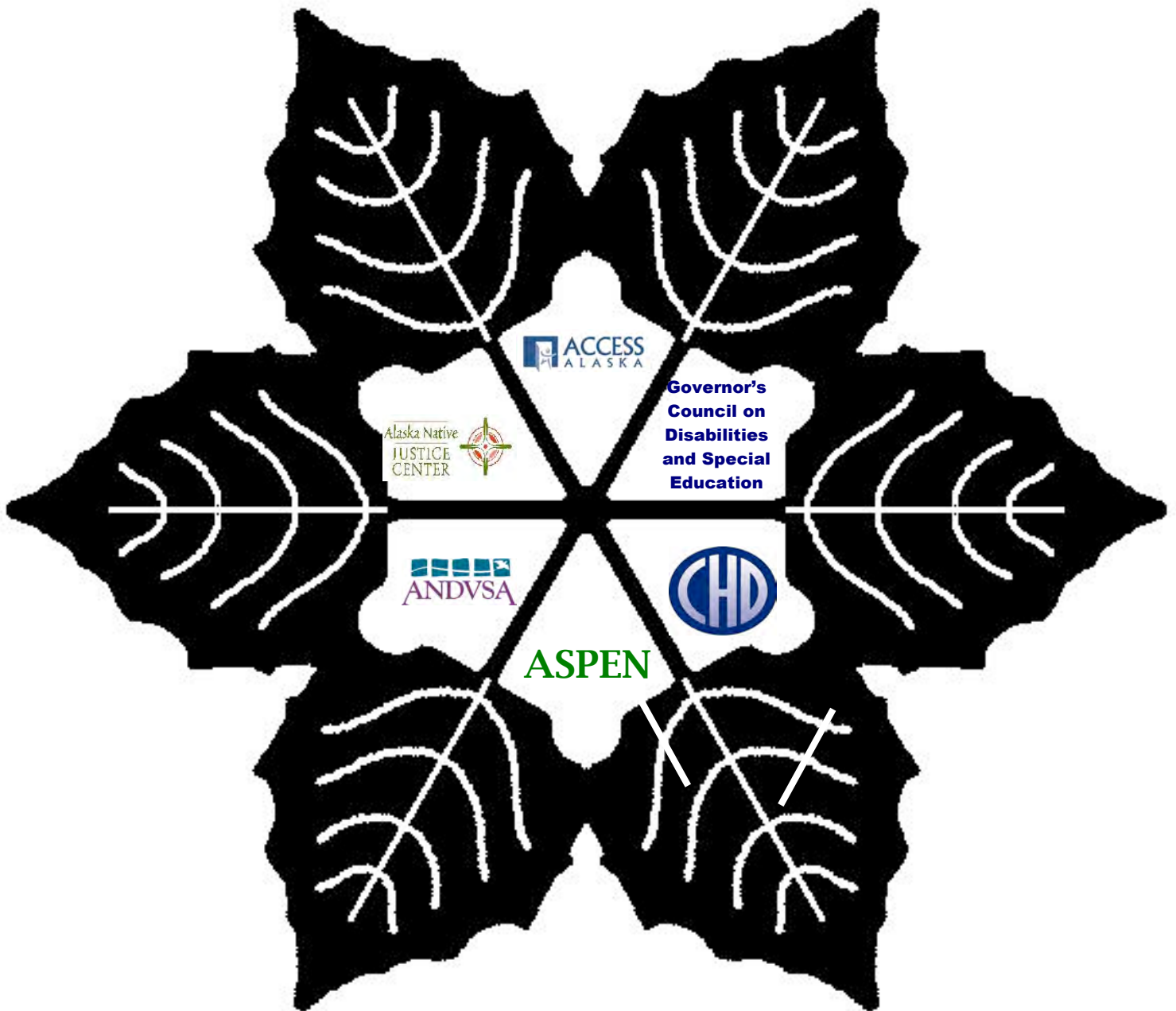


# Alaska Safety Planning & Empowerment Network

## ASPEN

### Site A Needs Assessment Report



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## Executive Summary

The Alaska Safety Planning and Empowerment Network (ASPEN) formed in 2007 to promote system change in the disability services and the domestic violence/sexual assault sectors that would improve their responses to survivors with disabilities (people with disabilities who have experienced domestic violence, sexual assault, or stalking). An Education, Training and Enhanced Services to End Violence Against and Abuse of Women with Disabilities Grant from the Office on Violence Against Women, US Department of Justice, funds ASPEN. ASPEN's members are:

- Access Alaska, Inc. (Access)
- The Alaska Native Justice Center (ANJC)
- Alaska Network on Domestic Violence and Sexual Assault (ANDV/SA)
- Center for Human Development (CHD)
- Governor's Council on Disabilities and Special Education (GCDSE)

ASPEN elected to work with local partners outside the collaboration itself to initiate system change in two communities. ASPEN found eight local partners in the domestic violence/sexual assault (DV/SA) and disability sectors in two communities separated by over a thousand air miles, Site A in southeast Alaska and Site B in southwest Alaska. We conducted needs assessments in each community to inform ASPEN and its local partners of the strengths/assets and weaknesses/gaps in services experienced by survivors with disabilities. The goals of the needs assessment were fivefold:

1. Identify community service delivery strengths, gaps, and barriers in providing accessible and appropriate services to people with disabilities and survivors.
2. Determine existing relationships between Community Partner organizations and the extent to which these meet the needs of survivors with disabilities.
3. Identify the policies, procedures, and practices of Community Partners and their strengths and barriers from the perspectives of people with disabilities, survivors, and staff and management Community Partners.
4. Identify the similarities and differences between the ideal set of effective person-centered services and supports from the perspectives of people with disabilities, survivors, and staff and management of Community Partners
5. Identify options that enhance collaboration between systems of service, better link survivors with those systems of service, and improve the services provided.

Using two methodologies (focus groups and individual interviews) to elicit information from four audiences (staff from each of the two service sectors, women with disabilities, and women who were DV/SA survivors), ASPEN worked with approximately 41 people from in Site A. It should be noted that while we achieved our overall target in terms of the number of women with disabilities and women who were survivors of violence who participated in focus groups, the numbers were slightly skewed toward the latter.

In terms of our interviews with Community Partners' staff and management, we were very successful, but had some difficulty again meeting all our targets, particularly among



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board members. Two factors are reflected here: 1) the reluctance of volunteer board members to commit additional time from their private lives and 2) the timing of the needs assessment process. The interview process, intended to wrap by end of spring, stretched into the summer, the time during which rural residents are preoccupied by the subsistence activities (hunting, fishing, and other traditional indigenous food gathering and preparation activities) fundamental to their culture and economy. This was a consequence of difficulties re-engaging our partners and unexpected delays attributable both to our interview process design and resources as well as to problems unique to Alaska which interfered with travel and communication (most notably, the eruption of Mt. Redoubt volcano in South Central Alaska and two avalanches near the Snettisham Hydroelectric Facility in Juneau).

Despite these setbacks and limitations, we believe the needs assessment identified several consistent themes in each of the two communities, some of which were similar and others of which were unique to the community. ASPEN identified eight key findings:

1. Policies in place at our eight partner agencies addressed concerns such as mandated reporting, the Americans with Disability Act, and provision of individualized services. There were few, if any, specific written guidelines or procedures concerning the safety and service needs of survivors with disabilities. Those guidelines that do exist appear to be neither clearly understood nor uniformly implemented by staff, management, and boards.
2. All our partner agencies interact on some level with each other. However collaboration beyond the basics (e.g. providing referrals, exchanging resources information) is limited. There is a moderate level of awareness of how the partners interact with each other within the community. DV/SA agencies were more likely to reach out to disability providers than the other way around.
3. There is wide diversity of perceptions of disability, experiences with disability, and accommodation of individual needs among DV/SA agencies. There is likewise wide diversity in perceptions regarding people with disabilities and experiences of DV/SA among disability agencies.
4. Community Partners and focus group participants identified behavioral health services as a crucial component to meeting the needs of all survivors.
5. Processes for change within our eight partner agencies are in place—whether through strategic plan development, budget development, or staff and client input, however each agency had a unique approach.
6. All our partners have clearly stated the desire, need, and support for training or cross-training, staff orientation, and disability and DV/SA specific training.
7. Culture, in all its diverse and complex manifestations, plays a key role in service provision as it is perceived and experienced by survivors with disabilities
8. Survivors and people with disabilities identified positive, respectful, and supportive attitudes and actions as keys to making them feel safe, welcome, and comfortable.



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The implications of these findings are many and suggest a number of possible solutions. Again, these will have to be individualized to be appropriate to the two distinct communities we partnered with. These include:

- Develop strategic plans for each community that recognize each partner's unique approach to change, but create a collaborative approach for community change. All other solutions follow from developing a planning model suitable for each partner communities.
- Develop MOA's and other mechanisms that define how partners collaborate with each other, each agency's roles and responsibilities, and delineate the resources available at each. MOA's should include the creation of an ongoing inter-agency council to address new issues as they arise and act as an agent to sustain the purpose and results of the project.
- Develop appropriate policies and procedures for serving survivors with disabilities and adequately orient staff to these policies and procedures. These should be similar, if not, identical, across our local partners.
- Develop a regular schedule of training and cross-training among local partners in each community, beginning with Disability 101 and DV/SA 101. Cultural understanding and competence will be an essential component of the training curriculum.
- Engage key behavioral health providers in our local partnerships in each community.
- Employ culturally resonant practices, such as potlatches, to engage elders and others from different cultural communities.

ASPEN thanks all those who participated in this needs assessment - obviously it would have been impossible to complete this process without their participation. Those are:

- The women who shared their experiences during focus groups and interviews,
- Our eight Community Partners in Site A and Site B, their boards, management, and staffs.
- The managers and staff at each of the five ASPEN collaborating agencies

**Note:**

In order to protect the safety and confidentiality of individuals and organizations, the original report has been altered to remove all potential identifying information.



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## Overview of Collaboration

The Alaska Safety Planning and Empowerment Network (ASPEN) formed in 2007 with the purpose of promoting system change in the disability services and the domestic violence/sexual assault/stalking sectors that would improve the response in both arenas to survivors with disabilities who have experienced domestic violence, sexual assault, or stalking. A 2007 Education, Training and Enhanced Services to End Violence Against and Abuse of Women with Disabilities Grant from the Office on Violence Against Women, US Department of Justice provides the funding for ASPEN's work.

ASPEN's efforts were preceded by the Alaskans Speaks Up (ASU) project, which involved several of the members of the current collaboration and which concluded in 2006. The five members of ASPEN are:

1. **Access Alaska, Inc.** (Access), incorporated in 1983, is a federally funded Center for Independent Living (CIL) that has two regional centers serving Southcentral, Western, Interior, and Northern Alaska. Its services include information and referral, advocacy, peer mentoring/support, independent living skills training, and deinstitutionalization.
2. The **Alaska Native Justice Center** (ANJC) is a private, non-profit agency created in 1993 to address the civil and criminal justice needs of Alaska Natives. ANJC addresses a wide range of issues: victim advocacy services, prisoner re-entry services, training/technical assistance, and tribal court development. ANJC staff has expertise and extensive knowledge regarding Alaska Native culture, history and values.
3. **Alaska Network on Domestic Violence and Sexual Assault** (ANDV/SA) is a nonprofit statewide coalition of 20 direct service domestic violence and sexual assault programs promoting social change to eliminate personal and societal violence in the lives of women and children in Alaska for over 30 years. It provides legislative and legal advocacy, training, technical assistance, coalition building, policy development and public education.
4. **Center for Human Development** (CHD) is the University of Alaska Anchorage's center on disability education, training, and research; 30% of its employees experience disabilities or are parents of individuals with disabilities. In 1991, CHD founded a nonprofit clinic to fill service gaps for women with cognitive disabilities who were violent crime victims. CHD specializes in staff development, multi-media and distance training/education, and research and evaluation and is needs assessment project lead.
5. **Governor's Council on Disabilities and Special Education** (GCDSE) is a state agency whose members include people with disabilities and their family members (60%) and state agency, service provider, and special education representatives appointed by the governor. The Council's 30 years of experience and expertise in capacity building, systems change and integration, advocacy and interagency collaboration reflect its mission to create change that improves the lives of people with disabilities.



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## **A Timeline of ASPEN's Planning Phase**

ASPEN began developing its collaboration charter in January of 2008. While completing the charter, ASPEN conducted a series of internal cross-trainings and a root cause analysis that deepened members' familiarity with their own purposes for pursuing the project and helped us determine each member's role. The root cause analysis identified several conditions impacting survivors with disabilities. We addressed the following major areas through this grant:

1. Women with disabilities do not identify as being abused—address via cross training;
2. Lack of response from disability service providers—address in sites of change;
3. Societal issues—address policy and program changes within sites of change;
4. Lack of response from DV/SA programs—address in sites of change;
5. Women with disabilities are not aware of DV/SA services and/or don't know how to access services—address in sites of change, especially in the area of accessibility;
6. DV/SA staff/program attitudes and challenges—address in sites of change;
7. Disability providers lack knowledge of DV/SA services—address in sites of change;
8. Women with disabilities don't report abuse—address through sites of change marketing services including individuals with disabilities; and
9. System issues—can be addressed in our sites of change.

Major categories that ASPEN recognized as areas of need that must be addressed outside this grant include: 1) Lack of justice system response; 2) Difficulty for women with disabilities to receive support to safely take empowering steps away from abuse; and 3) Lack of prevention.

Completing its charter in July 2008, ASPEN initiated work to narrow its focus, which culminated in the approval of our focus memo in January 2009. We elected to pursue a statewide focus with two pilot sites (Site A and Site B). ASPEN's next step was to engage our eight local partners, from January through March 2009. Needs assessment plan development consumed the period from April 2009 until approval in January 2010. We began conducting the needs assessment in February 2010 and finished in July 2010. Our Needs Assessment report was approved in October 2010.

### **ASPEN Vision**

ASPEN's vision is that survivors with disabilities will encounter a system where they feel empowered, can tell their stories, be believed without judgment, and receive appropriate services that are attitudinally, physically, culturally, and programmatically accessible. Service delivery systems in Alaska will have expertise and a clear understanding of their roles and responsibilities and will provide collaborative, effective person-centered services for survivors with disabilities.

### **ASPEN Mission**

ASPEN's mission is to build capacity of the service delivery systems (e.g., disability, victim advocacy, and others) by creating systems change designed to enhance the provision of collaborative, effective person-centered services for survivors with disabilities. ASPEN will strengthen response to survivors with disabilities by:

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- Identifying and resolving barriers (e.g. attitudinal, physical, cultural, and programmatic) to safety, empowerment and access to appropriate, non-judgmental services provided by both the disability and DV/SA systems;
  - Fostering local collaborations to link survivors with disabilities to services and resources;
  - Providing cross-training, technical assistance, and information that changes organizational cultures and practices; and
  - Developing sustainable, innovative policies and practices designed to prioritize safety, empowerment and access.

### **Project Scope in Site A**

ASPEN elected to pursue a statewide project, meaning ASPEN would work with local partners outside the collaboration itself to initiate system change in pilot communities rather than focusing on the organizations composing ASPEN. Site A was selected on the basis of social and cultural factors and their potential for change, as noted below.

**Demographics:** Site A, population 14,000 (15% Alaska Native), is XXX miles by air or sea from Juneau.

**Services, Relationships, and Change Potential:** ASPEN identified its local agency partners in Site A on the basis extensive direct experience and strong relationships. The existence of leadership at these agencies that has been at the forefront of systems change locally was a key consideration (for example, participation in local Disability Abuse Response Team initiatives). ASPEN's local partners in Site A are:

1. Community Partner 2 is a regional CIL headquartered in another community with a local office in Site A. Community Partner 2 is known for its innovative outlook. Community Partner 2 participated in the Alaskans Speak Up trainings that preceded and provided a foundation for ASPEN.
2. Community Partner 3 is a strong local DV/SA shelter program that interacts regularly with ANDVSA. Community Partner 3 is committed to social change work and has strong links with Community Partner 4 and other Site A programs.
3. Community Partner 1 is the local developmental disabilities provider in Site A with a long history of community involvement.
4. Community Partner 4 is an active Alaska Native village corporation. The Tribal Health Clinic is the division ASPEN will work with at Community Partner 4. Their Domestic Violence Program (Community Partner 4 has a model program) is housed in the clinic. We will also work with Community Partner 4's administrator.

## **Needs Assessment Description**

### **Purpose and Goals**

We conducted the needs assessment to inform ourselves, and our local partners, of the strengths/assets and weaknesses/gaps in services experienced by survivors with disabilities. The process engaged key providers of victim advocacy services, disability



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services as partners and women who have been the victims of violence, and women who experience disabilities from both sites.

The purpose of engaging these groups was to learn what qualities, processes, and relationships in each system and community must be understood and improved in order to build service delivery system (disability, victim advocacy, and others) capacity. The needs assessment illuminated elements of systems that need strengthening and identified opportunities to enhance provision of collaborative, effective, person-centered services for survivors with disabilities. The needs assessment will provide information guiding development of a strategic plan for system change initiatives. Ultimately, the strategic plan stemming from these needs assessments will serve as a blueprint to help a site of change better respond to identified needs and to support the development of integrated, comprehensive, and timely responses to the service needs of survivors with disabilities.

ASPEN's needs assessment activities aimed to determine strengths, weaknesses, gaps and barriers to supports for survivors with disabilities and to inform strategic planning process in Site A. These aims require we pursue several activities:

- Develop needs assessment methodologies
- Employ those methodologies to collect data from people with disabilities, service providers, and survivors.
- Analyze the data collected from these sources.

### **Goals**

Needs assessment goals grew out of the purpose of the project, our mission, and vision and were identified during an on site technical assistance session with the Vera Institute.

1. Identify strengths, gaps, and barriers of community service systems in providing accessible and appropriate services to people with disabilities and survivors.
2. Determine existing relationships between Community Partner organizations and the extent to which these meet the needs of survivors with disabilities.
3. Identify the existing policies, procedures, and practices of Community Partners and their strengths and barriers from the perspectives of people with disabilities, survivors, and staff and management Community Partners.
4. Identify the similarities and differences between the ideal set of effective person-centered services and supports from the perspectives of people with disabilities, survivors, and staff and management of Community Partners
5. Identify options that enhance collaboration between systems of service, better link survivors with those systems of service, and improve the services provided.

### **How will the information be used?**

ASPEN used this information to develop this needs assessment report, which will, in turn, inform ASPEN and its partners in Site A of the findings and implications of the needs assessment. The purpose will be to guide ASPEN and its partners in identifying which issues they choose to address during the project's implementation phase and which could better be addressed through other means.



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## **How the Report Relates to the Strategic Plan and ASPEN's Goal of Change**

The results of the needs assessment will be shared with Site A partners at on-site meetings. These sessions will initiate targeting of report findings and implications in order to develop a strategic plan creating a targeted initiative promoting seamless, comprehensive and timely responses for survivors with disabilities. The strategic plan will focus on initiatives within grant parameters and that will create sustainable change.

## **Methodology Summary**

Our needs assessment targeted four key audiences: 1) women with disabilities; 2) women who were survivors of domestic violence, sexual assault, and stalking; 3) staff and management from our partners in the disability service sector; and 4) staff and management from our partner victim services agencies. In this section, we discuss participation by each group and the methods used to gather information. We also discuss challenges encountered as we engaged our audiences and deployed our methodologies.

We used two basic methods to gather information from our four target groups, the first being focus groups and the second, individual interviews. This section describes each method, the audiences to which it was applied, recruitment strategies, and the number of people in each audience that eventually participated in needs assessment activities.

### **Consent Process**

We used a passive consent with all participants that allowed them to participate in a focus group or interview without providing identifying information. In particular during focus groups, this limited identifying information available to ASPEN personnel, all mandated reporters, should a disclosure requiring a report occur.

### **Access Considerations**

ASPEN's collaboration charter supports equal attitudinal, physical, cultural, and programmatic access to women with disabilities and survivors of domestic violence and sexual assault. This meant providing a welcoming and supportive environment for the broadest range of participants and circumstances. Focus group and interview tools were reviewed to ensure accessibility and cultural resonance and available in alternative formats. Recruitment included means to address accommodation requests.

Safety is a core ASPEN value encompassing freedom from abuse, neglect, and exploitation and requires environments in which survivors with disabilities are welcomed, valued, and respected. ASPEN recognized, by agreeing to participate in focus groups or optional interviews, individuals could encounter risk, which we minimized by informing all participants of the risks, using locations considered safe, stressing the need to respect confidentiality, stressing anonymity, discouraging disclosure, and providing supports/resources should a participant be in immediate risk during a session.



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## **Method 1: Focus Groups with Interview Option**

### **Purpose/Audience/Number**

Based on community engagement dialogues, collaborative discussions, and our team's experience soliciting input from rural residents, we chose a focus group methodology to gather information from individuals with disabilities and from survivors of domestic violence and sexual assault in Site A. The perspective and personal experience of survivors of domestic violence/sexual assault was the best source of specific information about safety, confidentiality and what is welcoming as related to service delivery. Likewise individuals with disabilities are the best sources of information on accessibility and accommodation issues and what makes with service delivery welcoming.

Focus groups are primarily used for exploration and discovery of a topic. They provide an opportunity for participants to share and compare information. Group participants helped us explore and discover what was needed to better serve survivors and women with disabilities. The focus group setting allowed participants to explore questions more deeply and the peer setting offered comfort and support during those explorations. Staff from our partners from Site A assisted with focus group participant recruitment. ASPEN provided on-site orientation for recruiters, covering:

- Purpose of the project and the focus groups
- Meeting logistics
- Risk factors, including confidentiality
- Food and gift cards
- Personal Care Assistants (PCA) and other care providers arrangements
- Accommodation requests
- Consent
- Focus group protocol and questions, and
- Interview option for individuals who wanted to participate, but not in a focus group.

The trained recruiters directly solicited participation in focus group sessions or optional individual interviews from the population each provider served. Each agency, or in some cases, a pair of agencies, conducted recruitment for one or more focus groups in their respective community. The two focus groups held were held, one for women with disabilities and a second for survivors of sexual assault and domestic violence. Recruiters were instructed not to seek out women they believed fell into both categories we wanted to interview. Recruiters offered the opportunity to participate via face-to-face, private interviews rather than in a focus group to all potential participants

### **Group Facilitation and Results**

A team of three ASPEN members conducted the focus groups: one representing domestic violence/sexual assault expertise, one with disability experience, and one with Alaska Native cultural competence. This balance produced group facilitation with broad expertise and grasp of cultural nuances. Advocates from each community were available in a safe room on site during the group sessions. ASPEN teams visited for two days to conduct four focus group sessions lasting 90 minutes or more. For individuals opting not



to participate in a focus group, we offered semi-standardized interviews using the same questions and probes, to ensure collection of consistent data.

ASPEN aimed to recruit a total of 20 – 40 at four focus group sessions. We expected some participants to request individual interviews protect their safety and confidentiality. Figure 1 displays the proposed number of participants from each target audience and session, compared to the actual number of participants. We expected participant numbers to vary from group to group and planned to conduct groups even if fewer than 5 individuals attended a particular session. We did not collect demographic data on participants, principally because such data can and has been used to identify individuals in small Alaskan communities. ASPEN facilitators noted participants in Site A appeared to be about 65% Alaska Native or American Indian.

**Figure 1**

<b>Focus Groups</b>	<b>Target Participants</b>	<b>Actual Participants</b>
<b>Site A</b>		
Survivors of DV/SA Group 1	5-10	5
Survivors of DV/SA Group 2	5-10	3
Survivors of DV/SA Interviews	Unknown	4
Individuals w/Disabilities Group 1	5-10	4
Individuals w/Disabilities Group 2	5-10	2
Individuals w/Disabilities Interviews	Unknown	2
<b>Total</b>	<b>20-40</b>	<b>20</b>

## **Method 2: Staff and Board Interviews**

### **Purpose of Interviews**

We interviewed staff, management, and boards at all four organizations. We expected each to provide unique perspectives. From staff we wanted an understanding of service delivery realities, policies and procedures in practice, and barriers to serving survivors with disabilities. We sought their knowledge of resources, agencies, and services specific to disability and DV/SA/S and history of working with other agencies serving survivors with disabilities. We wanted to assess comfort working with survivors with disabilities and what would help them better support such clients. Finally, we wanted opinions on what they did well and what they would like to do better as collaborative partners.

Managers, we thought, would provide understanding of budgeting, policies, procedures, and existing collaborations. We wanted to understand both informal and formal processes for changing policies and procedures. We wanted to know how they supported staff including recruitment, training and retention. We sought an understanding of their history



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of working with other agencies in support of survivors with disabilities. Lastly, we wanted opinions on what they did well and how they wanted to improve as collaborators.

From executive directors we looked to understand budgeting, relationships with boards, organization policies and procedures, and existing collaborations. We also wanted to understand how change occurs in the organization, and how they prioritized programs and service provision. Finally, we wanted their perspectives on what they did well and what they would like to do better as collaborative partners.

From board members we wanted to understand missions, processes for collaborating with other organizations, how change occurred, how strategic plans considered survivors with disabilities, how well they thought their organization responded to the needs of survivors with disabilities and what they thought were populations they should serve, but were not, and the reasons (e.g., budget, expertise, etc.). Finally, we wanted perspectives on what their organization did well and how they wanted to improve as collaborative partners.

### **Recruitment strategies**

Executive directors helped recruit staff, managers, and board members from their organizations. Interview targets for each partner were: 1) Executive Director; 2) Board of president and one other member; 3) 10% of staff/managers, randomly selected, a minimum of 3 per site (some partners had fewer than 3 staff/managers). ASPEN team members set up individual interviews with board members, staff, managers, and executive directors. Verbal consent avoided creating documentation with identifying information. ASPEN provided accommodations on request. As with focus groups, ASPEN minimized the risks to safety and anonymity.

### **The Interview Process**

We used a semi-standardized interview designed to take 30-45 minutes. In practice, interview ranged from 20 to 90 minutes. Standard questions were asked each interviewee, but interviewers had freedom to digress and probe beyond. This allowed us to get full answers to questions and allowed interviewees to reveal more about topics they felt important. All ASPEN members, in teams of two, did interviews, most by telephone.

Figure 2 displays the targeted number of participants from each organization and the categories within the organization. We completed 21 of a targeted 26 interviews (81%), a respectable rate under any circumstances. As the table demonstrates, we were close to our targets in each category, with a key exception. Recruiting board members proved to be more challenging than any other group; we ended up at 39% of our target. Many board members are volunteers who guard their personal time. One board chair felt the issues addressed were the responsibility of staff and declined to respond to the questions.

We did try hard to obtain more board interviews, making numerous phone calls and sending many emails to potential interviewees and related contacts, but we had to conclude the needs assessment short of our target in this area. Fortunately, board interviews are a less important information source in terms of service delivery and other



issues. For development and adoption of initiatives that require board involvement or concurrence, this circumstance will result, for the former, on greater reliance on evidence gathered from agency staff and management and, for the latter, on ASPEN's capacity to be persuasive with a less involved element of our partners' governance structures.

**Figure 2**

<b>Partner Interviews</b>	<b>Target Interviews</b>	<b>Completed Interviews</b>
<b>Site A</b>		
Community Partner 3		
Staff/Managers	3	3
Executive Director	1	1
Board Members	2	2
Community Partner 4		
Staff/Managers	3	2
Executive Director	1	1
Board Members	2	0
Community Partner 1		
Staff/Managers	6	5
Executive Director	1	1
Board Members	2	1
Community Partner 2		
Staff/Managers	2	4
Executive Director	1	1
Board Members	2	0
<b>Total</b>	<b>26</b>	<b>21</b>

## **Key Findings and Implications**

### **Opening statement**

This section presents information and analysis in a manner that highlights similarities and differences of two separate systems, disability and victim advocacy. While we did not ask about the experience of disability, many survivors in Site A, when describing what worked and didn't work for them, alluded to benefits and barriers from their own experience. These often included experiences associated with disabilities. Disability service recipients when describing what made them feel welcome often referred to comfort or lack thereof based on safety issues.

Although we asked no leading questions, four focus group facilitators noted 1) many participants self-identified as survivors shared experiences of disabilities and 2) many self-identified as people with disabilities disclosed DV/SA experiences. People with



disabilities and survivors were literally one and the same. Culture plays a key role in how services should be delivered and by whom. Both focus group participants indicated provider attitudes (e.g., manner in which direct care staff treated them, policies and procedures, confidentiality practices) were crucial to their opinion of the benefits of any services.

***Finding 1***

*Typically, the policies in place at our partner agencies addressed issues such as mandated reporting and the Americans with Disabilities Act. We were unable to identify any specific written guidelines concerning the safety and service needs of survivors with disabilities. Further, any informal practices that exist appear to be neither clearly understood nor uniformly implemented by staff and management.*

This first illustrates considers the following Needs Assessment goal:

3. Identify the existing policies, procedures, and practices of Community Partners and their strengths and barriers from the perspectives of people with disabilities, survivors, and staff and management Community Partners.

Interviews and focus groups revealed each partner agency had policies and procedures addressing their specific clientele. However, none had policies and procedures focused on survivors with disabilities. During the interviews we targeted the following areas in regards to policies and procedures (focus groups/interviews participants were not asked questions around policies and procedures, but some offered comments):

- How policies and procedures are shaped
- How they are used to guide services to survivors with disabilities
- How they may be barriers to working with survivors with disabilities

ASPEN’s partner agencies shape policies and procedures using a variety of methods. Mostly, boards shape policy, with input from executive directors and, in some cases, staff or committees. For example, at the time Of The Interviews, The Community Partner 3 Board had begun examining their policies and procedures, reviewing one policy and procedure per board meeting. Interviews with the Community Partner 3 executive director, line staff, and managers indicated the board solicited staff input as they worked through updating policies and procedures.

The board shapes policy through the Program Committee with input from the Executive Director. The committee then makes recommendations to full board –Board Member

The focus of the policy and procedure review at Community Partner 3 is to ensure accessibility to everyone. The current procedure for addressing the needs of program participants with disabilities from the executive director’s perspective is to find out what is needed to ensure safety, accept into the program, and then attempt to provide reasonable accommodations. In practice, this focus helps make sure advocates do not screen people out. Community Partner 3 has a high level of clients with behavioral health



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and/or substance abuse issues and tries to work with each, but in some cases they are unable to shelter everyone. Currently there are a number of “gray areas,” in some cases policies are not written.

Staff at Community Partner 2 said they had no formal policies and procedures directly addressing needs of survivors with disabilities. They indicated that it was informal - if they needed assistance, they called Community Partner 3. The director said there are procedures in place and that there has been an effort to revise policies and procedures over the last several months, specifically around intake questions. Several Community Partner 2 interviewees said that as a Center for Independent Living, Community Partner 2 is consumer controlled so consumers set their own goals and priorities. The local Disability Abuse Response Team (DART) was mentioned by the director, but not by the manager or staff.

I think it’s implied, it’s in place (existing policies and procedures), looking at the individual – Executive Director

Community Partner 1 interviewees, said they consider individual need in providing services. They mentioned mandatory reporting policy and a procedure to notify proper agencies of suspected abuse. At least one interviewee felt this was not a policy issue. Although it didn’t appear there were specific policies and procedures to guide services to survivors with disabilities, there appeared to be informal practices agencies used. At least one interviewee from each of our disability partners identified mandatory reporting as a policy. At DV/SA partners, the focus seemed to be on safety and accommodation.

Creating an atmosphere where the participant feels safe allows for disclosure. Also, many... participants tell us if they are receiving services from agencies such as Community Partner 1 or Community Partner 2 - Manager

Current practice for determining if a person has a disability is speaking directly to the client and/or observing behavior or physical limitations – Staff

Determining whether a person has a disability is not in the assessment or intake form. The intake form does ask if the client needs medical assistance - Staff

Community Partner 4 interviewees noted they complied with the Americans with Disabilities Act; that their facility was accessible and that waivers were available for clients in the DV/SA program for financial assistance if the individual applying is disabled, suffering extensive injuries, or requires additional time to recover from mental injury. These policies allow staff to provide additional services, a path to more effective work with survivors.

Although it didn’t appear there were specific policies and procedures to guide services to survivors of DV/SA with disabilities, there did appear to be practices that some partners were using. Some staff indicated they weren’t sure if disability issues are addressed in any policy or procedure. A Community Partner 4 staff member noted, “The intake form does ask if the client needs any medical assistance.” Staff described a binder



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of resources available for staff to go through to provide program participants with a list of phone numbers for agencies and individuals able to provide assistance.

Community Partner 3 Staff indicated they try to accommodate when the need is apparent (e.g., “If an individual can’t go downstairs, someone else can assist with the chores,” “For a program participant with mental health issues-always having an advocate is available to offer moral support; “Making sure a person with a bad back is comfortable.”).

## **Implications**

Organization leaders (Board Members/Executive Directors) frequently felt the agency mission and service provisions implied it would serve the “other” population; most did not see the need to include explicit references in missions or policies and procedures directed at survivors with disabilities. Although none of our partners have written policies specifically addressing survivors with disabilities, all eight partners indicated a willingness to address individual needs.

Policies and procedures addressing survivors with disabilities are not common to either our disability or victim advocacy partners. Policies and procedures beginning with intake and assessment should be reviewed by all ASPEN partners. Appropriate policies and procedures for working with survivors with disabilities should be developed collaboratively with the goal of putting in place consistent and complementary guidelines that address the unique characteristics of each community.

### ***Finding 2***

*Our Community Partners appear to interact on some level with each other. However collaboration beyond the basics (e.g., providing referrals, exchanging resources information) is limited. It appeared that DV/SA agencies were more likely to reach out to disability providers than the other way around.*

In this section, we considered two Needs Assessment goals:

1. Identify strengths, gaps, and barriers of existing service delivery systems in providing accessible and appropriate services to people with disabilities and survivors.
2. Determine existing relationships between Community Partner organizations and the extent to which these meet the needs of survivors with disabilities.

Our Community Partners acknowledged they worked with overlapping populations to a large extent, but did not consciously realize this until becoming involved with ASPEN. While the disability community recognized people with disabilities were victimized, they usually identified this as generalized abuse - primarily caregiver abuse. Victim advocates acknowledged many survivors experienced disabilities, such as behavioral health or substance abuse issues; however they did not recognize these as disabilities. Most advocates identified only people who experienced cognitive or physical disabilities as persons with disabilities.

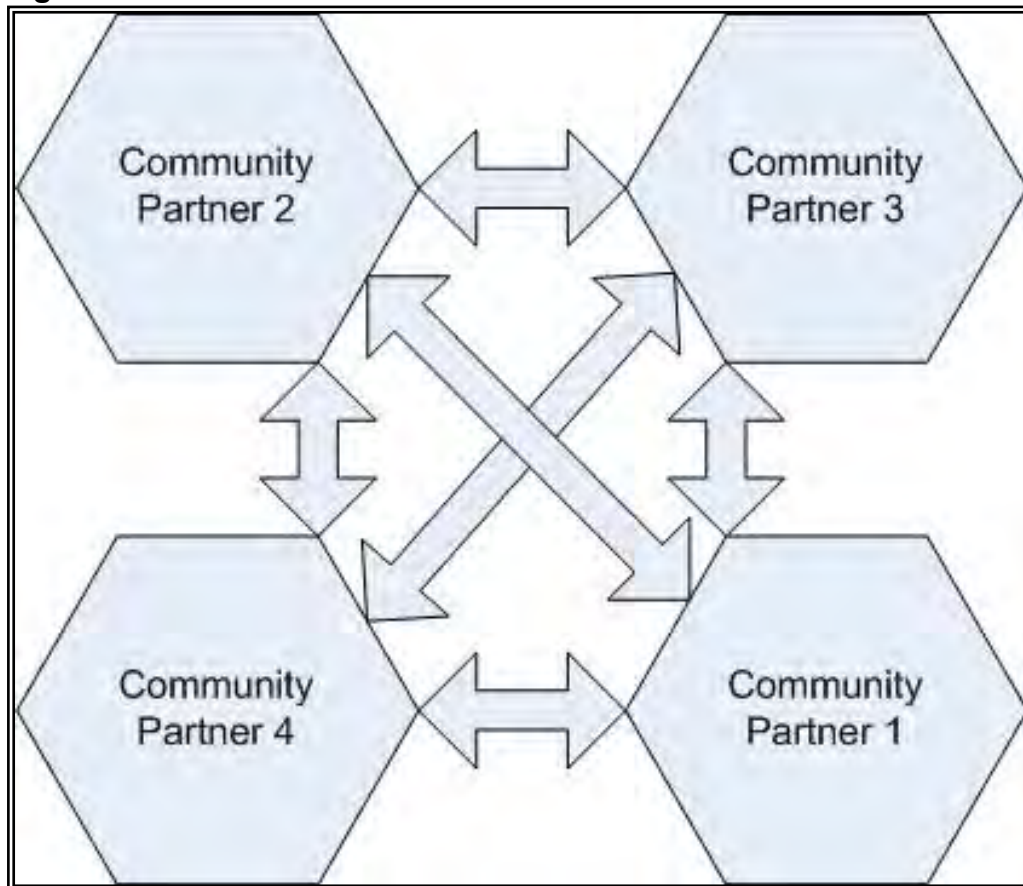


Our partners all agreed both systems were crucial to help individuals navigate and access resources (e.g., financial, housing, medical) and help them feel safe and empowered. Disability providers and victim advocates referred individuals for services they did not provide. Providers said follow up could be challenging and sometimes did not occur. In some cases, providers tried to address individual needs within their own framework.

Disability staff we interviewed understood they were mandatory reporters, however, some were uncomfortable or reluctant to make reports to authorities (i.e. Adult Protective Services, law enforcement, Long Term Care Ombudsman, Office of Children’s Services); reports seemed to them to violate confidentiality or rights to self-determination.

In order to investigate the inter-agency connections among our Community Partners, ASPEN’s staff interviews included questions about with whom our partners worked. Figure 3 (see below) depicts the collaborations between ASPEN Community Partners. We elected not to ask specifically about partner agencies; we didn’t want to lead interviewees, and we also wanted to discover what non-partner agencies they found to be helpful in serving the needs of clients. Figure 4 lists non-ASPEN agencies that at least two of our partners worked with. We also asked focus group participants what referrals were made to address service needs that ASPEN partners could not address.

**Figure 3. Site A Partner Connections**





**Figure 4. Other Site A Agencies/Organizations**

	Community Partner 3	Community Partner 1	Community Partner 4	Community Partner 2
XX Human Services	X	X	X	X
Senior Service/Senior Center/XX Center	X		X	X
Medical Services (Hospital, Nursing Facilities)		X	X	X
Adult Protective Services		X		X
HOPE		X		X

Not only did most of our partners already work together, they all worked with the local behavioral health provider. As shown in Figure 4 all four partners interacted with XX Center for Human Services, the principal behavioral health provider.

Interviewees also noted other local groups, task forces and/or coalitions to which their organization belonged, including XX, Inc, Violent Crime Compensation Board, the Courts, Salvation Army, Site A Regional Youth Facility, school district, city and borough, Disability Abuse Response Team, Healing Trauma Through Stories, borough transportation, XX Alaska Regional Resource Center, Site A Youth Leap, Domestic Violence Task Force and the Wellness Coalition. Some interviewees said there were too many other resources to list - these are not captured in this needs assessment.

### **How Helpful Were ASPEN Partners?**

We asked focus group participants how well our Community Partners helped them find other needed services. While some individuals commented only on how their “home” agency assisted them, many described how other agencies as well helped them find other services. A synopsis of responses follows.

#### **Site A Survivors**

Many participants said the ASPEN partners from which they received DV/SA services helped them find other needed services. At Community Partner 4, participants said:

- If Community Partner 4 can’t help, they lead you in the right direction; sometimes they are too busy to answer questions, but they usually get back to you.
- Community Partner 4 Staff was good about offering different solutions, informing about meetings and acting in a respectful manner.
- Financial assistance can be “maxed out;” since Community Partner 4 can’t pay for all needs, it should cap assistance to individuals so all who need help can get it.
- Unable to find needed help from the Office of Children’s Services.
- Uncomfortable Using Community Partner 4 because it is too easy for people to see client folders.
- Bad experiences have led to mistrust of social workers.
- Comfortable in the support group on surviving the death of a loved one because they are aware of feelings and don’t blame.



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Focus group participants indicated Community Partner 3 helped in the following areas:

- Public assistance;
- Alaska housing;
- Custody lawyer;
- Alcohol counselor; and
- Information on getting a job.

One woman said she was told at Community Partner 4 where to go and she made the calls herself. Participants brought up ways in which partner agencies could improve. Two Community Partner 4 clients said when they came in there was a lot of paperwork. Both said they would have preferred to be listened to and hear about options and available resources before doing paperwork. Others wanted Community Partner 4 to keep its referral list current and posted, and provide handouts and current resource lists to clients. Some clients felt Community Partner 3 could have offered more information on options; more information on volunteering; and more focus on preventive practices—including more in-school information. One woman said advocates should ask more often if you need help.

### **Site A People with Disabilities**

Most participants indicated the ASPEN partners from which they received services helped them find other services the partner could not provide, including:

- Filling out paperwork and applications, including paperwork for a Medicaid waiver;
- Helping with long words and telling her when she needed to come in and sign papers;
- Referring to counseling.
- Referring to budget and life skills workshops.
- Connecting to Community Partner 1 and the Special Olympics.

Asked how partners could better serve them, one participant said they could help more with housing, food, schooling, and employment. Another said she would like to see more money for adaptive accommodations. Finally, one felt her agency needed more staff.

### **Implications**

Interviews and focus groups identified over 20 other organizations ASPEN partners collaborate with. Resource richness was an asset in Site A. People with disabilities and survivors felt good about the helpfulness of our partners in linking them with outside assistance, another strength. The two groups identified approximately 20 ways in which more help could be provided.

To address these implications, Site A should catalog community resources, develop collaboration mechanisms, and facilitate access to resources for survivors with disabilities. Partners should review areas focus group participants identified in which assistance could be improved and determine how to address those. Resource lists for survivors with disabilities should be available at all partners and collaborators.



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### **Finding 3**

*There is wide diversity of perceptions among DV/SA staff about what a disability is; they also have varying experiences in working with people with disabilities. Likewise, there is great diversity of perceptions among disability staff about what constitutes domestic violence/sexual assault of people with disabilities and they have varying experiences working with survivors.*

Finding 3 responds to two Needs Assessment goals:

1. Identify strengths, gaps, and barriers of community service systems in providing accessible and appropriate services to people with disabilities and survivors.
4. Identify similarities and differences between an ideal set of effective person-centered services and supports from perspectives of people with disabilities, survivors, and staff and management of Community Partners.

As we discuss elsewhere, partners from both sectors served survivors with disabilities on a routine basis, but often did not recognize they were working with survivors with disabilities. The ASPEN interview process seemed to act as a catalyst for this recognition in many cases, sparking the understanding that perceptions of who fit into this category were incomplete.

### **Perception of DV/SA by Disability Partners**

The focus of disability providers is on individualized services and support as it relates to the disability. In Site A, front line workers at two disability partners noted they were not aware of working with any survivors.

While some staff were comfortable dealing with disclosure, others were not. Strategies for dealing with disclosure varied from “go to supervisor” to “not an expert in responding, but communication skills would go part way.” One staff involved with employment of individuals with disabilities noted that he/she would go to the service coordinator or director to talk about it if he/she were concerned. In a number of cases, the thought of taking on duties related to DV/SA was overwhelming to staff having difficulty keeping up core duties as disability providers.

In asking whether partners have any survivors or people with expertise on their boards, one partner did have members with experience or knowledge of DV/SA or victimization issues, although individuals with this expertise were not intentionally recruited.

I really feel like we do so much...right now that focusing on that [DV/SA] is not necessarily in our best interest. Especially when so many people have multiple issues - Staff

(Our) strength is in one on one services. If we identify need for support, we are there. We give them the skills to not become a victim - Executive Director

I don't think it's inherent in our mission statement. It is part of our day-to-day work to detect DV/SA - Board Member



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## Perception of Disability by DV/SA Partners

Victim advocacy organizations focus on legal and system advocacy, shelter services, and support safety, autonomy, confidentiality, and other relevant concerns of the people they serve. The board and executive director in Site A voiced an inclusive notion of the range of disability (behavioral, cognitive, physical, etc), but staff and managers perceived disability as primarily related to physical or mobility issues. Many discussed problems with their facility and how they hoped a new building was in the works. Staff described difficulties with stairs, the washer/dryer being on the bottom floor, and barriers stemming from many of the rooms not being on the main floor. One person described how a new building with critical elements on one floor would be better for many residents, including those with infants or small children, the elderly, and pregnant women.

While most staff members described disability in terms of mobility, one individual revealed she helped individuals with their writing or reading, provided telephonic services for court accompaniment and offered other assistance and services to individuals with anxiety disorders or agoraphobia. She asked us, “Is that working with people with a disability?” She said, “I never thought of these services as creating accessibility for a person with a disability. I always thought of disability access only in terms of what someone needs when they use a wheelchair or a cane.”

The focus is on being hopeful and helpful - Board Member

Staff is trained to work with all people as long as they are not a (danger) to themselves or others - Line Staff

As with disability agencies, it was enlightening to note if DV/SA partners’ boards had members with disability experience. Again, although none specifically recruited for such members, our DV/SA partner did have board members with such experience. Likewise it was enlightening to ask whether people with disabilities, survivors, or people with expertise in one or the other served on the board of our tribal partner. Although not specifically recruited, our Site A tribal partner did have such board members. In terms of services, that organization seemed to focus on individuals with behavioral health and substance abuse issues.

Services are consumer/patient drive - Executive Director

## Implications

Site A has a broad history of cross training and collaborations around disabilities as a result of involvement and funding with other programs that focus on the victimization of people with disabilities/Elders and the need for cross training (i.e., Abuse Prevention for Vulnerable Adults, Alaskans Speak Up/DART). There is a broad range of perceptions of whom people with disabilities and survivors are and what is done to serve them across all our partners in Site A. Basic education on awareness, philosophy, and service delivery approaches of both the disability and DV/SA sectors should be developed and provided to all current staff and new staff during orientation.



**Finding 4**

*Community Partners and focus group participants identified behavioral health services as a crucial component to meeting the needs of survivors with disabilities.*

Finding 4 illustrates two ASPEN Needs Assessment goals:

1. Identify strengths, gaps, and barriers of existing service delivery systems in providing accessible and appropriate services to people with disabilities and survivors.
2. Identify the similarities and differences between the ideal set of effective person-centered services and supports from the perspectives of people with disabilities, survivors, and staff and management of Community Partners

In Site A, when ASPEN originally began to engage potential partners in early 2009, we were asked why behavioral health providers were not at the table. When we returned at the beginning of 2010 to begin the needs assessment process, the queries were even more emphatic. During the assessment itself, interviewees from all our partners said local behavioral health providers should be part of the ASPEN project.

Advocates are not sure what to do with people with... schizophrenia. This may have to do with fear and/or just not feeling comfortable - Staff.

During the needs assessment process, our partners became increasingly aware they worked with each other’s populations, despite not recognizing doing so. Disability providers acknowledged many people with disabilities experienced victimization, although they spoke primarily about caregiver abuse. Victim advocates acknowledged many survivors experienced “hidden” disabilities (mental health or substance abuse); however they did not generally see these as disabilities precisely because they were hidden. They were more likely to describe recognizing survivors with cognitive or physical disabilities.

Our DV/SA partner encountered individuals with mental health and substance abuse issues frequently. The “ideal shelter,” as envisioned by its executive director, would have mental health and substance abuse counselors on site. The shelter is currently developing a new strategic plan that will most likely address behavioral health issues; it is unclear whether other disabilities will be addressed.

Therapists are petrified to provide mental health services (to adults with developmental disabilities); we had kids’ therapists working with adults - Manager

Site A disability staff indicated they have no guidelines for serving survivors. One partner does not provide behavioral counseling, but refers to XX Center for Human Services. Staff said they are clinicians, a psychologist, and a psychiatrist for children. Access to these services is difficult for adults, so they refer to XX. They

said availability of mental health services for people with developmental disabilities is very limited.



Our tribal partner has a strong behavioral health component, but staff identified two barriers to meeting the immediate needs of people with disabilities: 1) When someone needs assistance for a severe substance abuse problem, for example, the referral process and short staffing lead to a waiting list. Beds may not be available for 6 weeks to 6 months. This gap between a client decision to seek treatment and accessing treatment may result in losing the client; and 2) often there is automatic denial of applicants seeking public financial or medical assistance and people must reapply.

Some of our partners also participate in the Site A Wellness Coalition, which has been addressing gaps and deficiencies in services. There was uncertainty whether there was a disability subgroup; there is one on youth suicide prevention.

## Implications

There appears to be commitment across all of ASPEN’s partners to collaborate and improve services to survivors with disabilities, most especially those with mental health and substance abuse issues. This commitment represents a unique opportunity to address a serious gap in services to survivors with disabilities. Our partners in Site A already have some sort of relationship with local behavioral health providers.

### ***Finding 5***

*Processes for change within ASPEN’S partner agencies are in place—whether through strategic plan development, budgeting process, or staff and client input; however each agency has a unique approach.*

This section addresses the following Needs Assessment goal:

1. Identify the existing policies, procedures, and practices of Community Partners and their strengths and barriers from the perspectives of people with disabilities, survivors, and staff and management Community Partners.

All our partners have strategic plans and appear to have a formal development process for those plans. Neither disability agencies nor victim advocates specifically addressed the needs of survivors with disabilities in strategic plans. The strategic plans at the four agencies are primarily developed through processes driven by the boards. In some cases, the executive directors or program managers oversee plan development. In one case, the plan is developed at a board retreat. In two other cases, partners hire consultants to review what they are doing and/or to assist with the plan development. While it appears all request staff input, some noted they also request direct consumer or customer input (our interviews didn’t specifically ask whether consumer input was sought).

The board is seeking funding for a new, improved facility; if the needs assessment determines there are additional needs, the board would look for the funding, either within the current budget, or...look to reallocate funds, use emergency funds or seek grant funding to meet existing needs of people with disabilities - Board Member



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All partners indicated their board or council approved the budget, but once approved, executive directors or managers, as the case may be, have freedom to approve expenditures within it. Several reported the executive director or program manager was in charge of developing the budget with input from staff and/or community members. Some agencies reported substantial funding is tied to grants with specific scopes of work. One noted, while there were no budget line items currently addressing disabilities, they might be peripherally covered in line items, such as case management or elder care.

## Implications

Most of ASPEN's partners appear to employ something of a top down approach to planning and budgeting. Services appeared to largely reflect the requirements of funding sources, current or potential. For the most part, our partners rely on direct service or line staff to voice the perspective of service recipients, as in the below model.

**Client input → Staff → Manager → ED → Board → Agency P&P/services**

Board member participation in our needs assessment was less than hoped. As the needs assessment process was one means of introducing the project to our partners, lacking that may be an issue for some board members. As a result, particular attention may need to be devoted to engaging board members during the strategic planning process in each community. Change processes are in place at all our partners and the willingness to collaboratively change is also present, based on our needs assessment.

All our partners expressed an absolute willingness to work more on addressing the needs of survivors with disabilities, however they require more information on the scope of the problem and possible solutions in order to do so.

### ***Finding 6***

*All ASPEN partners have clearly stated the desire, need, and support for training or cross-training, staff orientation, and disability or DV/SA specific training as appropriate.*

This section addresses the following Needs Assessment goal:

3. Identify strengths, gaps, and barriers of existing community service delivery systems in providing accessible and appropriate services to people with disabilities and survivors.

All ASPEN's partner agencies supported the need for formal training enabling them to better serve survivors with disabilities. Site A has a history of cross training and collaborations around disabilities as a result of involvement and funding with other programs as noted in previous sections. In terms of current training, some staff indicated they received on-the-job or informal training. Other staff stated they had not received any formal training, but identified several trainings they would like to have on a regular basis:



- Sexuality training;
- Community Partner 2's training on victimization; and
- Trainings from Community Partner 3.

One executive director indicated the agency doesn't hesitate to train staff if it is of benefit to customers. A manager said they encourage staff to attend local trainings, as well as annual education to enhance staff effectiveness in working with individuals with disabilities.

Another executive director indicated her agency should provide better basic staff training, especially for frontline staff such as receptionists.

Another disability partner doesn't train specifically for work with survivors, but offers trainings to staff about core values of respect and supporting people's choice, a culture of openness, and accountability with the hope that this will instill in staff the proper attitude and response to survivors with disabilities.

Disability staff identified training around how to collaborate with the DV/SA provider and how to find DV/SA resources. They wanted a process/mechanism for working with Community Partner 3 and more frequent meetings with Community Partner 3 to improve collaboration. Such exchange does not happen now unless the two agencies happen to serve a common client. Community Partner 3 always invites their staff to trainings. A disability offers training on vulnerable adults abuse prevention.

While DV/SA staff gets policy and procedure training at hire, they would like more training on how to better serve individuals with disabilities. According to a manager, they were in the process of starting a "Safe and Sober" group based on an Alaska Network on Domestic Violence and Sexual Assault training.

DV/SA board members indicated that one way their agency could be more effective serving people with disabilities would be "placing a focus on staff training because, while the staff may be good, they may not have the skills to work with people with different disabilities." While survivors with disabilities were not identified specifically in the budget, the training line item was flexible and could include disability training.

It would be good to...offer training and also look at the accessibility of the facility - staff

We need...a good orientation program for staff. When new hires come...we need to provide education about community resources and cooperative ventures. Continuing education is needed in disability, co-occurring issues, accessibility, and breaking down stigma - staff

Training for staff to better understand the signs of undetected abuse. We probably are not seeing the whole picture. Training is probably the area - Board Member

I would really like ... to do more with Community Partner 3. I saw an example (of DV) in a disability support group, but didn't know quite what to do - Staff



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Relatively isolated areas such as Site A face significant barriers staging trainings in the community. Another significant barrier common to both sectors, indeed to providers statewide, is maintaining staff coverage during training events, particularly when the event occurs outside the community. Local labor pools are thin in both communities. Another concern, in even the largest Alaskan communities, is direct service staff tends to turn over at a high rate. Constantly replacing staff brings with it the need for continuous training at the local level.

## Implications

Site A recognizes the need for training across disciplines and is willing to institute such training. A history of Alaskans Speak Up training and establishment of a DART augurs well for expanded training for serving survivors with disabilities. This foundation of experience and willingness provides a good starting point for this training.

### ***Finding 7***

*Culture, in all its diverse and complex manifestations, plays a key role in service provision as it is perceived and experienced by survivors with disabilities.*

Our seventh finding addresses three goals of this needs assessment:

1. Identify strengths, gaps, and barriers of existing community service delivery systems in providing accessible and appropriate services to people with disabilities and survivors.
2. Identify the existing policies, procedures, and practices of Community Partners and their strengths and barriers from the perspectives of people with disabilities, survivors, and staff and management Community Partners.
3. Identify the similarities and differences between the ideal set of effective person-centered services and supports from the perspectives of people with disabilities, survivors, and staff and management of Community Partners

Our tribal partner reminded us to ensure the voices of elders were heard as we assessed what was needed for welcoming and comfortable services. Interviewees stressed many elders experience disability and/or domestic violence/sexual assault. For many, this experience has been accompanied by the experience of historical trauma related to social and cultural devastation including loss of language, the breakdown of family roles following the boarding school experience and a cultural legacy that includes decades long marginalization, mistreatment and abuse.

Alaska Native focus group respondents in Site A discussed their concerns for children who witness violence and stressed both elders and youth face many barriers such as limited economic and social power. Many voiced a need for services linking elders with youth to help foster intergenerational transmission of cultural values stressing nonviolence, cooperation and respect. Safe and welcoming services were described as reflecting Alaska Native values rather than services that emphasize mainstream western



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culture. Subsistence activities including opportunities to learn how to gather and process traditional foods were described as critical.

Contemporary subsistence activities and traditional ceremonies are still essential elements of cultural identity to the indigenous peoples of Southeast Alaska, however most Northwest Coast Indian peoples in Site A are generally integrated into the western economy. In part this reflects a historically more settled and structured life style and a greater material wealth due from a milder climate and abundant resources.

Site A survivors reported that activities celebrating Tlingit, Haida, and Tsimshian values and identity such as “potlatches” (celebrations and food sharing) helped them feel welcome and comfortable. They live in a highly sophisticated and structured clan system that governs social identity. Site A participants talked about making their first “button blankets” and “regalia.” These traditional activities serve as connectors and reminders of identity. Some survivors noted they sometimes experienced a sense of being lost or disconnected if cultural values were not supported by service providers from “outside.” They also stressed, “Knowing who you are and where you come from,” is a very important cultural element. Culturally relevant activities serving to connect program participants to, “those who came before and those who are to come,” were described as meaningful and healing.

### **Implications**

Traditional cultural values remain strong in Site A. ASPEN will need to engage elders, since elders sanction what is appropriate. Since ASPEN members are “outsiders” cultural activities, such as potlatches, will be needed to support collaboration among Community Partners. Subsistence activities need to be considered when we strategize how to promote collaboration.

A three-pronged approach to trauma - historical trauma, DV/SA trauma, and disability trauma – is necessary. For culturally resonant services that make recipients feel welcome and safe, we need to acknowledge intergenerational ties. ASPEN will need to work with the community to develop a culturally relevant strategic plan. This plan will also need to include strategies to incorporate non-indigenous viewpoints (e.g., Filipina, Latina).

### **Finding 8**

*Both survivors and people with disabilities in Site A identified, in general and in specific, positive, respectful, and supportive attitudes and actions as keys to making them feel safe, welcome, and comfortable.*

Finding 8 addresses the following three ASPEN Needs Assessment goals:

1. Identify strengths, gaps, and barriers of existing service delivery systems in providing accessible and appropriate services to people with disabilities and survivors.
3. Identify the existing policies, procedures, and practices of Community Partners and their strengths and barriers from the perspectives of people with disabilities, survivors, and staff and management Community Partners.



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4. Identify the similarities and differences between the ideal set of effective person-centered services and supports from the perspectives of people with disabilities, survivors, and staff and management of Community Partners

In laying out the basis for this finding, we honored the contributions and lives of the women who participated in focus groups and individual interviews. To ASPEN, this meant giving them appropriate space in these pages to fully illustrate their experiences and perspectives on services as survivors and people with disabilities. To the reader, it may appear that this section contains repetition or excessive detail. We did so in order to present the full picture of these women’s experiences as they related them to us.

We found, while conducting focus groups, most of the participants recruited by our victim advocacy partners disclosed experiencing disabilities without prompting on our part. We must emphasize the vast majority of focus group participants and interviewees were generally pretty well satisfied with their experience of services from both sectors. Despite this overall satisfaction, they had many ideas how services could be made safer, more welcoming, and more comfortable. A number related specific experiences that could be described as unsatisfying. Finally, some addressed issues beyond the stated focus of our needs assessment; we elected to include some of these in our narrative.

### **What was helpful in Site A - Survivors**

When ASPEN asked survivor focus group participants to discuss the helpful aspects of DV/SA services, there were a variety of responses. Focus group participants indicated Community Partner 3 did a number of helpful things:

- Helped with restraining insert protection orders (something the police wouldn’t do);
- Listened;
- Provided a safe place, warm bed and a warm welcome;
- Referred to a Pro-Bono program and other legal services; and
- Provided the manifestations of violence sheet as well as resources for housing, food stamps, and custody information.

Community Partner 3 was helpful when no one else would help - “Within 10 minutes of calling, a cab was there to pick me up.” Community Partner 3 offered police protection, and was very welcoming, “Both to me and my child.” Another woman described wanting to get sober, but not wanting to attend Alcoholics Anonymous because everyone knew where it was. The director brought classes to Community Partner 3 that helped her. She also said she was comfortable because it was a women’s group and she was uncomfortable with men.

Community Partner 4 provided a variety of helpful services, according to focus group participants:

- Immediate assistance--without an appointment;
- Activities reducing stress and helping with

Community Partner 4 helped me by getting kids involved. Every kid should be aware of domestic violence and sexual assault. It happens so much in Southeast Alaska.



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- sobriety;
  - Child custody assistance;
  - Confidentiality;
  - Information and classes about DV/SA;
  - Help with divorce through a DV lawyer; and
  - Financial help.

### **Service Barriers Encountered**

Most focus group participants did not describe experiencing barriers At Community Partner 3, with most indicating they couldn't think of any unhelpful aspects. A few indicated they had wanted more direction and, at first, didn't feel like they got much direction and wanted counseling to understand why they kept finding themselves back at Community Partner 3. Specific issues, each from a single participant, were:

- Some advocates felt the participant wasn't important enough, that her questions weren't important enough (stated in the past tense by the participant).
- It would be nice to have emergency funding for medications.
- Community Partner 3 legal advocate was not helpful (again, stated in past tense).
- Need access to an attorney

Many survivors indicated Community Partner 4 had been helpful with most concerns; two exceptions (again each voiced by a single participant) were:

- Gave pills, instead of solutions.
- Batterer intervention program taught perpetrators "how to beat the system and manipulate it to their advantage."

### **How providers show they can be trusted to help**

Participants mentioned a number of ways Community Partner 3 inspired trust including:

- Non-judgmental attitude
- Locked doors – no one can come in
- Door always open to victims
- Supportive and calming treatment of victims and their children
- Patience in explaining the process - willing to work to assure safety
- Confidentiality honored, immediate signing of a confidentiality release reassuring

If someone calls here they can't say that I am staying here - that made me feel safe.

Focus group participants said that Community Partner 4 showed they could be trusted because staff:

- Were familiar to victims;
- Kept confidentiality;
- Helped with children;
- Respected choices;
- Supported victims learning to make their own decisions.
- Was responsive - they called back.



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### **Other things agencies can do to help**

Many participants said Community Partner 3 already did all it could to help. One noted she got a cycle of violence handout, but would have liked to talk to someone about it. She needed more information on how to avoid situations that would bring her to Community Partner 3 again. Another woman said she lost focus after a major medical incident and Community Partner 3ed they had pushed her to get back on her feet. She also Community Partner 3ed there had been more counseling for her child (note: now available). Other things participants said Community Partner 4 could do to help included:

- Grief and loss support;
- More child custody assistance;
- More parenting support;
- More counseling for children and teenagers; and
- More services and facilities for abused teenage boys and men.

One woman believed perpetrator violations of conditions of release should be reported to authorities. Because most perpetrators used some kind of substance, she felt they should be tested prior to being allowed to participate in the batterers program.

### **People with Disabilities - Helpful vs. unhelpful aspects**

When asked what about our Site A partners helped, women with disabilities participating in focus groups offered several answers. They indicated Community Partner 2 helped with:

- Emergency rent money;
- Outdoor and other recreation through Outdoor Recreation Community Access;
- Volunteer opportunities;
- Support groups around disabilities, such as the low vision support group; and
- Respectful and patient support (use of name and not giving up).

One woman said Community Partner 2 had not been helpful with her particular disability.

Community Partner 1 provided monthly bus passes and housing assistance for eligible clients, as well as assistance with Social Security eligibility. One individual said an unidentified agency provided a Personal Care Assistant; very helpful because a family member, her primary care provider, got breaks. As for unhelpful aspects, one participant indicated Community Partner 1 had not helped with her rent or other housing, employment, or recreational activities.

### **How providers show they can be trusted to help**

Two individuals noted Community Partner 2 kept confidentiality. Another said Community Partner 2 helped her feel more empowered. Another indicated they showed patience and helped when needed.

### **Other things that help**

Many indicated prompting them to keep involved and letting them know what things were going on would be another way Community Partner 2 could help. One participant said additional recreational activities would improve her quality of life and her health.

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## Confidentiality

Site A is a small community, where everybody seemed to know everybody's business. Some, especially those seeking non-residential dv/sa services, found it hard to seek services where they knew many staff and/or many family members worked. There were concerns that family members had access to confidential records and that their business would be spread around town. More than one woman described instances where her confidentiality was breached. Many women did indicate that "downstairs" (behavioral health) was much better than "upstairs" (medical clinic) as far as keeping confidentiality. Many indicated they wouldn't go to the clinic as a result of confidentiality breaches.

Other participants described going to the Community Partner 4 pharmacist for medications and, if the medication was controlled, being taken to a room where the pharmacist went over the medication. These women described how, when they left the building, people waited outside to ask what kind of medication they got (looking for controlled substances).

Women indicated that shelter services, for the most part, respected confidentiality. Community Partner 3 staff, including acquaintances, were respectful and refrained from discussing their situation or acknowledging they had been at the shelter. Although, one woman did indicate that within two hours of arriving at Community Partner 3, a family member called. An unintended result of confidentiality rules involved the child of a woman using services. This child had a friendship with a staff member's child, but the two children were not allowed to play with one another due to the mother's status as a shelter worker.

A few women had concerns about parking in Community Partner 3's lot, because everyone would know they were there. Another individual noted that the indoor smoking ban made smokers visible to passersby.

I wait until the borough parking lot empties out, so that people I know won't see me going into Community Partner 3.

My perpetrator might see my car in the lot and know that I am there.

Though we didn't ask about confidentiality at disability services focus groups, there were comments. At the Community Partner 2/Community Partner 4 disability group, as we described the "flower name" system we used to protect participant identities, one woman asked why the big deal about confidentiality. Confidentiality did not come up as important in either of the disability focus groups or in individual interviews.

## Who do Focus Group Participants Call?

As Figure 7 shows, nearly half of focus group participants indicated they would call a family member if they needed help. Others would talk to friends, medical professionals, police, counselors, therapists, advocates, or "anybody who would listen." One noted she was taught "not to air dirty laundry," until recently she wouldn't talk to anyone about DV/SA. Many women who used services at Community Partner 4 had either used services or known about Community Partner 4 much of their lives. Women interviewed



accessed Community Partner 3 through several sources: friends or family; newspaper ads; signs in the police station, medical offices, or other facilities; notices on community bulletin boards; and other domestic violence programs. At disability programs, women learned of services through friends and family; agency staff; and other agencies.

**Figure 7**

	<b>Agency</b>	<b>People talk to or call</b>	<b>Found out about agency</b>
1	CP 3	Stepmom-female family member	225-CP 3, bulletin boards at MD office, health dept; boyfriend's mom
2	CP 3	Grandma	Son's grandma
3	CP 3	Sister, other family members	Sister
4	CP 3	Friends, through the Police station	Signs in ER, friends, police station
5	CP 3	Family	Ad in newspaper, came here first, didn't want family to know
6	CP 3	Friends, work friends, other women	Contacted Domestic Abuse in another community
7	CP 2 CP 4	Grandma	Grandma
8	CP 2 CP 4	Sister, Doctor	Friend
9	CP 2/CP 4	Home Health, the hospital	Through CP 2 staff—family told me to follow-up
10	CP 2/CP 4	Therapist, psychiatrist	DVR, SILC
11	CP 2 CP 4	Depends on help needed: kids - family; DV/SA - CP 3; counseling - CP 4	Learned about them as a kid-used services
12	CP 2 CP 4	Staff at CP 2	From staff at CP 2
13	CP 1	Friend, police, library	?
14	CP 1	Family, foster mom	Foster mom-have used services since I was a kid
15	CP 4-Survivor	Foster mom	Learned about them as a teen-used services
16	CP 4-Survivor	Counselors at school; counselors at school	Been coming here most my life
17	CP 4-Survivor	Wouldn't talk to anyone about DV/SA; need hotline	Always known about CP 4
18	CP 4-Survivor	Law enforcement officer	Known CP 4 for years. Police hand you a card for CP 3, CP 4
19	CP 4-Survivor	Anybody who will listen	Known about CP 4 all her life
20	CP 4-Survivor	Comfortable speaking with DV/SA staff and agency staff	Worked for another agency-knew about services that way
	<b>CP = Community Partner</b>		



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## Feeling Welcome, Comfortable & Safe vs. Unwelcome, Uncomfortable & Unsafe

### Survivors

While we asked what makes one feel welcome, comfortable and safe or, conversely, unwelcome, uncomfortable or unsafe, when seeking out services for the first time, many survivors described their own experiences in addition to hypothetical situations. Many did not receive services only through DV/SA or disability providers, but were referred or sought help through other services, such as mental health, substance abuse, or medical.

**Staff:** For survivors of domestic violence/sexual assault the attitude of staff was critical to making them feel welcome, comfortable and safe. Manifestations of this included:

- The vibe of the people and knowing that they helped the first time.
- Explaining things not understood
- Seeking information.
- Allowing a family member to come into the room with her.
- Staff seeming like they wanted to be there - it wasn't just a job.
- Staff wore regular clothes (rather than business suits, etc.).
- Good eye contact, good communication skills, and being non-judgmental.
- First contact critical - a smile, a laugh, gentle hug, shake of the hand was calming.
- Not being pushed onto an advocate when first walking in the door.
- Conduct (from providing stuffed animals to respectful behavior) toward children.
- Access to a 24-hour crisis line.
- A welcome basket.
- Patience.

While most focus group participants had few complaints about services received from our Community Partners, they indicated what might make them feel uncomfortable, unwelcome, or unsafe:

- Negative comments such as “you’ll never get a house or your kids back”;
- Indifference or disrespect
- Disbelief or minimization of experiences;
- Accusations of drinking; and
- Staff attitudes of bother or superiority.

<p>Putting me down; not paying attention to me; not having time for me; or blowing me off.</p> <p>Don't say I'm sorry or apologize... one day, I won't forget what they were like the day before.</p>
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Many said it could be uncomfortable when they knew a staff person; one woman described an experience when people found out where she was because staff told others. Another said she wouldn't go to one provider because a family member worked there. Another said she felt unsafe because her perpetrator was right there (at mental health services), he was in the same services and wanted to be in every counseling session.



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Paperwork also led to negative experiences for many. One person said, “I am dyslexic, don’t give me a form and say, here write your feelings.” She explained “I would prefer to do hands on or practice rather than read about it.” An interviewee shared, “I had to have my former abuser help me with my paperwork because I wasn’t able to do it.” Another said she felt unwelcome when she was given a stack of papers to complete.

Confidentiality breaches made interviewees feel unwelcome, uncomfortable, or unsafe. When people, such as the receptionist, asked questions in front of other people, many felt unsafe. One participant said “Don’t blurt things out.”

**Service Location:** DV/SA services can be delivered in shelter or community based settings. There is a community-based domestic violence victim program at Community Partner 4; Community Partner 4 also provides health care, behavioral health, and social services. Community Partner 3 provides a shelter as well as community based services.

Most women described the ideal shelter environment as having an interior that resembled a home: big chairs and a place to put up feet, a couch in the front room, blankets, pillows, a warm bed and a welcome basket - the comforts of home. Many women said locked doors, locked windows, and a safe neighborhood, also made them feel welcome, comfortable and safe. Other factors included:

- Not knowing a building was a shelter - it looked like a house.
- A place for kids to play where they wouldn’t disturb other people.
- A place with pictures on the wall, comfortable chairs, not sterile like a hospital.
- A well-run organization
- Knowledge no one from outside was going to talk to residents.

Focus group participants said a shelter that looked institutional or that “gave you a number” would feel unwelcoming, unsafe, and uncomfortable. Likewise, open windows, unlocked doors, and lax visitor screening and security would provoke the same feeling. Other physical conditions noted as negative by survivors included:

- Spaces that were dirty, untidy or a fire hazard.
- Dark stairs, alleys, parking lots or isolated areas.
- Chaotic or disorganized.

In a community-based setting, participants said that receptionists closing the window or ignoring customers or acquaintances or perpetrators present in waiting rooms made them feel unsafe, unwelcome, or uncomfortable. They suggested a creative solution to these concerns: use pagers like at restaurants.

**Returning for Services:** Asked what made one feel welcome, comfortable, and safe enough to return to a location, several participants identified the attitude of staff:

- A calming attitude when people arrived frazzled, shaken, angry, or upset, good staff.
- Caring people.
- Advocates who were willing to help or give advice and direction.
- The door was always open.
- Ability to pick up the phone and be welcomed her back - “let’s get you safe tonight”



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- Feeling helped or benefited—received the information needed.
  - Confidentiality;
  - Ability to speak openly and be believed.
  - When you walk in the front door, people know why you go there.

When asked what would make one feel so unwelcome, uncomfortable, or unsafe that one wouldn't want to go back, the attitude of staff again was key. For example, if staff were rude, unhelpful, unsupportive, breached confidentiality, or spread rumors. People would not want to return if staff:

- Acted superior.
- Shared other people's stories around town.
- Showed disrespect to survivors or their children.
- Disbelieved or minimized survivors' stories.

Other concerns would be shelters in which the spaces for mothers and children felt unsafe or presented a risk of harm. Violent people in a place would also be cause for not returning. One woman said the police station made her feel unsafe with its "what do you want" attitude.

## People with Disabilities

**Staff:** For women with disabilities, as with to survivors, the attitude of staff was critical to feeling welcome, comfortable and safe. Staff that smiled and engaged in conversation engendered these feelings. One person described it as, "treating me like a good friend they've known forever." Also the option of meeting face-to-face was important. Other characteristics of welcoming staff included: being really nice, approaching in a friendly manner, listening, being respectful, reassuring, and having unconditional acceptance of the individual. One woman emphasized the need for staff to use understandable language. Another woman, who experiences a sensory disability, said staff at her current disability agency took the time to make sure she understood and to make sure she was understood. For her, as well as other interviewees, patience and respect were critical in making them feel comfortable, safe and welcome. One woman said she felt safe with one staff because he had a cell phone.

When I'm in a social group, the conversation could be about potatoes and I chime in and talk about tomatoes and people would drift away.

Focus group participants also identified sources of help in the community not associated with social services, including the library, city bus drivers, and city workers.

Although we asked, "When you ask for help for the first time, what makes you feel safe, welcome and comfortable?" many women said family and friends made them feel safe, welcome and comfortable. One indicated she doesn't talk to strangers much, and/or share with social service staff, including our partner agency that recruited her, but she does have a close relationship with some family members.



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For people with disabilities, just as survivors, a negative attitude on the part of staff could lead to them feeling unwelcome, uncomfortable and unsafe. Five of the eight said men made them uncomfortable, unsafe, or unwelcome. One indicated she was uncomfortable if forced to go to a male in a position of authority. Others said when people act like they are better than you, judge you, try to tell you how act, push you down, or stick their noses up, they felt unwelcome, uncomfortable, and unsafe. Another, although not specifically related to staff, described how screaming, disrespectful children and teenagers engendered these feelings.

**Returning for Services:** Many women described a place that was welcoming, safe, and comfortable as having an open, homey feel with warm colors (e.g., soft yellow, light violet). In a hospital setting, one woman said a “comfort room” instead of a “seclusion room” was much better. While one individual said that a deadbolt made her feel safe, others liked windows being open just a bit, open doors, and space to move around. Several described a place free of drugs, alcohol, name-calling, loud parties and violence, including domestic violence.

Two women interviewed used animals, one service and one companion. Both of them said these animals helped them feel safer. One told a story about how her dog had prevented her being injured to emphasize its importance. Responses to what makes a building unsafe, uncomfortable or inaccessible, individuals said:

- Not being able to get out because there is no plan for safe evacuation in a building with multiple floors;
- Tight corners and clustered living arrangements;
- Cracks in the walk; and
- Dark streets.

**Returning:** When asked about what would make one feel welcome, comfortable, and safe enough to return to a place, there were a variety of answers:

- Always being welcome and encouraged with her sobriety
- Help with anxiety and depression
- A deadbolt on the door
- Allowing animals
- Allowing her space
- Kind words from the staff
- We are here to help, not harm attitude

When asked about what would make them feel so unwelcome, uncomfortable, or unsafe that they wouldn’t want to go back, women said:

- People yelling at them;
- Men approaching them;
- People know your history from gossip;
- People who are drunk around or the potential to be alone with a drunken man;
- Agencies, such as Office of Children’s Services, say one thing and do something else (it was important to have a witness in these situations);



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- Service providers made one feel like one was trying to rip off services, as if services weren't really needed;
  - Meetings/events at night; and
  - Nothing happening or services didn't meet needs.

## **Understanding and respecting needs and choices**

### **Actions Or Words That Show Staff Respect For Survivors As Individuals**

In general, survivors said staff showed they understood and respected individual needs and choices by focusing on the person, taking their time, listening, showing they are there for the person, valuing the person's time; helping the person from one goal to another; being respectful, and treating the person kindly. Other specific demonstrations of understanding and respect included:

- Positive body language - turning towards you when talking, polite demeanor;
- No blaming or judgment;
- Timely information and encouragement in making choices;
- Advocates being prepared and knowledgeable;
- Follow-up phone call to see if she was following her guidelines;
- Listening;
- Showing empathy;
- Going out of the way to write supporting documentation;
- Willingness to explain things numerous times;
- Keeping confidentiality;
- Asking if there is anything else that would help or whether a question was answered;
- Accompanying to court, help with documents, and explaining the process; and
- Being there without regard for anger or upset.

### **How Providers Show They Understand Participants' Situations**

Focus group participants described several ways a service provider showed understanding of their situations including: they try to get you the help you need—they go out of their way more than an average person; and try to help people out in their situation. One woman said she appreciates an advocate who has been through the situation and says reassuring things like, “you’re not the only one” or “that’s typical.” She said it helps to know you’re not, “crazy or alone.”

Don't speculate the worse of me is as bad as him.

You shouldn't require proof from victims.

### **People with Disabilities**

In general, people with disabilities indicated staff showed they understood and respected individual needs and choices through listening, not judging, and allowing individuals to make their own choices. Specific offerings included:

- Suggestions, options and ideas, rather than being told what to do;
- It was OK to make mistakes;
- Understanding it was one day at a time;



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- A friendly, instead of a clinical, manner, and understandable language;
  - Staff of comparable in age; and
  - Staff not being so controlling.

### **Actions or words that show staff respect participants as individuals**

Participants described various ways that staff showed respect for them as individuals:

- Giving positive praise, saying, “good job, that’s the way”;
- Commiserating and/or sharing a little of their personal self;
- Asking why someone is upset or crying;
- Showing empathy, which is more important than sympathy;
- Treating people as they would like to be treated; and
- Being understanding; one woman said staff show they respect her when they do the best they can to help her. Another said when staff members show respect, “They don’t imply I shouldn’t be alive.”

### **How A Service Provider Shows They Understand A Disability**

Participants described various ways service providers can show they understand participants’ disability including: suggesting different tools that may be helpful, for example, magnifying glasses; not looking down on their choices; not treating them like an outsider, using their history to help them; not using their disability against them; role playing with them for better understanding; giving unconditional acceptance, and recognizing their education.

### **Implications**

Consistently, DV/SA program participants stressed physical safety e.g. locks, lighting, cameras, places to park car that were hidden. Recipients of tribal services talked about security issues as well. Both groups stressed the need for privacy and confidentiality.

I don’t want to feel like I have to apologize for my existence.

Are they here for you or here for a paycheck - that doesn’t come from a book or form.

Interestingly, DV/SA service recipients often expressed a need for more guidance and direction while disability service recipients expressed a need for less. This suggests autonomy needs be directed by the service recipient and that both victim advocates and disability service providers may need to evaluate how they can meet individual needs, adhere to their philosophy and support empowerment as it is perceived from the service recipient’s point of view as well as their own.

Disability service users discussed safety as well - people not yelling, not being drunk and not being violent is essential. This group seemed less concerned about locks, secure windows, and hidden parking but shared more frequently how others not necessarily aligned with our partners, e.g. bus drivers, receptionists, librarians and strangers on the street had been helpful. While our focus is on ASPEN and our Community Partners, we need to be aware of what others are doing in the community to help and support survivors and people with disabilities.



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Both groups talked about safety in terms of how people made them feel and whom they could trust; a friendly attitude by staff was critical. Both survivors and people with disabilities described in detail barriers caused by non-verbal communication and attitude. Findings indicate both DV/SA and disability service recipients felt uncomfortable when rushed, not listened to, interrupted by phones, staff, or others or made to feel their concerns are unimportant by a brusque attitude or a cookie cutter approach.

Both groups had confidentiality concerns although DV/SA program participants appeared more anxious about physical safety as well as emotional harm if confidentiality was breached. Disability service users also expressed concerns about physical and emotional safety yet appeared more concerned about gossip and lack of privacy in a broader sense.

## **Broader Implications**

In addition to the implications presented in each of our eight findings, there are other issues we believe some or all of our partners should address. Some of these manifested as community attributes, others as artifacts of the two service systems. That said, the extent or intensity of some findings varied noticeably. Key examples of such distinctions were:

- The need for training and cross-training was expressed consistently in Site A.
- Site A wanted behavioral health providers included somehow in strategic planning. Our tribal partner has a behavioral health component (services are available only to Alaska Natives) and there are several other behavioral health providers.
- A significant element of disability sector staff in Site A, appeared to believe a focus on individualized services was sufficient to ensure all necessary services are competently delivered to survivors with disabilities. At the same time, most staff interviewed believed targeted training and cross-training was necessary in order to collaboratively serve survivors with disabilities adequately.
- There appeared to be some significant differences in perception between management and line staff in all service sectors. We encountered examples of management citing the existence of policies related to working with survivors with disabilities of which direct service staff were unaware.
- Unsurprisingly, survivors and people with disabilities expressed some differences in what they looked for from providers in terms of safety, comfort, and welcoming characteristics, as we described in Finding 8. In some ways these differences are complementary and thus could potentially be addressed through universal design principles as we move into collaborative implementation.

## **Change Opportunities and Obstacles**

A strong basis for change to local service systems exists in Site A, which has a strong history of cross training and collaboration resulting from the involvement with and funding from other programs focusing on the victimization of people with disabilities/elders and the need for cross training.

Our DV/SA partners appeared to universally believe that collaborative training and cross-training are crucial to their ability to appropriately serve people with disabilities. This

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belief has led some of these agencies to attempt to do just that and this is an attribute that ASPEN should be able to build on in its strategic planning and implementation work.

This project has already contributed to the forging of stronger relationships between the disability and victim advocacy sectors in Site A. One example is our tribal partner's major sponsorship of our DV/SA partner's principle annual public awareness event.

## **Possible Solutions**

- Develop a strategic plan that recognizes each Community Partner's unique approach to change and create a collaborative approach for community change consistent with ASPEN's strategic plan. All other solutions follow from developing a planning model suited the partner community.
- Facilitate Memoranda of Agreement (MOA) and other mechanisms that define how partners collaborate with each other, each agency's roles and responsibilities, and delineate the resources available at each. MOAs should include the creation of an ongoing inter-agency council that addresses new obstacles and opportunities as they arise and acts as an agent that sustains the purpose and results of the project.
- Develop policies and procedures for serving survivors with disabilities and orient staff to these policies and procedures. These should be similar, if not, identical, across our local partners, allowing for differences between the service sectors.
- Develop a regular schedule of training and cross-training to facilitate collaboration among local partners, beginning with Disability 101 and DV/SA 101. Cultural understanding and competence will be an essential component of the curriculum.

## **Conclusion**

### **Key Findings And Opportunities For Change**

- Policies and procedures at ASPEN's partners in Site A include few, if any, specific guidelines concerning the safety and service needs of survivors with disabilities. Guidelines that do exist appear to be neither clearly understood nor uniformly implemented by staff or management.
- In Site A, our partners interact on some level with each other. However collaboration is at a basic level (e.g. providing referrals, exchanging resources information). There is some awareness of how the partners interact with each other within the community. DV/SA agencies were more likely to reach out to disability providers than the other way around.
- There is wide diversity of perceptions of disability, experiences with disability, and accommodation of individual needs among our DV/SA partners. There is likewise wide diversity in perceptions regarding people with disabilities and experiences of DV/SA among disability partners.
- Community Partners and focus group participants identified behavioral health services as a crucial to meeting the needs of all survivors.
- Change processes within our four partner agencies exist—whether through strategic plan or budget processes. In some cases, these processes were self-contained; in others they included client input.



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- All our partners clearly stated support for training or cross-training, staff orientation, and disability and DV/SA specific training.
  - Culture, in all its diverse and complex manifestations, plays a key role in service provision as it is perceived and experienced by survivors with disabilities
  - Survivors and people with disabilities in Site A identified positive, respectful, and supportive attitudes and actions as key to feeling safe, welcome, and comfortable.

### **Next Steps**

We will develop and submit to the Office on Violence Against Women a strategic plan outlining how we will work with our Community Partners to implement initiatives identified by the needs assessment. We will collaborate with our partners to develop a strategic plan specific to the community to implement these initiatives. We will involve individuals with disabilities and survivors of DV/SA in this planning work.