Abuse, Exploitation & Violence Prevention

A disability-informed framework for prevention, recognition, reporting, response, and recovery

Evidence-informed • person-centered • trauma-informed • rights-respecting

CORE PRINCIPLE

The goal is not to make people less free in the name of safety. Strong prevention reduces unchecked power, isolation, communication barriers, and dependency while increasing knowledge, trusted relationships, accessible reporting, accountability, and control over one's own life.

1. Why disability-informed prevention is necessary

People with disabilities are not inherently unsafe or incapable. Risk is shaped by environments, relationships, power, access to communication, dependence on others for essential needs, and whether systems respond when concerns are raised. CDC notes that children with disabilities may have increased chances of bullying, abuse, and neglect and identifies dependence on adults and communication or social-understanding barriers as potential contributors. Research also documents elevated violence exposure in disability populations, but estimates vary substantially by population and method.

- A 2022 updated systematic review and meta-analysis of 98 studies estimated that 31.7% of children with disabilities had experienced violence and found roughly twice the odds of violence compared with children without disabilities; heterogeneity across studies was substantial.
- A 2021 systematic review/meta-analysis of adults with intellectual disability estimated pooled adult sexual-abuse prevalence at 32.9% (95% CI 22.7%-43.0%), with extremely high heterogeneity (I^2 99.8%). The estimate is a research synthesis, not a universal individual risk rate.
- A 2026 scoping review found that disability-related abuse help-seeking is hindered by inaccessible services, stigma, fear of disbelief or retaliation, dependency, fragmented systems, and unclear referral pathways; supportive relationships, trained professionals, accessible services, and interagency coordination can facilitate help-seeking.

2. Forms of harm to recognize

Physical abuse

Hitting, shaking, burning, choking, restraining, force-feeding, inappropriate use of physical force, or deliberately causing pain or injury.

Sexual violence and abuse

Any sexual act or contact that is nonconsensual, coerced, exploitative, unlawful, or undertaken when valid consent cannot be given under applicable law.

Emotional or psychological abuse

Threats, humiliation, intimidation, degrading treatment, manipulation, deliberate isolation, gaslighting, or using fear to control behavior.

Neglect

Failure to provide necessary care, supervision, food, hygiene, medication, medical care, communication access, mobility assistance, or other essential support when a person is responsible for providing it.

Financial exploitation

Improper or unauthorized use of money, benefits, property, accounts, identity, wages, or resources; coercing purchases, gifts, loans, signatures, or financial access.

Coercive control

A pattern that limits freedom through intimidation, monitoring, isolation, threats, dependency, control of resources, or punishment for resistance.

Institutional or service-related harm

Abuse, neglect, rights violations, retaliation, unsafe restraint/seclusion, inaccessible complaint processes, or practices that prioritize organizational convenience over a person's safety, dignity, or rights.

Digital exploitation

Coercive requests for images, sexual exploitation, scams, account takeover, stalking, location tracking, threats, or manipulation through online platforms.

3. Conditions that can increase opportunity for harm

These are system and context factors, not reasons to blame a disabled person or family.

- One person controls transportation, communication, money, medication, housing, personal care, and access to outside relationships.
- The person has no private way to communicate with someone outside the immediate caregiving or service system.
- Staffing is unstable, poorly supervised, inadequately trained, or complaints are handled by the same person implicated in the concern.
- Communication supports are absent, ignored, or controlled by others.
- The person has been taught unquestioning compliance with adults, professionals, caregivers, or authority.
- Privacy and ordinary relationships are restricted so heavily that the person has few opportunities to learn boundaries, compare relationships, or build a trusted network.
- Reporting procedures are complex, inaccessible, punitive, or dependent on literacy, speech, hearing, vision, technology, or executive functioning that the person may not have access to.
- Organizations normalize unexplained injuries, abrupt behavior changes, repeated boundary violations, or retaliation against people who report concerns.

4. Warning signs: look for change, pattern, context, and explanation

No single sign proves abuse. Some signs can have medical, sensory, psychiatric, environmental, or disability-related explanations. The correct response is to notice, document, assess, and avoid diagnostic overshadowing.

Possible physical/medical indicators

- Unexplained or repeated injuries; injuries inconsistent with the explanation
- Pain, bleeding, bruising, sexually transmitted infection, pregnancy, or genital symptoms requiring medical assessment
- Dehydration, malnutrition, pressure injuries, poor hygiene, medication problems, or missed medical care
- Frequent emergency visits or delays in seeking care

Possible behavioral/emotional indicators

- New fear of a particular person, place, shift, vehicle, activity, or type of touch
- Sleep disturbance, regression, withdrawal, agitation, new self-injury, aggression, or loss of previously used skills
- Sexualized behavior or knowledge that is unexpected for the person's developmental history or education
- Sudden avoidance of communication devices, phones, online accounts, or previously enjoyed activities

Possible financial/system indicators

- Missing money or property; unexplained withdrawals, purchases, debt, or changes in account access
- A caregiver or staff member blocks private contact, insists on answering everything, or resists outside review
- Repeated complaints disappear without documented investigation, follow-up, or corrective action
- A person loses services, privileges, contact, or opportunities after reporting concerns

5. If someone discloses harm: first-response protocol

1. Attend to immediate safety and urgent medical needs.
2. Listen calmly. Communicate belief and concern without making promises you cannot keep.
3. Do not conduct an amateur investigation or repeatedly question the person. Ask only what is necessary to understand immediate safety and next steps.
4. Use the person's communication method. Arrange qualified interpretation or other communication supports when needed; do not automatically rely on the suspected caregiver or companion.
5. Record the person's words or communication as accurately as possible, distinguishing observation from interpretation.
6. Explain what will happen next in accessible language, including any limits on confidentiality or mandatory-reporting duties.

7. Follow applicable reporting law and organizational policy promptly. Mandatory reporting varies by age, setting, profession, jurisdiction, and type of suspected harm.
8. Preserve potentially relevant records or evidence when lawful and safe, without asking the person to take risks to obtain it.
9. Offer choices wherever possible: who is present, communication method, advocacy support, medical care, transportation, and follow-up.
10. Close the loop. Confirm that the referral/report reached the responsible entity and that the person has a safe, accessible way to reconnect if circumstances change.

6. Survivor-centered, trauma-informed response

A survivor-centered response seeks to return control where possible while meeting safety and legal obligations. Trauma-informed practice emphasizes safety, trustworthiness, collaboration, choice, and empowerment; disability-responsive practice adds communication access, individualized accommodations, and awareness that trauma may present differently.

- Ask before touching, moving mobility equipment, changing communication devices, or bringing additional people into the room.
- Provide private communication opportunities when safe and appropriate.
- Do not require the person to tell the story repeatedly to multiple systems when coordination can reduce duplication.
- Do not interpret limited eye contact, atypical affect, delayed disclosure, inconsistent chronology, AAC use, or need for processing time as evidence that the person is not credible.
- Avoid withdrawing community participation, relationships, devices, or privacy as a reflexive "safety" response unless a specific, proportionate, time-limited restriction is necessary.
- Offer advocacy and victim services that are physically, digitally, cognitively, and communicatively accessible.

7. Organizational prevention standard

- Screen hiring and volunteers consistent with law and role risk; verify references and investigate concerning gaps or patterns.
- Define professional boundaries, prohibited conduct, gifts, transportation, social media, private messaging, intimate care, and conflicts of interest.
- Create at least two independent reporting routes, including one outside the immediate chain of command.
- Make reporting accessible: phone, text, web, AAC-compatible, interpreter-supported, plain-language, and anonymous options where appropriate.
- Prohibit retaliation and track retaliation allegations separately.
- Use incident trend review: repeated injuries, medication errors, restraint, missing money, staff complaints, elopement, emergency calls, and unexplained changes.
- Ensure supervision is observable and accountable without eliminating reasonable privacy.
- Train staff to distinguish disability characteristics from possible trauma, abuse, medical problems, and environmental distress.

- Include people with disabilities and lived experience in policy design, training, audits, and quality-improvement review.
- Measure outcomes: reporting access, response time, substantiated process failures, recurrence, corrective action completion, survivor access to support, and whether restrictions imposed after incidents are reviewed and reduced.

8. Prevention checklist for families, schools, healthcare, and services

- ☐ Does the person have more than one trusted adult/person or service they can contact?
- ☐ Can they communicate privately using their preferred method?
- ☐ Do they know basic rights, body boundaries, consent, and what to do if a rule or request feels unsafe?
- ☐ Can they identify who controls money, medication, transportation, devices, passwords, and records?
- ☐ Are intimate-care routines explained and consent/assent sought to the greatest extent possible?
- ☐ Are injuries, abrupt changes, complaints, and financial irregularities documented and reviewed for patterns?
- ☐ Can a concern be reported without going through the person being complained about?
- ☐ Are interpreters/communication supports available without depending on family or staff?
- ☐ Are staff and caregivers trained on trauma, disability, abuse dynamics, and retaliation?
- ☐ Does someone verify that reports are actually resolved rather than merely "closed"?

9. Reporting and emergency planning

This guide intentionally does not publish a single universal reporting instruction because legal duties and agency jurisdiction vary. Organizations should maintain a jurisdiction-specific reporting sheet identifying: emergency services; child protective services; adult protective services; law enforcement; licensing/regulatory bodies; protection-and-advocacy systems; ombudsman programs; healthcare/forensic services; victim advocacy; and internal safeguarding contacts. Review it at least annually and whenever law or contracts change.

10. What high-quality prevention looks like

A high-quality system does not wait for a disclosure. It reduces opportunities for unchecked power, builds communication and relationship skills, creates accessible independent reporting, detects patterns across incidents, responds without retaliation, and learns from failures. Safety is strongest when people have both protection and meaningful control over their own lives.

References & trusted sources

Source hierarchy: authoritative disability/civil-rights and public-health guidance; systematic reviews/meta-analyses; peer-reviewed research; and technical standards. Research limitations are stated where they materially affect interpretation.

1. CDC. Maltreatment, Violence, and Self-Injury (updated Jan. 28, 2026). Source

2. Fang Z, et al. Global estimates of violence against children with disabilities: updated systematic review and meta-analysis. Lancet Child Adolesc Health. 2022. Source

3. Tomsa R, et al. Prevalence of Sexual Abuse in Adults with Intellectual Disability: Systematic Review and Meta-Analysis. IJERPH. 2021;18:1980. Source

4. Help-seeking behaviours of abused persons with disability: a scoping review. BMC Public Health. 2026. Source

5. Kildahl AN, Helverschou SB. PTSD and experiences involving violence or sexual abuse in autistic adults with intellectual disabilities. Autism. 2024;28(5):1075-1089. Source

6. Administration for Community Living. Protecting Rights and Preventing Abuse. Source

7. U.S. Department of Justice. ADA Title II Regulations - effective communication requirements. Source

8. United Nations. Convention on the Rights of Persons with Disabilities, Article 16. Source

EVIDENCE INTEGRITY

Prevalence estimates should not be treated as universal rates. Disability populations, definitions, settings, reporting methods, and study quality vary substantially. This resource distinguishes research findings from practice recommendations and avoids implying causation where evidence is observational.

Prepared for Oklahoma Child Wellbeing • Disability, Safety & Autonomy

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