice as likely as men without a disability to experience sexual abuse over their lifetime.

- A study of Deaf adults reports that 50% of deaf people experience sexual abuse as children.

- 1 in 5 female and 1 in 6 male psychiatric inpatients reported sexual abuse that was recurrent.

The MA BRFSS, from 2005 to 2009, shows that people who reported having a disability are more likely than those without disabilities to experience sexual violence over their lifetime. The following statistics from the MA BRFSS illustrate the way in which people with disabilities in the Commonwealth of Massachusetts experienced sexual violence victimization:

- Women with disabilities experienced sexual violence at a rate of 26.6% compared with those without a disability at 12.4%.
• Men with disabilities experience sexual violence at a rate of 13.9% compared with those without a disability at 3.7%.\textsuperscript{127}
• Women with disabilities experienced completed rape at a rate of 18.3% compared with those without a disability at 5.9%.\textsuperscript{128}
• Men with disabilities experienced completed rape at a rate of 6.0% compared with those without a disability at 1.0%.\textsuperscript{129}

In addition, the Massachusetts Disabled Persons Protection Commission provides the following information online with regard to the rates of sexual violence victimization amongst persons with disabilities.

• People with developmental disabilities experience sexual abuse at a rate of 90%, of which 49% will experience ten or more incidents.\textsuperscript{130}
• Incidences of sexual abuse for those with disabilities are highly underreported. The 2010 Massachusetts BRFSS found that only 3% of sexual abuse cases that involve people with developmental disabilities are reported.\textsuperscript{131}

**Dynamics of Sexual and Domestic Violence for People with Disabilities**

**Culturally-Specific Dynamics of Domestic Violence**

Domestic violence may involve the use of emotional, physical, sexual, and financial abuse, as well as abandonment and neglect. People with disabilities who experience domestic violence are subject to all forms of abuse, including cultural/identity abuse, wherein one person uses the identity of a partner to gain and maintain power and control in an intimate relationship. Cultural/identity abuse does not only include ability status, but may also include race, ethnicity, religion, sexuality, gender identity/expression, class, amongst others. Survivors who identify with more than one marginalized identity may experience cultural abuse in different forms. Examples of cultural/identity abuse experienced by survivors living with disabilities include:

• Threatening to withhold/withholding or controlling access to medication.
• Threatening to withhold/withholding or controlling access to mobility, communication, or breathing assistance devices.
• Threatening to withhold/withholding or controlling access to transportation.
• Controlling access to doctor’s appointments related to an individual’s disabilities.
• Limiting communication and access to those outside the relationship.
• Controlling access to personal care services or neglecting personal care services.
• Defining the reality of the relationship around an individual’s ability status.
• Blaming the abuse on a person’s ability status.
• Convincing the survivor that nobody will help them because they have a disability.
For people with disabilities, the definition of “intimate partner” may be expanded to include those who have a very close connection with the individual. This may include personal care attendants or other caregivers, both inside and outside of the family. Additional barriers to accessing services and tactics of abuse that are unique for people living with disabilities will be discussed further in this report.

It is important to recognize that it may be quite easy for some abusers to assert power and control over a survivor with a disability based on the abuser’s “ability status” in the relationship. For example, an able-bodied abuser may have greater control over mobility and communication. Ultimately, the way in which an individual experiences domestic violence may be influenced, to some degree, by their ability status.

**Culturally-Specific Dynamics of Sexual Violence**

People with disabilities may confront a number of additional factors with regard to sexual violence victimization. The rate of sexual violence is greater for people living with disabilities, and they are most likely to experience such victimization by a family member, acquaintance, residential care staff, transportation provider and/or personal care attendant. It is important to recognize that sexual and domestic violence survivors with disabilities may specifically be vulnerable to and selected for victimization by the offender due to the survivor’s ability status, and the survivor may confront a number of additional barriers when seeking services.

**Barriers to Accessing Support and Services**

Survivors of sexual and domestic violence who are living with disabilities may experience barriers to accessing support and services due to a number of factors, including perceived or actual lack of communication and/or mobility accessibility. In addition, survivors with disabilities may have to overcome physical and social isolation that is connected to their ability status. Survivors may have additional fears about seeking support and services, including the fear that they may not be able to communicate due to their ability status, that others may learn about a confidential aspect of their ability status (mental health and/or HIV/AIDS), or that the abuse will worsen when the abuser is unintentionally notified of the disclosure due to their relationship with the survivor (e.g., guardian). Such additional worries may compound the trauma the survivor has already experienced.

An ad-hoc committee of the Governor’s Council to Address Sexual and Domestic Violence conducted a survey on sexual and domestic violence support and services for people with disabilities. Below is a brief summary of the barriers to accessing services, the needs and the priorities regarding survivors with disabilities as identified by advocates, state and community agencies, and other concerned activists.

**Lack of Service Provider Competency:** Many sexual and domestic violence service providers still lack the knowledge, expertise, skills, and training to properly provide support and services for people with disabilities as well as those who are D/deaf or hard of hearing. In addition, many community-based disability service agencies lack the knowledge to support survivors of sexual and domestic violence. Despite the fact that the Americans with Disability Act has existed since
1990, many providers at sexual and domestic violence agencies have a lack of awareness about disability rights and accommodations, as well as Deaf culture, which can lead to negative situations when working with survivors with disabilities. A lack of interagency training between sexual and domestic violence agencies and disability service providers contributes to the barrier in providing culturally-competent services.

**Lack of Accessibility:** Survivors of sexual and domestic violence who are living with disabilities report barriers to accessing services due to physical, cognitive, or communicative abilities. For those whose abusers are also their primary caretakers, there may be additional barriers to accessing services due to the abuser’s degree of power and control over the survivor’s mobility and communication.

**Lack of Interpreter/Poor Communication:** The National Association of the Deaf (NAD) emphasizes the need for effective communication. It states that when a deaf victim does not have effective communication with an attorney, court, law officer, medical personnel or shelter staff member, then no real communication is processed. This fails to provide justice for the deaf survivor, and often the perpetrator is not punished.

One of the barriers to effective communication in Massachusetts is a shortage of qualified, skilled ASL interpreters and/or appropriate accessible alternate modes of support for communication (example: Communication Access Real-time Translation [CART]). Qualified ASL interpreters complete formal rigorous training programs in ethics, professionalism, confidentiality, and are objective in their interpretation. Presently there is no specialized ASL training for domestic violence situations; however, there have been trainings on rape crisis for some legal interpreters. It is imperative to have qualified interpreters rather than have someone who is fluent in ASL but not properly trained in the above manner. There are many legal situations whereby Certified Deaf Interpreters (CDI) in conjunction with ASL interpreters are necessary. Certified Deaf Interpreters are trained to break down the language barriers further for deaf individuals with cognitive barriers, delays in ASL language development, and for those from other countries who are not fluent in ASL, or those who may be in trauma.

A second barrier for D/deaf victims of violence is that many agencies, services and programs are uneducated about the needs of this population. They are not aware of the cultural implications and may be unaware as to how to make the request for ASL interpreters or CART services to allow the survivor equal access to support services. This is hampered by either a lack of education (knowledge of the ADA), or perceived lack of funding for interpreters/CART services, or lack of protocol to pay for these services. Availability of certified legal and/or medically-trained ASL Interpreters also hinders service access. It should be noted, at this writing, in Massachusetts there are only 17 ASL Legal interpreters and eight qualified Certified Deaf Interpreters. Lastly, some D/deaf or hard of hearing survivors who are not fluent in ASL are not informed of their rights to alternative modes of communication access, such as CART, remote CART, and/or oral interpreters, and do not know how to advocate for themselves.
Attitudinal Barriers/Lack of Cultural Understanding: Ableism, or discrimination and social prejudice directed toward people with disabilities, is a significant barrier for survivors in accessing culturally-competent support and services. People who are D/deaf or hard of hearing that seek assistance at domestic violence service providers often experience staff who are unfamiliar with ASL and D/deaf cultural norms and are therefore at a complete disadvantage when trying to effectively serve people who are D/deaf or hard of hearing. There is a “double code of silence” related to domestic violence because services are typically not culturally sensitive or accessible for deaf survivors and because D/deaf communities have been historically misunderstood or minimized the issue. Individuals often have hesitancy about accessing services due fear about being subjected to myths and stereotypes regarding people with disabilities and/or those who are D/deaf or hard of hearing.

Lack of Knowledge/Education & Awareness Among Survivors: People living with disabilities and those who are D/deaf or hard of hearing experienced a lack of knowledge with regard to the prevalence of sexual and domestic violence within their community, as well as a lack of knowledge of culturally-competent support and services. A lack of consistent outreach with regards to sexual and domestic violence services, as well as community stigma associated with sexual and domestic violence, were barriers to increasing knowledge.

Lack of Agency Coordination & Collaboration: A number of systemic barriers exist that inhibit one’s ability to access support and services. An overall lack of interagency collaboration exists between disability service providers and sexual and domestic violence organizations. An overall lack of knowledge about each other’s services, as well as the lack of a coordinated response system for referring survivors to support and services creates additional barriers for survivors living with disabilities.

Program & Service Limitations: The lack of resources for disability service providers and sexual and domestic violence agencies created barriers for survivors in the forms of understaffing, competing priorities, and a lack of capacity to support survivors with physical, cognitive, and communicative disabilities.

Lack of State-Level Coordination: State agencies that provide services for people with disabilities and survivors of sexual and domestic violence do not have systems in place for coordinating sharing of resources and data to better support survivors who are living with disabilities.
**Funding Trends**

A survey conducted by the 2007 Ad-Hoc Committee on Disabilities of the Governor’s Council to Address Sexual and Domestic Violence also concluded that there is a lack of funding for sexual and domestic violence services for people living with disabilities. The report notes that sufficient funds have not been made available to support necessary changes in the field and that more funding is needed to provide adequate services.

The funding trends in the Commonwealth of Massachusetts for the Disabled Persons Protection Commission (DPPC) from FY2010 to FY2014 show a relatively stable rate of funding. The DPPC funding levels by fiscal year for the past five years is as follows:

- FY2010: 2,222,665
- FY2011: 2,174,159
- FY2012: 2,210,698
- FY2013: 2,293,758
- FY2014: 2,412,668

At this time, it is not possible to disaggregate the funding that is dedicated to sexual and domestic violence services for people with disabilities.

**Current Efforts**

The State Prevention Team/Governor’s Council on Sexual and Domestic Violence Developmental Disabilities Committee, a partnership comprised of the Department of Developmental Services (DDS), Department of Education (DOE), the DPPC, Department of Public Health (DPH) and Impact Ability and other appropriate parties, works to promote primary and secondary sexual violence prevention for people with developmental and other disabilities. They have created a Healthy Relationships, Sexuality and Disability Resource Guide. This work was initially supported by the Centers for Disease Control and Prevention.

The Building Partnerships Initiative, a program of the DPPC, created a peer-to-peer training curriculum entitled *Awareness and Action: Educating Persons with Disabilities on Recognizing, Reporting and Responding to Abuse*. The curriculum and materials were developed by persons with disabilities to educate persons with disabilities about abuse against these populations. Triangle Inc.’s IMPACT: Ability program empowers people with disabilities and the organizations that serve them to prevent abuse. Triangle develops model policies, teaches risk reduction techniques, includes primary prevention, and trains clients and staff members in how to respond to and report abuse.

DPH currently requires rape crisis centers in Massachusetts to have a disability access policy, which includes appointing an ADA coordinator, training for employees, transportation access, linguistic access for ASL, and making accommodations for interviewees and program staff with disabilities. Progress is beginning to be seen in this area; however, more resources are needed in order to ensure a robust effort. These DPH protocols could also be shared with domestic violence programs and their funding agencies.
In 2014, DPH and DPPC began engaging in cross-agency training efforts, and co-sponsored a session for DPPC investigators and rape crisis staff members on providing services to sexual assault survivors who have developmental or intellectual disability. Additionally, the two agencies are working on a referral guide for mental health clinicians who are trained to provide trauma-informed therapy services to this same population.

In 2005, Jane Doe, Inc., coordinated Project GAINS, which assessed physical and programmatic access for people living with disabilities at domestic violence shelters and rape crisis centers. They provided technical assistance to programs on their findings and assisted programs in creating plans to improve their accessibility.

**Recommendations**

The Services Accessibility Working Group of the Governor’s Council to Address Sexual and Domestic Violence provides the following recommendations to improve access to support and services for survivors of sexual and domestic violence who are living with disabilities.

1. Increase coordination and training among state agencies (Department of Children and Families, DPH, Massachusetts Office of Victim Assistance, Executive Office of Public Safety, Executive Office Elder Affairs, DPPC, Massachusetts Commission for the Deaf and Hard of Hearing, DDS, Office for Refugees and Immigrants, and the Department of Mental Health), disability service providers, as well as sexual and domestic violence service providers to provide better support and services for survivors who are living with disabilities. Increased collaboration may include improving information sharing systems, data collection, and/or cultural-competency training.

2. Sexual and domestic violence direct service providers should improve their knowledge and accordance with laws that impact the lives and experiences of survivors living with disabilities, such as the ADA.

3. State and federal agencies that provide funding to sexual and domestic violence agencies should increase mandated and monitored compliance with laws and policies that impact the lives of survivors who are living with disabilities.

4. Improve the response from law enforcement and courts by ensuring accessibility (mobility and communication technology per survivors’ needs). This may include media relay, appropriate translator services, or wheelchair accessibility.

5. Improve the ability for DPPC to collect data on sexual and domestic violence experienced by people living with disabilities.

6. Increase funding to support domestic violence agencies that provide support and services to survivors living with disabilities. This may include additional funding for service specialists, emergency and interpreter services, and/or additional volunteers.
Disparities in Prevalence, Access to Services and Outcomes for Rural Survivors of Sexual and Domestic Violence
Introduction

In rural Massachusetts, sexual and domestic violence continue to be leading health problems exacerbated by social and geographic isolation and the lack of public transportation, housing, employment, child care, anonymity, and accessible health and human services. Although sexual and domestic violence cross all socioeconomic lines, the overwhelming poverty of many rural communities in Massachusetts further limits the choices of victims there, preventing escape and access to assistance.

Without understanding the unique characteristics of rural environments, it is impossible to respond appropriately and fully to sexual and domestic violence in rural areas. Rural environments are distinct from urban environments in ways that affect the ability of the criminal justice system to investigate and prosecute sexual and domestic violence, and to provide appropriate and effective intervention. It is also more difficult for service providers to treat and counsel victims. The geographical and cultural features of the rural environment also impact the ability of abused rural victims and their children to access the justice system and social service agencies and these challenges impact holding perpetrators accountable.

Demographics

The US Census defines ‘rural’ as places with low population density, usually meaning a town of 2,500 people or less. Poverty levels are typically higher in rural areas but rural communities also display great differences in demographic, economic, and social characteristics. "Rural" can mean many things in terms of living situations and realities for victims of sexual and domestic violence. For example, it can mean a single family living on a farm miles from the nearest neighbor or town, a small dispersed community with limited services and resources, pockets of families and ethnic groupings, or a small town/village that has experienced economic and population decline.

Massachusetts is often identified with the urban character of greater metropolitan Boston, yet the reality is two thirds of the State’s more than ten thousand square mile landmass is rural. Nearly half of Massachusetts towns (48%) are rural by a federal definition and are primarily located in the western, central, and coastal southeastern parts of the state. Berkshire, Franklin, Dukes (Martha’s Vineyard), and Nantucket counties are the most rural in character, with parts of Hampshire, Hampden, Worcester, Barnstable and Middlesex counties also including several rural communities. Among the 169 rural Massachusetts towns, 42% have populations of less than 2,500, and 41% have population densities of less than 100 people per square mile. 12% of the state’s 6.5 million residents live in rural communities.

Poverty in the region is a significant barrier for many families affected by domestic violence. According to US Census data, an average of 24% of the population in Massachusetts’ four predominantly rural counties is low income, at below 200% of the poverty level (Berkshire, Franklin, Hampshire, and Dukes Counties). In these rural counties, an average of 31% of female-headed households with children under the age of 18 have incomes below the federal poverty level. In Berkshire and Franklin Counties, the poverty rates are substantially higher than
in the Commonwealth as a whole with the percentage of poverty among all people being 20% greater than that for the state.\textsuperscript{138}

While there is a great need for Massachusetts-specific evidence-based studies of rural sexual and domestic violence, national research suggests a significant need for expanded services for victims of sexual and domestic violence in rural areas.\textsuperscript{139} Less than 33\% of rural US counties have domestic violence victim service programs, including hotline, legal services, or counseling programs (as opposed to 71\% of urban counties), and only 25\% of rural counties have domestic violence shelters (compared to 66\% of urban counties).\textsuperscript{140}

According to the National Sexual Violence Resource Center, over 70\% of sexual assaults nationwide are never reported to law enforcement: underreporting in rural communities is much higher.\textsuperscript{141} Studies have consistently pointed to the importance of the victim-offender relationship in affecting whether the victim reports the crime.\textsuperscript{142} Although some rural residents can be quite isolated and relatively unknown, in general, the lower population density in rural areas and the often close-knit nature of rural communities translates into a lack of anonymity. Some studies show that in rural communities, law enforcement personnel are likely to be a part of the social network, so victims may not feel that the reporting process is safe or confidential.\textsuperscript{143}

**Prevalence**

Rates of sexual and domestic violence in all rural and urban areas are alarmingly high, with women disproportionately impacted by such violence. According to the largest national study to date, nearly 1 in 5 women and 1 in 71 men have been raped in their lifetime; 1 in 4 women have been the victims of severe physical violence by an intimate partner while 1 in 7 men experienced severe violence by an intimate partner.\textsuperscript{144} These figures are borne out by the experience of rural service providers throughout the country.\textsuperscript{145}

While no studies comprehensively examine the prevalence of rural sexual and domestic violence in Massachusetts, there is abundant evidence from a variety of data sources including criminal justice, social service and public health statistics, as well as testimony from rural victims and their advocates.

- The rate of issuance of restraining orders in predominantly rural Berkshire, Franklin and Northwest Worcester counties are 37\%, 36\% and 53\% higher, respectively, than the state rate.\textsuperscript{146}

- In 2005, a Department of Justice study found that 18\% of all homicides in rural areas involved an intimate partner compared to 6\% in larger cities.\textsuperscript{147}

- Data from the 2009 MA Youth Health Survey indicates that 17.3\% of MA rural female high school students report a lifetime history of dating violence vs. 13.8\% for their peers in urban or suburban areas of the state.\textsuperscript{148}
• Survivors in this region reported rapes to area rape crisis centers at a rate twice as high as the state rate (67 vs. 33 per 100,000).\textsuperscript{149}

• The rural towns of Athol, Greenfield, Hancock, Hatfield, Montague, North Adams, Orange, Otis and Wendell have over 3 times as many registered sex offenders as the state average.

• Franklin, Berkshire and Dukes Counties have no SANE (Sexual Assault Nurse Examiner) certified sites. Sexual assault victims must either find a way to travel long distances or forgo having appropriate forensic evidence collection performed by a dedicated specialist.

• Dukes and Franklin Counties have no domestic violence shelters and there is no Department of Transitional Assistance office in Hampshire County.

• For the past five years, Dukes County has lacked an on island Certified Batterers Intervention Program (CBIP). On Nantucket Island, there are no Child Advocacy Center’s and the CBIP has not had a referral to its program in almost five years.

**Barriers to Accessing Support and Services**

While perpetrators of sexual and domestic violence tend to isolate their victims in any geographic setting, for victims living in rural areas this isolation is often even more severe. They may live miles from their nearest neighbor, friend or family member. Lack of available childcare, few job opportunities, inadequate and/or extremely limited public transportation, distance from shelters and services, poverty and economic dependence are just some of the barriers that can make escaping a violent relationship even harder for rural victims.

"Not only was I just isolated from family and friends, but we lived three miles out of town which was basically a mini police station, post office and a church I think was empty. We had no neighbors. No one else. My partner controlled it all. He made sure that everyone in the community didn’t trust me. Even if I wanted to walk into town, there was nothing there. I felt like I was in the middle of nowhere. I felt like no one even knew I was there."

—Joseph, Survivor from rural Western Massachusetts\textsuperscript{150}

A lack of anonymity and confidentiality also make it more difficult for victims of abuse to come forward and seek help. In small towns, it can seem as if everyone knows everyone else. Judges, police officers, and health care providers who know both the perpetrator and the victim socially
may be less likely to recognize or acknowledge the severity of an assault, and confidential disclosures of abuse may be problematic or impossible. A rural advocate working in the western hill towns of Hampshire County commented:

“Privacy is also a big concern since everyone knows everyone else and this makes it difficult to come forward or get support. Batterers are well integrated into the community and people don’t want to take sides. The batterer can even be friends with police in the community. These factors only make it more difficult for the victim to come forward, and in some communities, residents rally around the abuser.”

The increased availability of weapons (such as firearms, hunting knives and everyday tools common in rural households) also increases risk and lethality in domestic attacks upon rural victims. In winter months and during mud season, rural roads are frequently impassable and drive times to area hospitals can take well over an hour. Many roads are not paved, making access in or out extremely difficult or impossible during bad weather.

Many rural communities have no full-time local police officers, so State Police must respond to domestic violence calls. For example, in the nine southern hill towns of Hampshire and Hampden Counties, State Police and Emergency Medical Services response time to a domestic violence call can take more than an hour. The Russell State Police Barracks, which covers this region, has only two cruisers available at any given time to cover 357 square miles. Also, several rural communities may have to share one officer that is certified to handle a sexual assault investigation and these officers may have limited experience in conducting such investigations.

“He didn’t beat me up day after day; it wasn’t that kind of abuse. He raped me well over one hundred times while I was with him. I was afraid every day that it would happen again...He learned from his time of beating his ex-wife that people can see the bruises. People can see the scars. But with the stuff he did to me, people can’t see that.”

—Maya, rural Western Massachusetts

Rural children who witness domestic violence often have little to no access to services specifically directed toward their needs and there is only one pediatric Sexual Assault Nurse Examiner (SANE) site in all of rural Massachusetts.

Rural families may not have phone service or access to the Internet or service is intermittent. Calls for help may all be long distance, enabling abusers to track phone calls. Cell phones often don’t work in rural areas, and there are virtually no public payphones. These gaps in communications infrastructure place victims in increased danger.
Seasonal work may mean months of unemployment on a regular basis and result in victims being trapped with an abuser for long periods of time. Alcohol and drug use, which often increases in winter months when rural people are underemployed and isolated in their homes, can also heighten the frequency and severity of abuse.

Most rural communities lack taxi services or public transportation of any kind. The expense of car ownership and maintenance can be prohibitive for victims of domestic violence, and/or their batterer may disable their car, take their keys, monitor a car’s odometer or maintain control over registration, insurance, etc. The closest domestic violence and/or rape crisis program may be many miles away in a town or city unfamiliar to the victim.

Accessing those services is all but impossible for victims who don’t have a car and must rely on their abuser for transportation. Victims may also be held hostage in their own homes with no winter clothing and no access to a vehicle or other means of escaping their extreme isolation. A provider from the domestic violence shelter in Nantucket reports:

“It can be very expensive and difficult for a victim to get off the island if they’re trying to flee. Also, during bad weather no planes or boats are leaving the island.”153

Religious and cultural values including self-reliance, a deep sense of place, strong allegiance to the land, kinship ties and traditional gender roles also increase the challenges faced by rural victims when they attempt to end the abuse in their lives.

“Living in a small, rural community there’s this kind of ‘Yankee behavior,’ – whatever you want to call it – you know, ‘that’s their business, don’t interfere.’”

—Emily, rural Western Massachusetts154

Another unique characteristic of rural victims is that a higher percentage of them own livestock and other animals. When animals are an integral part of the victim’s livelihood, many people either cannot or will not leave their animals behind to escape a batterer, increasing the risk of lethality.155

Victims of sexual and domestic violence who are also members of underserved rural populations—including immigrants, refugees, seasonal workers, African Americans, Native Americans, and lesbian/gay/bisexual/transgender (GLBT) people—face many additional barriers due to racism, homophobia, ethnocentrism, xenophobia and other forms of discrimination.

“We lived in an area of mostly white people where everyone spoke only English...From the moment we got married I told him that I had to obtain legal residency as soon as possible...he told me that if I did not stay with him, he would make sure I would go back to Colombia...He kept all the documents locked away.” – Maria, rural Western Massachusetts156
Members of underserved, poverty-affected, and oppressed groups often fear bringing 'negative' attention to their already-targeted community by disclosing abuse to law enforcement or other authorities they may not trust. They may lack access to culturally-informed support and face additional layers of stereotypes and biases from rural service providers if they do seek help. Finally, they may not be able to access help at all due to lack of programs and services, lack of physical access to the ones which do exist, lack of documentation, and/or total lack of the transportation and translation services more commonly accessible in urban contexts.

Finally, Certified Batterers Intervention Programs (CBIPs) work toward increasing victim safety while holding perpetrators accountable. According to the MA Department of Public Health, which oversees CBIPs, there is insufficient infrastructure to meet the needs in the rural communities of the five counties in Western MA, including a lack of funding and trained personnel.

**Funding Trends**

In general, running a rural domestic and/or sexual violence program is expensive and entails costs urban programs do not typically face. Basing funding on absolute numbers of victimizations\(^1\) is not appropriate for rural communities, which are often expected to provide direct-service outcomes comparable to urban programs without the necessary additional funding required to provide services in a region with low population density.

The cost of recruiting and maintaining a high quality, experienced staff, and ensuring opportunities for professional development is greater in rural communities than in urban ones. Wages are lower, there are fewer qualified candidates, and it takes longer to fill empty positions. Geographical distance also imposes additional expenses for providers. Rural advocates commonly require a significant travel budget to facilitate their work: programs in Massachusetts report spending $5,000-$10,000 annually to provide transportation for victims, and staff often must travel long distances to meet victims and to attend collaborative meetings. CBIPs report similar fiscal needs and challenges. The Greenfield based CBIP in Franklin County reports the added fiscal challenge of providing services in Berkshire County.

In Massachusetts, there is very limited state funding to address the complex needs of rural sexual and domestic violence survivors and CBIPs, and recent funding cuts in FY10 and FY11 have made things worse. Many programs and services are facing closure. In Franklin County, housing advocacy for victims of domestic violence has been cut, there is no longer any local domestic violence shelter program, and as is true in most rural areas of the State, there is a near-total lack of affordable rental housing. Homeless shelters in rural areas may house sex offenders and batterers who prey on vulnerable victims. Victims have no alternative but to leave their hometowns entirely, even when this means leaving their farms, livelihoods, school systems, etc.
Current Efforts

State Agency Level Assets

- The MA Department of Public Health has developed a project in partnership with three community based rural sexual and domestic violence programs (Elizabeth Freeman Center in Berkshire County, New England Learning Center for Women in Transition in Franklin County and Center for Women and Community- formerly Everywoman’s Center at the University of Massachusetts in Hampshire County) the Northwest District Attorney’s Office, the Berkshire County District Attorney’s Office, Jane Doe Inc. and the Governor’s Council to Address Sexual and Domestic Violence, The project, has received limited federal funding through the Federal Department of Justice, Office on Violence against Women to create and maintain the Massachusetts Rural Domestic and Sexual Violence Project (MRDSVP). Established in 1996, this statewide program serves to fill a critical gap in direct services to rural victims of sexual and domestic violence and their children. In addition, the Project has built a strong collaborative rural network and implemented innovative violence prevention trainings, initiatives and policies that aim to improve the systemic response to this violence in 84 rural jurisdictions in the Commonwealth.

- The Domestic Violence Intervention Project of the Northwestern District Attorney’s Office is an early intervention program designed to coordinate the efforts of police, advocates, court personnel and batterer's intervention programs serving many rural communities in Hampshire, Franklin Counties and the town of Athol in Worcester County. Specially trained advocates from local domestic violence programs are immediately available following a domestic violence incident. Police departments contact an on-call advocate who in turn contacts the victim. Advocates offer victims immediate support, safety information and referrals for counseling, shelter and/or legal advocacy. Representatives from the local CBIP (Moving Forward) are also available to meet with offenders in court at the time of arraignment. Offenders receive information about their responsibilities under the law and available batterer’s intervention groups.

- Limited state funding for sexual and domestic violence programs serving rural areas is provided by the Sexual Assault Prevention and Survivor Services program of the Massachusetts Department of Public Health as well as the Massachusetts Department of Children and Families.

Community/Organizational Level Assets

- The Southern Hilltown Domestic Violence Task Force, comprised of residents, police, schools, and local service providers in the nine western hill towns of Hampshire and Hampden counties, was launched in 1998 to develop a local response to domestic violence after State Police complained about the lack of services for rural victims in this area. The Task Force funded through a Community Development Block Grant (CDBG), has been extremely effective in building capacity to support rural victims in these
communities through numerous violence prevention initiatives and relevant policies/protocols, The taskforce has implemented a social norms campaign to prevent dating violence in the local high school, and conducted a comprehensive fatality review following the aftermath of a domestic violence homicide. This review resulted in systematic changes to increase victim safety at the Hampden County District Attorney’s Office and the Massachusetts Department of Mental Health as well as several other local agencies. The Taskforce has been instrumental in establishing and funding the Hilltown Safety at Home Program founded in 2006, a non-profit organization that works in collaboration with the Russell State Police to provide civil/legal advocacy to rural victims in the region.

- The Ware Domestic Violence Task Force, also funded by a CDBG grant is community collaboration in Ware Massachusetts. The Ware Task Force has launched locally based domestic violence advocacy services that did not exist previously. The advocate provides follow-up on all domestic violence police calls, transportation and court accompaniment if safe. The Ware Task Force is comprised of approximately 50% local survivors and 50% service providers and works extensively on community education, prevention in the schools, and training.

- The North Quabbin Community Coalition’s Sexual Abuse Prevention Project is a community-wide alliance dedicated to providing sexual abuse prevention education initiatives serving the nine town area in the North Quabbin region. This Project was one of three pilot sites selected by the Massachusetts Child Sexual Abuse Partnership to implement the Enough Abuse Campaign, a program designed to educate parents and professionals who work with children, and other community residents about ways to identify and subsequently prevent child sexual abuse. While there is currently no funding to support these efforts in this community, the coalition continues to offer this program in the region.
Recommendations

Enhanced funding and training is needed in the following areas to support service and law enforcement programs for victims of sexual and domestic violence who live in the most isolated and remote areas of the Commonwealth.

Safety and Access

Offering accessible, culturally relevant services is crucial in the success of rural victim service programs. Because of the profound isolation of rural victims, programs need funding to establish and maintain accessible satellite offices and safe home networks, as well as the capacity to support ongoing safety strategies with survivors who remain in abusive relationships.

- Economic advocacy and transformation of economic opportunities for rural victims of domestic violence is an essential component of assisting victims in getting free from their abuse. Economic advocacy also plays a vital role in sexual violence cases in ensuring victim privacy and safety from their perpetrators.
- Programs could reach more victims if there was improved transportation access including expanded bus service, cab vouchers and van services.
- High-speed Internet access and reliable cell phone reception would greatly enhance the safety net for rural survivors.
- Locating program offices in buildings with other services and businesses would promote confidentiality.

Law Enforcement

State Troopers in rural areas respond to the majority of sexual and domestic violence calls, and need to coordinate their efforts with local police departments.

- Particular attention should be paid to ensuring that State Police in rural areas are trained in responding to rural sexual and domestic violence.
- Providing an advocate or liaison to follow-up on police calls—one who can provide transportation and home visits as well as accompaniment to court—is an effective model for rural areas.
- A formal or informal coordinated community response that includes an active, ongoing collaboration between rural law enforcement personnel, community leaders, advocates and educators, schools, and community groups has been found to be a critical strategy in improving outcomes for victims.
- Police must be trained in recognizing the additional barriers to leaving an abusive situation that rural victims face, as well as reporting a sexual assault and must be skilled in working with victims to access uniquely rural resources for support and help.
Partnership and Buy-In with Rural Leaders and Key Stakeholders

In rural communities, building strong relationships and partnerships with respected community members is essential. Community members provide critical information and knowledge about the traditions, cultural values and community resources that will work to resist and respond effectively to sexual and domestic violence.

- It is imperative that people from the rural community are involved, and not always placed in the position of being the “recipient” of services. Programs will fail if the attitude is “we’re doing a good thing by providing services for those people” rather than one of creating community partnerships for change.
- Cultivating culturally appropriate outreach to, and relationships with, leaders of rural sub-communities who may be doubly-isolated—such as immigrant/seasonal workers, GLBT individuals, people with disabilities and elderly people—is essential.
- A victim’s animals/livestock must be an integral part of safety planning, and collaborations between law enforcement, victim’s advocates, foster networks and animal shelters must be cultivated.

Creative Outreach and Community Organizing Strategies

Programs and policies should match local characteristics as much as possible; one solution will not work for all rural areas. Effective violence prevention activities must take into account the unique nature of the rural community through creative engagement strategies. These include:

- Intentional partnerships with local select boards, granges, community health centers and rural hospitals, and school based programs.
- Working with business leaders and establishing informal networks at general stores, county and health fairs, and other community gathering places.
- Partnering with faith based organizations and clergy, hairdressers, medical and criminal justice personnel, and other service providers (such as migrant labor rights organizations, GLBT outreach groups, elder programs, etc.).
- Developing sexual and domestic violence coordinated community coalitions and task forces.
- Developing systems for protecting and/or fostering animals and livestock, such as the Safe Pet Program in Berkshire County or the Western Massachusetts’ Safety Plan for Animals (SPAN).\footnote{158}

Being conscious and sensitive to the communication styles of a particular rural community may help to reduce the discomfort people feel when talking about these issues and serve to establish the trust needed to carry out a program’s objectives. Many victims will not ask for help, but will accept help when it is offered. Funding support for infrastructure to support survivors is essential.
Disparities in Prevalence, Access to Services and Outcomes for Elder Survivors of Sexual and Domestic Violence
Introduction

Sexual and domestic abuse of elders is an emerging field that lies at the intersection of domestic violence and elder abuse. A theory and definition of sexual and domestic violence of elders has not yet emerged, and data is not yet available on the extent to which it is a problem for elders. What is known is that the population over 65 is the fastest growing segment of the US and Massachusetts population. Reports of elder abuse, of which sexual and domestic violence are a subset, grew faster than the elder population growth, at a rate of 70% between 2000 and 2010.\(^{159}\) It is not known whether the increase in elder abuse reports reflects an actual increase in abuse or is a result of an increase in reporting. What is known is that funding for services for elder victims/survivors, despite receiving an increase in fiscal year 2014, has not kept up with the increase in the elder population or with the increase in elder reports.

There are two systems designed to respond to sexual/domestic violence and to elder abuse. Services for sexual and domestic violence are provided by rape crisis centers and domestic violence programs which are funded by the Department of Public Health, Department of Children and Families, Executive Office of Public Safety and Massachusetts Office of Victim Assistance. Services for elder abuse are provided through elder protective services and are funded by the Executive Office of Elder Affairs. Each system responds differently to abuse, and often, elder victims/survivors fall into the gaps between the systems.

“Marge is 67 years old and abused by her husband. She has diabetes and requires two shots of insulin daily. She went to a domestic violence shelter, where she didn’t relate to the other residents who were 30-40 years younger, where her medical needs were not attended to, and where she worried that the small children might knock her off balance. Marge didn’t stay in the shelter.”\(^{160}\)

“Paula is 79 years old, has Parkinson’s disease, and is … abused by her adult son. Adult Protective Services was called and the social worker assessed that the son was overwhelmed with caretaking responsibilities. The son was offered time off and the services of a home health agency was secured. The son was advised to petition for guardianship which would remove Paula’s right to make decisions about her own care.”\(^{161}\)

Elder abuse victims/survivors can benefit from the services offered by both systems, for example, sexual and domestic violence programs can focus on safety and legal advocacy, while Elder Protective Services agencies can focus on health care, transportation, and longer term options.\(^{162}\) Because of the increasing growth of the elder population and the increase in elder abuse reports, it is timely and imperative that state systems and non-profit agencies develop a greater understanding of the nature and extent of elder sexual and domestic violence and develop better systems integration to support this vulnerable population.
**Demographics**

The definition of elder, or senior, is ambiguous, as different ages are used to define them. The most common age at which elder is delineated is 65, used by the Social Security Administration as the age at which someone can receive social security retirement benefits; gradually this age will increase to 67 years old. In Massachusetts, eligibility for services through the Executive Office of Elder Affairs begins at age 60. The various ages at which elder is delineated can create confusion in eligibility for benefits, entitlements and mandated reporting, often resulting in elder abuse victims/survivors not gaining access to the resources that they need for safety.

The population over 65 is the fastest growing portion of the US population. This population growth is also occurring in Massachusetts. The table below illustrates the growth of elders over 60 in Massachusetts in 2000, 2010, and the projected growth for 2020.

![Population 60+ Years Old, Massachusetts](chart)

*Source: MA Executive Office of Elder Affairs.*

The US Census projects that by 2030, one in five people will be 65 older. Older women outnumber older men 21 to 15 million.

Most people in the US can expect to live one quarter to one third of their lives over the age of 65.  

Contrary to stereotypes that late adulthood is a period of decline, elders are living healthier, the rate of disability in this age group is declining, and elders are engaging in intimate relationships.

Elders are a racially diverse population, with over 20% identifying as Black, Asian, or Native American. This diversity is expected to increase; by 2050, one third of elders are projected to be non-white.  

Hispanic elders constitute 7% of people over 65 in 2010, and by 2050, are expected to comprise 19.3% of the elderly population.
For elders, an accumulated lifetime of opportunities or disadvantages are important considerations to factor into elders’ vulnerability to sexual and domestic violence. These opportunities or disadvantages are determined by factors such as race, gender, sexual orientation, etc. Overall, 9.7% of elders are living in poverty, yet when this is disaggregated by race, 7.4% of White elders live in poverty, while 11.3% of Asians, 17.1% of Hispanics, and 23.3% of African Americans live in poverty. Elder women are twice as likely to be poor as elder men. The life expectancy of a white elder is four years longer than it is for black elders. Prior to the U.S. Supreme Court finding Article III of the Defense of Marriage Act (DOMA) unconstitutional in U.S. v. Windsor (2013), the New York Times did a comparison of two similar couples, one a married heterosexual couple and the other a gay couple barred from marrying. Their research found that over a lifetime the heterosexual couple would have $467,000 of benefits (such as social security, health benefits, etc) that the same sex couple did not have access to. For many older same-sex couples, the Windsor decision will have little effect on closing the gap between the $467,000 of benefits enjoyed by heterosexual couples and decades of benefits denied to same-sex couples. A lifetime of accumulated privilege and/or disadvantage are factors in the choices that elders have access to and on their dependence on caretakers.

**Prevalence**

**Domestic Violence**

There is a lack of data on domestic violence for elders since research aggregates domestic violence against all adults and does not separate out domestic violence by age to provide a clear picture of domestic violence perpetrated against seniors. Thus, data on older domestic violence is sometimes extrapolated from elder abuse reports. The US Senate Special Committee on Aging estimates that there are up to five million victims of elder abuse each year. Abuse by intimate partners accounts for 11.3% of these reports. Adult children (32.6%) and other family members (21.5%) account for over half of abuse reports and some of these may also meet criteria for sexual and domestic violence.

Elder abuse reports have been increasing over the past decade, and since domestic violence is a subset of the elder abuse reports, one can assume that domestic violence reports against elders are also increasing. The Massachusetts Elder Protective Service program saw an increase of 70% in elder abuse reports between 2000 and 2010, from 9,385 to 15,935 reports. This data mirrors the national trend, in 2004 the Survey of State Elder Protective Services showed a 19.7% increase in total reports of abuse and neglect and a 15.6% increase in substantiated cases since 2000.

There are significant limitations to using the elder abuse data to extrapolate domestic violence data. A narrow definition of domestic violence, which only includes abuse by an intimate partner, would ignore other perpetrators with whom there can be a power and control dynamic, such as caregivers or adult children. Also, elder abuse reports can be filed for neglect and may not meet the criteria for domestic violence if the intimate partner or adult child neglected the elder without the intention to harm.
Theories of sexual and domestic violence based in power and control are not sufficient to explain the shifting power dynamics and myriad relationship patterns that are seen in elder abuse. There is evidence that elder domestic violence is part of a pattern of lifetime violence and is related to other forms of violence such as child abuse. The most recognized pattern of elder domestic violence is an intimate relationship with a continuing pattern of domestic violence from earlier years, or where abuse is experienced in a new intimate relationship. Theory still needs to be developed to explain other dynamics and relationships commonly seen in elder abuse. Abuse can arise in relationships where one partner develops health problems that include symptoms of irritability and aggression. Elder abuse is also commonly perpetrated by an adult child who witnessed domestic violence when they were younger or who was formerly abused by the parent. A final pattern is when the former victim/survivor gains power over time and retaliates by abusing the partner who was formerly abusive. Thus, elder domestic violence needs to be understood in the context of family history and shifts in relative power that can change over time.

**Sexual Violence**

There is a lack of research into the sexual abuse of elders since studies often do not separate sexual abuse of older adults from younger adults. Evidence that does exist suggests that sexual assaults on elders may be far more under-reported than sexual assaults on younger women. In a 2003 comprehensive study examining all reports of elder abuse in 29 states, only one percent of the reports included sexual assault. Researchers have estimated that sexual assaults on elders could easily be three to ten times higher than is currently being reported. Under reporting of sexual abuse against elders is also seen in the Massachusetts data. The Massachusetts Executive Office of Elder Affairs (EOEA) Protective Services Program initiated only 100 investigations into elder sexual abuse in FY 2012.

Societal stereotypes about elders and ageism (stereotyping and/or discriminating on the basis of age) can ignore or compound the problem. Elders are not seen as sexual beings, which ignores the fact that sexual assault is an issue of power and control, not sex. This may result in elders not being screened for sexual abuse due to lack of knowledge or recognition that sexual violence affects people of all ages or discomfort in discussing any sexual related topics with older populations.

Shame and dependency significantly contribute to the difficulty of disclosure of sexual abuse. The perpetrators of sexual assault are often someone with whom the elder is very close. The most frequently identified perpetrators of elder sexual assault in community settings (such as private homes, assisted living) are care providers (81%) and family members (78%), of which 92% are male. The elder may depend on their perpetrator for caretaking and assistance with activities of daily living. Alternatively, the elder is sometimes the caregiver for the person who is abusing them, and may fear the consequences to the person if the elder reports the abuse. Similarly to other abuse victims, the elder may fear that they will not be believed and that, if they tell, the abuse will become worse. The elder may also have generational views in which discussions about sex and abuse are private matters that one does not discuss with others.
In residential care facilities, such as nursing homes and rehabilitation centers, staff and other residents are usually implicated as the perpetrators. Perpetrators prey on elders who may not have the capacity to give consent or to report abuse, such as elders who have dementia. Residential care facilities are reluctant to report on sexual abuse in their institutions, and may be particularly reluctant to report abuse perpetrated by staff. In addition, the US Government Accountability Office estimated that over 700 registered sex offenders lived in residential care facilities and that these facilities frequently reported that they did not see any particular need for additional oversight of sex offenders in their residences.

**Barriers to Accessing Support and Services**

Older people may experience and respond to sexual and domestic violence differently than younger people. They may have been socialized to espouse more traditional values, particularly with regard to gender roles, thus divorce may be viewed as taboo, sexual and domestic violence are under-recognized, and privacy surrounds family and sexual matters. Seniors are less likely to be open about same sex relationships, thus making disclosure and help seeking even more complex. In addition, older survivors may experience more acute financial barriers than younger survivors. Ageism makes it difficult for older victims to find and sustain work, thus, they may not report abuse occurring in the workplace. Older women in particular may not have had paid employment when they were younger, thus they may experience greater economic dependency on their abusers.

As elders continue to age, their vulnerability has the potential to increase: many outlive their friends and family who make up their social support system, become more isolated, and can increasingly become dependent on their caregiver(s). Feelings of shame and taboo also contribute to the growing isolation of elders within their communities.

Cognitively, elders may have diminished capacity, which makes it harder for them to report abuse to others or even to be believed when they do tell someone. Bruises and fractures can be attributed to falls rather than to abuse. Sometimes the symptoms are seen as the normal aging process, rather than being a consequence of trauma.

Cultural concerns related to ethnicity, sexual orientation, religion, etc. present additional complexities. Older adults may fear leaving their cultural community to enter systems of care and senior living arrangements that are not sensitive to their needs. They may lack knowledge of resources and language barriers may prevent them from seeking help or effectively communicating with service providers.

The varying definitions of “elder” determine the eligibility criteria for the safety net of services. For example, a 60 year old survivor may not have minor aged children in order to qualify for some safety net programs, such as Transitional Aid to Needy Families (TANF) and family housing, yet they are too young to qualify for Social Security and Medicare. These different criteria among social services systems can create a chaotic and confusing environment that results in older survivors not being given the resources that they need.
Currently, few shelters and domestic violence programs have services specifically geared towards older victims and no studies on sexual violence services were available for review. Several surveys of domestic violence programs found that elders were drastically underrepresented among the survivors that the programs served. An early study in Florida, where 27% of the population are seniors, only 2.2% of the victims served in shelter programs were seniors. Four of the most frequently cited barriers in accessing domestic violence resources are lack of awareness among seniors about the resources, lack of awareness among service providers about the concerns of seniors who experience sexual and domestic violence, programs do not have programming specific to the needs of older survivors, and short term crisis oriented interventions may not be appropriate for older survivors whose needs are long term. Elder Protective Services often lack a focus on gender or power relations in sexual and domestic violence dynamics. This lack of understanding could result, for example, in referrals for both the victim and perpetrator to the same adult day services. There is a need for improved cross-agency collaboration in order to bridge the gap in the knowledge, resources, and skills of sexual/domestic violence programs and elder protective service programs.

**Funding Trends**

As with services for elders, the funding for sexual and domestic violence programming is separate from funding streams for elder protective services. In sexual and domestic violence services, an analysis conducted by the Services Accessibility Working Group of the Governor’s Council to Address Sexual and Domestic Violence found that Massachusetts received a total of $35,890,955 in state and federal funding in FY11 for services for sexual and domestic violence, of which only 0.3% were for services specifically tailored to the needs of older survivors. In FY12, the total funds expended was $36,531,913, yet only 0.2% was for services for elder survivors, despite elders comprising 19.5% of the state population.

For elder protective services, the chart below illustrates the Massachusetts state funding trends from FY2010 to FY2014. Currently, there is no way to disaggregate the amount of elder protective services funding that was specifically for sexual or domestic violence services for elders. There has been a significant increase in funding for elder protective services in FY2014, however, this increase is still insufficient to accommodate the large increase in the number of elder abuse reports filed (a 70% increase between 2000-2010) and the large number of people who are aging into this population.
Current Efforts

- A multi-disciplinary collaborative named Stop Abuse, Gain Empowerment-Boston (SAGE), meets monthly to address the gaps that exist in knowledge and service between elder services and sexual/domestic violence providers. SAGE has offered conferences and trainings focused on increasing awareness of sexual/domestic violence, in addition to improving services for elder survivors of sexual and domestic violence.
- In 2013, the Massachusetts Executive Office of Elder Affairs recognized the need for collaboration between Elder Protective Services staff and sexual and domestic violence programs and awarded a small Department of Justice Violence Against Women STOP grant to improve cross-agency collaboration, consultation and service provision between Elder Protective Services staff and local domestic violence and rape crisis agencies.
- A legislative Special Commission on Massachusetts Elder Protective Services Program is convening to study and investigate elder protective services and make recommendations to enhance services. The Commission is comprised of state agencies as well as legal services, the statewide sexual and domestic violence coalition, elder and retiree programs, health care providers, financial services and law enforcement. Recommendations from this Commission are scheduled to be issued in early 2014.

Recommendations

Abused elders fall through the cracks between the systems designed to serve them. These recommendations focus on improved systems coordination between Elder Protective Services, funded through Elder Affairs, with sexual and domestic violence services, which are funded through Department of Public Health, Department of Children and Families, Executive Office of Public Safety and Massachusetts Office of Victim Assistance.

1. The Executive Office of Elder Affairs should meet with the Department of Public Health, the Department of Children and Families, the Executive Office of Public Safety and the Massachusetts Office of Victim Assistance to discuss abuse in later life and coordinate services across the lifespan.

2. Increase funding for the MA Elder Protective Services Program to account for the increased number of elder abuse reports filed annually, ensuring that all elders needing assistance have access to Elder Protective Services interventions. Create interventions that are specific to the power and control dynamics of sexual and domestic violence in these elder abuse interventions.

3. Increase cross training, cross referral and coordination between Elder Protective Services and sexual and domestic violence programs. Staff at domestic violence programs should be trained to manage the chronic health and long-term care concerns of elders, while elder protective services should be trained in the power and control dynamics of sexual and domestic violence.
4. Educate seniors on elder sexual and domestic violence and other forms of elder abuse.

5. Support the creation of sexual and domestic violence services specifically designed to meet the needs of elderly victims. Currently, only two programs in Massachusetts focus on elder domestic abuse, and none exist that focus on elder sexual violence.

6. Create emergency and long term safe housing options for abused elderly and home based counseling and support services that are sexual and domestic violence trauma informed. Housing options need to have services for abused elderly needing assistance with their activities of daily living.

7. Increase the capacity of legal counsel and representation for restraining orders, separating assets, divorce, guardianship, power of attorney, and health care proxy.

8. Provide access to safe guardians for elders who have experienced sexual or domestic violence and do not have the capacity to make their own decisions.

9. Create funding for direct services in the line item for Elder Protective Services (such as legal costs associated with guardianship filings, etc.)

10. Conduct further research and theory development on sexual and domestic abuse of seniors.
Financial Analysis
Financial Analysis of State Funding for Sexual and Domestic Violence Services for Five Underserved Populations

A financial analysis was conducted of sexual and domestic violence programs funded by state agencies that serve on the Governor’s Council to Address Sexual and Domestic Violence to learn 1) how much state funding and federal funding was going to sexual and domestic violence programs and 2) of that funding, how much was specifically allocated for programming for GLBT survivors, immigrant survivors, survivors with disabilities or survivors who are D/deaf or hard of hearing, rural survivors, or elder survivors.

Methodology

Surveys and follow-up interviews were conducted with 102 programs funded by the Executive Office of Public Safety, Department of Public Health, MA Office for Victim Assistance, and Department of Children and Families. This analysis includes only funding for programs that had staff expertise and services that were specifically designed to respond to these populations. Generalized services that happen to also serve these populations but that did not have staff expertise and specially designed services were not included in the data.

Allocation of Funding for Five Populations

Massachusetts received a total of $35,890,955 in state and federal funding for sexual and domestic violence programming in FY11, administered by the Department of Children and Families, Department of Public Health, Executive Office of Public Safety, and the MA Office for Victim Assistance. In FY 12, $36,531,913 was allocated by these state agencies for sexual and domestic violence services.

Significant additional funding was also dedicated to elders and people living with disabilities through the general operations of Elder Protective Services ($15.25M in FY’11 and $16.25M in FY’12) and the Disabled Persons Protection Commission ($2.17M in FY’11 and $2.21 in FY’12); however it was not possible to determine how much of these funds were specifically dedicated to sexual and domestic violence since neither state agency tracks funding for sexual or domestic violence services.

Of the total funding, a disproportionately low percentage is allocated to serve survivors who are GLBT, immigrant, people living with disabilities, deaf or hard of hearing, living in rural areas or elders.
GLBT
The total state funds allocated to sexual and domestic violence for GLBT specific services was 2.4% in both FY11 and FY12. Demographic data for GLBT communities varies widely depending on whether researchers measure attraction, behavior or identity. According to government-administered population based surveys, 3.4% of the population identifies as GLBT. National GLBT organizations and researchers advocate that because some people who engage in same sex behavior do not identify as GLBT, a broader population count should include GLBT identification and behavior. This figure is between 4-10%.

Immigrants
The total state funds allocated to sexual and domestic violence funding allocated for immigrant specific services was 7.3% and 6.4% respectively for FY11 and FY12. The immigrant community is estimated to represent 14.9% of the general population.

People with Disabilities
The Disabled Persons Protection Commission is the primary state funder of abuse prevention and services for people with disabilities, including sexual and domestic violence services. The DPPC does not disaggregate funding specifically for sexual and domestic violence from funding for other forms of abuse. In FY ’11 and ’12, the total funding for DPPC (which include more services than sexual and domestic violence) was $2.17 and $2.21 respectively. Sexual and domestic violence funding allocated specifically for People with Disabilities through the Departments of Children and Families, Public Health, Executive Office of Public Safety and MA Office of Victim Assistance was 1.5% and 1.74% respectively for FY11 and FY12. The population estimate for people with disabilities is 11.4% of the general population.

Rural
The total state funds allocated to sexual and domestic violence funding allocated for rural specific services was 3.3% in both FY11 and FY12. This represents the total state funds allocated to specifically serve this population. The rural population is estimated to represent 12% of the general population.

Elders
Elder Protective Services is the primary state funder of abuse prevention and services for elders, including sexual and domestic violence services. EPS does not disaggregate funding specifically for sexual and domestic violence from funding for other forms of abuse. In FY ’11 and ’12, the total funding for EPS (which include more services than sexual and domestic violence) was $15.25M and $16.25M respectively. Sexual and domestic violence funding allocated for elder specific services through the Departments of Children and Families, Public Health, Executive Office of Public Safety and MA Office of Victim Assistance was 0.3% and 0.2% respectively for FY11 and FY12. The elder population is estimated to represent 19.5% of the general population.
References


7 Grant, J. (2010).

8 Grant, J. (2010).


16 Grant, J. (2010).


29 Previously unpublished statistics from Batterer Intervention Program Services, Bureau of Community Health and Promotion, MA Dept of Public Health, 2007-2010
37 FORGE. (2005).
40 FORGE. (2005).
44 FORGE. (2005).
63 GLBTQ Domestic Violence Project unpublished internal survey data from GLBT Pride events 1996-2010.
64 GLBT Domestic Violence Coalition & Jane Doe, Inc. (2005).
79 Klein, C. & Orloff, L.


Interview with Maria Jose, Brazilian. (2006). Reported to MA Alliance of Portuguese Speakers.


MA Department of Public Health, Massachusetts Rural Domestic and Sexual Violence Project. (2005).


SAFETY PLAN FOR ANIMALS (SPAN) is a Western MA coalition of human and animal service providers including the Dakin Pioneer Valley Humane Society, Safe Passage, NELCWIT, and others. http://www.dpvhs.org/help/safety.php


U.S. Senate Special Committee on Aging. (2003). “Guardianship Over the Elderly: Security Provided or Freedoms Denied?”


National Center on Elder Abuse. (2006).


References 81


181 MA Executive Office of Elder Affairs, (2012). Elder Abuse Reports.


201 Grant, J. (2010).


