

Alaska Community Partner safety Planning & **ASPEN**

SITE B NEEDS ASSESSMENT REPORT



Alaska Safety Planning and Empowerment Network Site B Needs Assessment Report

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Executive Summary

The Alaska Community Partner 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 the response in both arenas to survivors with disabilities (people 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, funds ASPEN. ASPEN's members are:

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

ASPEN pursued a statewide project, meaning it would work with local partners outside the collaboration itself to initiate system change in target communities. ASPEN elected to work with 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 35 people from Site B. 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 somewhat skewed toward the latter in Site B. This was the result of several circumstances. First Site B has a large number of individuals with disabilities who primarily served through the behavioral health system,



which is not a partner on this project. Individuals with behavioral health disabilities who did not receive services from our partners in the disability sector were not interviewed for this needs assessment; their participation was beyond the scope of this project and they were not recruited as individuals with disabilities. Second, among the potential participants recruited by our partners were several people with disabilities who experienced serious health issues. This ultimately made it difficult or impossible for a larger number of people with disabilities to participate in the focus groups. Tragically, several potential recruits for the project died during the needs assessment process and were not interviewed. Other factors also included transportation obstacles that prevented willing participants from villages in the area who used services in Site B from being on site as planned. All this said, so many of the participants recruited by the DV/SA sector ended up self-disclosing experience with disabilities that we believe we have adequate representation of that perspective.

In terms of our interviews with community partners' staff and management, we were successful, but had some difficulty again meeting all our targets, particularly in Site B. One factor reflected here was the timing of the needs assessment process. The interview process, intended to wrap up by end of spring, stretched into 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).

Despite these setbacks and limitations, we believe the needs assessment identified several consistent themes. ASPEN identified eight key findings:

1. Policies in place at our four partner agencies addressed concerns such as mandated reporting, the Americans with Disability Act, and provision of individualized services. There were few specific written guidelines or procedures concerning the Community Partner 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. Our Site B 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.



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5. Processes for change within our four 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 in Site B identified positive, respectful, and supportive attitudes and actions as keys to making them feel safe, welcome, and comfortable.

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 a strategic plan that recognizes each partner’s unique approach to change, but creates a collaborative approach for community change. All other solutions follow from developing a planning model suitable for our 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, 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.
- 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 community partners 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.



Overview of Collaboration

The Alaska Community Partner safety Planning and Empowerment Network (ASPEN) was 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.



A Timeline of ASPEN's Planning Phase

The five members of ASPEN began development of 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 others' roles. The root cause analysis identified several conditions impacting survivors with disabilities. We may be able to address 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) Difficult for women with disabilities to 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 involving two separate pilot sites (Site A and Site B). Approval of our focus memo took this long in part due to ASPEN's unsuccessful bid to include behavioral health providers among its local partners. This, in addition to geography, weather, and volcanic activity, produced cascading effects on the project progress. Other challenges the collaborative faced included loss of staff from amongst the ASPEN team due to illness and change of residence or job status.

ASPEN's next step was to engage our four local partners, a process which took precedence 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.

In choosing to work in a small Alaskan community, ASPEN understood we would have to schedule project activities around the summer subsistence season. Beginning in June and into September, residents of rural communities in Alaska increasingly devote time to gathering and processing natural food resources (fish, game, berries, plants, etc). Both the activities themselves and the food harvested are economic and cultural cornerstones of Yupik societies. We believed we could conduct needs assessment activities so as to accommodate the subsistence cycle without significant delays to the project. We were only partially successful, encountering difficulties scheduling and completing interviews



with several of our local partner organizations. As we moved deeper into subsistence season, those difficulties were compounded.

The design of our needs assessment plan also turned out to be a factor that slowed progress. ASPEN opted to assign partner organization staff interviews to teams of two ASPEN members. Completing interview assignments turned out to be problematic for some teams and took well past our targeted deadline. We did provide backup capacity for the interview teams in the event of scheduling difficulties, however internal ASPEN turnover rendered this backup resource unavailable for several months. Drafting our needs assessment report began in July and continued for two months.

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:

- 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 Community Partner safety, empowerment and access.

Project Scope

ASPEN elected to pursue a statewide project, meaning that ASPEN would work with local partners outside the collaboration itself to initiate system change in target communities rather than focusing on the organizations composing ASPEN. ASPEN elected to work in two communities separated by over a thousand air miles, Site A in southeast Alaska and Site B in southwest Alaska. Both were selected on the basis of social and cultural factors and their potential for change, as noted below for Site B.

Demographics: Site B, a community in XXX Bay about XXX air miles from Anchorage has a population of about 2,500, just over half of which is Alaska Native.



Services, Relationships, and Change Potential: ASPEN identified its local agency partners in Site B 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).

Site B is a community that welcomes new ideas and has demonstrated the capacity to take concepts brought to it by others and to shape them into unique, locally appropriate adaptations. ASPEN's partners in Site B are:

1. Community Partner 1, the DV/SA shelter, was a participant in Alaskans Speak Up and in the Delta Project. Community Partner 1 is also a participant in an innovative collaboration with the local children's services agency and provides innovative services in partnership with their local substance abuse program.
2. Community Partner 2 independent living services in Site B are unique in being provided by itinerant staff. Community Partner 2 in Anchorage provides independent living services to Site B, when requested. Community Partner 2's representative to ASPEN was also the point person in Site B, a circumstance that has since changed with the recent appointment of new ASPEN project liaisons.
3. Community Partner 3 is Site B's only developmental disabilities provider. Community Partner 3 was one of the founding members and leaders of the Key Coalition, which advocates for system improvements. Community Partner 3 has a long history as one of the more innovative developmental disability providers in the state. While TA and training is provided from the Anchorage office, each community program operates under local control.
4. Community Partner 4, Site B's Alaska Native Claims Settlement Act village corporation, is a central point for social and economic development for the local Alaska Native population and an enthusiastic participant in Alaska Native Justice Center initiatives to reform rural justice.

Description of Needs Assessment

Purpose and Goals

In order to inform both ourselves and our local partners of strengths/assets and weaknesses/gaps in services experienced by survivors with disabilities, we conducted a needs assessment in Site B. The process engaged key providers of victim advocacy services, disability 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 systems (disability, victim advocacy, and others) capacity. The needs assessment illuminated elements of these 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 foundational information guiding development of a strategic plan for system change initiatives. Ultimately, the strategic plan will serve as a blueprint to help Site B 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. 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

Our needs assessment goals grew out of the project purpose, 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 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.
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 will use this information to develop this needs assessment report, which will, in turn, inform ASPEN and its four partners in Site B 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.

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

The results of the needs assessment will be shared with the community and four partners teleconference and on-site meeting. These sessions will initiate a targeting of the 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 those initiatives that fall within the grant parameters and those that will create sustainable change.

Methodology Summary

Our needs assessment design 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 local partner victim services agencies.

We used two methods of information gathering 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 process 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 committed to supporting equal attitudinal, physical, cultural, and programmatic access to individuals with disabilities and survivors of domestic violence/sexual assault. This meant providing a welcoming and supportive environment appropriate for the widest range of potential participants and circumstances. Focus group and interview tools were reviewed to ensure accessibility and cultural resonance and were available in alternative formats. The recruitment process included means to address accommodation requests.

ASPEN defines safety as a core value that encompasses 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 some risks, which we minimized by informing all participants of the risks, using locations considered safe, stressing the need to respect confidentiality to all participants, neither sharing nor using the names of participants, providing alternate PCAs as requested, discouraging disclosure during focus groups, and providing supports/resources should a participant be in immediate risk during a session.

Method 1: Focus Groups with Interview Option

Purpose/Audience/Number

Based on community engagement dialogs, 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 B. The unique 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 in service delivery. Likewise individuals with disabilities are the best sources of information on accessibility and accommodation issues and what makes service delivery welcoming.



Focus groups are primarily used for exploration and discovery of a topic. Focus groups 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.

Our partners from Site B assisted with focus group participant recruitment, designating staff for that purpose. ASPEN used its recruitment tools and protocols to provide on-site orientation for recruiters. The tools covered included the following:

- 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 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. The two focus groups were: 1) Women with disabilities and 2) Survivors. Recruiters were instructed not to recruit based on a presumption a woman was a survivor with a disability; in other words they were told 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. Our focus group facilitators completed University of Alaska Anchorage Institutional Review Board certification for the protection of human research subjects prior to traveling to Site B. ASPEN teams visited each pilot site 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 as in the focus group, to ensure collection of consistent data.

ASPEN aimed to recruit 20 – 40 participants at four focus group sessions. We expected some participants to request individual interviews protect 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.

Figure 1

Focus Groups	Target Participants	Actual Participants
Survivors of DV/SA Group 1	5-10	11
Survivors of DV/SA Group 2	5-10	7
Survivors of DV/SA Interviews	Unknown	1
Individuals w/Disabilities Group 1	5-10	0
Individuals w/Disabilities Group 2	5-10	0
Individuals w/Disabilities Interviews	Unknown	1
Total	20-40	20

We did not realize our goal of two groups for each population in Site B, as the table shows. We believe this to be the result of several factors. One was the decision to narrow the scope of the project to exclude behavioral health providers and consumers in the project. We knew from long direct experience in Site B many of the women we would want to talk to were clients of behavioral health providers. Serious health issues and the deaths of a number of potential recruits identified by our disability partners during the needs assessment process played a role. Other factors included transportation obstacles and a smaller recruitment pool identified by disability partners. As a consequence, we ended up with 19 focus group participants and one individual interview in Site B, all but one individual recruited by victim advocacy partners.

A last note on the focus groups is in order. We did not collect demographic data on the participants, principally because such data can and has been used to identify individuals in small rural Alaskan communities. However, ASPEN facilitators noted that virtually all the participants in Site B were Alaska Native women. This circumstance appears to bear out the statements of our Site B partners during the initial engagement process that upwards of 80% of their clients was Alaska Native.

Method 2: Staff and Board Interviews

Purpose of Interviews

We interviewed staff, management, and boards at all four sites of change organizations. Because of their unique perspectives and experiences, we felt that executive directors, staff and managers, and board members would provide differing information.

From staff we wanted an understanding of service delivery realities, policies and procedures on the ground as related to survivors with disabilities and barriers to providing services to survivors with disabilities. We also sought to understand their knowledge of resources, agencies, and services specific to disability and DV/SA/S and their history of working with other agencies working with survivors with disabilities. We



wanted to assess their comfort working with survivors with disabilities and what would help them better support survivors with disabilities. Finally, we wanted their perspectives on what they did well and what they would like to do better as collaborative partners.

From managers we looked for understanding of budgeting, information about policies, procedures, and existing collaborations. We also wanted to understand both informal and formal processes for changing policies and procedures. We wanted to understand how they supported staff including recruitment, training and retention. We also sought an understanding of their history of working with other agencies in support of survivors with disabilities. Lastly, we wanted perspectives on what they did well and how they wanted to improve as collaboration partners.

From executive directors we looked to understand budgeting processes, 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 from Site B partners helped recruit staff, managers, and board members from their organizations, providing a complete staff list to ASPEN. ASPEN interview targets for each organization included:

- 1) Executive Director
- 2) Board of Directors president and one other board member
- 3) 10% of staff/managers, randomly selected, with a minimum of 3 per site (some partners had fewer than 3 staff/managers).

Assigned ASPEN team members set up individual interviews with board members, staff, managers, and executive directors. If a potential participant did not wish to participate, we referred to a list of alternates to secure the appropriate sample. Verbal consent avoided creating documentation with identifying information. ASPEN provided accommodations on request. As with focus groups, ASPEN minimized the risks to Community Partner safety and anonymity by avoiding the use of names, considering the Community Partner safety of the interview time and location, discussing mandated reporting, and other means.

The Interview Process

We used a semi-standardized interview format designed to take 30-45 minutes to complete. In practice, we found interview times ranged from 20 to 90 minutes. Standardized questions were asked of each interviewee, but interviewers had freedom to



digress and probe beyond those questions. This allowed us to get answers to specific questions and also allowed interviewees to reveal more about topics they felt to be important. The process employed all ASPEN team members as interviewers. We hoped this interaction with our community partners' staffs would foster both a sense of investment in the project and open and honest communication. Most interviews were conducted by telephone. Two team members, one from each discipline, conducted each interview. All team members conducted one or more interviews.

Figure 2

Partner Interviews	Target Interviews	Completed Interviews
Site B		
Community Partner 2		
Staff/Managers	1	1
Executive Director	1	1
Board Members	2	2
Community Partner 3		
Staff/Managers	2	1
Executive Director	1	1
Board Members	2	1
Community Partner 4		
Staff/Managers	3	1
Executive Director	1	1
Board Members	2	0
Community Partner 1		
Staff/Managers	4	4
Executive Director	1	1
Board Members	2	1
Total	22	15

Figure 2 displays the targeted number of participants from each organization and the categories within the organization. We completed 15 of a targeted 22 interviews (68%), a respectable rate under any circumstances.

Key Findings and Implications

Opening statement

This section presents information and analysis in order to highlight both similarities and differences. Because only one participant with a disability was interviewed in Site B, information from our Site A interviews and focus groups of women with disabilities are included in this report in some cases. While we did not ask about the experience of disability, many survivors in Site B when describing what worked and didn't work for them alluded to benefits and barriers from their own experience. These often included experiences related to disabilities. Disability service recipients in both communities when



describing what made them feel welcome often referred to comfort or lack thereof based on Community Partner safety issues.

Although we asked no leading questions, focus group facilitators observed that many women with disabilities in both communities were survivors of domestic violence/sexual assault and that many women who were survivors experienced disabilities. People with disabilities and survivors were one and the same, essentially. Our 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.

Finding 1

Typically, the policies in place at the four 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 Community Partner 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.

Each of our Findings sections addresses one or more Needs Assessment goal. This first finding considers the following 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 specific policies and procedures focused on survivors with disabilities. During the interviews we targeted the following areas in regards to policies and procedures (program participants in the focus groups/interviews were not specifically asked questions around policies and procedures, but some did offer comments on them):

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

ASPEN's partner agencies shape their policies and procedures using a variety of methods. Most used their boards to shape policy, with input from executive directors and, in some cases, staff or committees.

Community Partner 2 staff highlighted mandatory reporting policy. One noted that although victimization is prevalent in the lives of people with disabilities, this was not the focus for services provided at the agency. Community Partner 3 interviewees noted that service provision is based on individualized services. They also highlighted their mandatory reporting policy.



Although it didn't appear that there were specific policies and procedures to guide services to survivors with disabilities, there did appear to be practices that agencies were using. At least one interviewee from each of our disability partners identified mandatory reporting as one of their policies. At DV/SA partners, the focus seemed to be on safety and accommodation.

According to Community Partner 1's executive director, the organization does have policies on screening and working with individuals with disabilities. The line staff however did not seem to be aware of these policies. Everyone interviewed explained that work with people with disabilities would be accomplished through creative collaboration and other means. Interviews with line staff indicated they desire written policies on identifying and working with survivors with disabilities. Community Partner 4 policies and procedures primarily focus on wellness. Serving people with disabilities falls within that overarching mandate, staff there believed.

Although we didn't find consistent, specific policies and procedures guiding services to survivors with disabilities, there did appear to be practices some partners used. Some staff said they weren't sure if disability issues are addressed in any policy or procedure.

Implications

Organization leaders (Board Members/Executive Directors) frequently felt the agency mission and service provisions implied the agency would serve the "other" population and most did not see the need to include explicit references in missions or to develop policies and procedures directed at survivors with disabilities. Although our partners have very limited written policies addressing survivors with disabilities, all four 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 in Site B. Policies and procedures beginning with intake and assessment should be reviewed at all partner agencies. 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 of the Needs Assessment, we considered two ASPEN goals:

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. 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 that 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.

The community agreed both systems were crucial in helping to navigate and access resources (e.g., financial, housing, medical) and helping individuals to feel safe and empowered. Both disability providers and victim advocates referred individuals for services they did not provide. Providers indicated follow up could be challenging and sometimes did not occur. In some cases, providers tried to address individual needs within their own service framework.

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

In order to investigate the inter-agency connections among our four community partners, ASPEN's staff interviews included questions about with whom our partners worked. Figure 3 (see below) visually depicts collaborations that occur between ASPEN community partners. We elected not to ask specifically about the partner agencies, as we didn't want to lead interviewees, and we also wanted to discover what other non-partner agencies in the communities 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.

Not only did most of our partners already work together, they all worked with the local behavioral health provider. Note: arrows in Figure 3 indicate ASPEN partner connections. For example, Community Partner 4 interviewees said they interact with Community Partner 2 and Community Partner 1, but did not identify Community Partner 3 during any interviews.

Interviewees also noted other local groups, task forces and/or coalitions to which their organization belonged. These, along with other resources noted by only one partner are listed following. In Site B, these included the Community Justice Alliance, local hotels, Alaska Center for Blind and Visually Impaired, Adult Basic Education, Leadership Advance Youth Coalition, DELTA program for youth, the Children's Advocacy Center,



STAR, Early Childhood/Infant Learning Interdisciplinary Team, CANDU – city of Site B prevention and wellness program, and the school district. Some interviewees said there were too many other resources to list, these are not captured in this needs assessment.

Figure 3. Site B Partner Connections

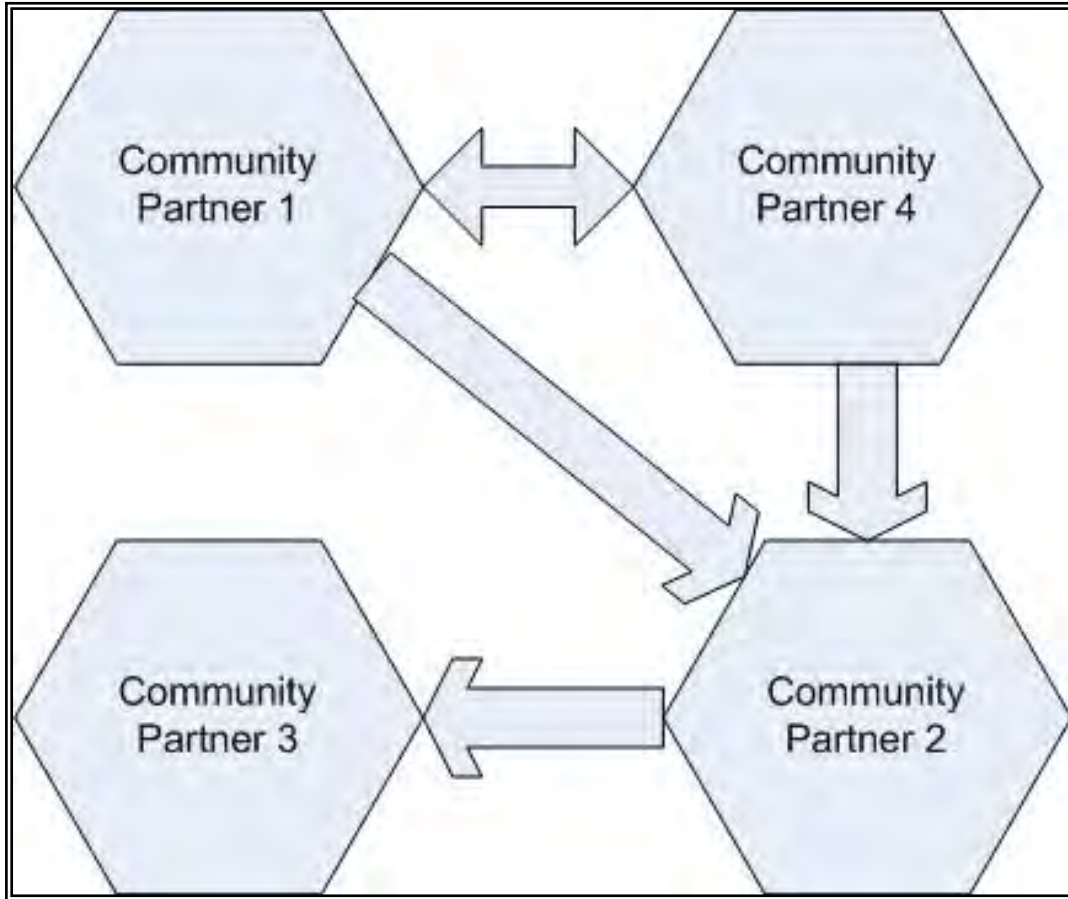


Figure 4. Other Site B Agencies/Organizations

	Community Partner 1	Community Partner 4	Community Partner 3	Community Partner 2
XX Area Health Corporation (including XX Counseling Center, XX place)	X	X	X	X
XX Native Association (including Tribal Vocational Rehabilitation & Care Coordinators)		X		X
XX Housing Authority	X	X		
Site B Senior Center			X	X
Other Native Corporations, Tribal Councils			X	X



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 (the partner that recruited them to participate) assisted them, many described how it helped them find other services. A synopsis of responses follows.

Site B Survivors

Many participants said the ASPEN partners from which they received DV/SA services helped them to find services the ASPEN partner did not provide, including:

- Getting on a housing list;
- Getting an apartment;
- Seeing the doctor;
- Helping with their children;
- Finding or providing legal and financial help;
- Finding and arranging for a counselor to come to the shelter;
- Providing the names of mental health providers;
- Getting a restraining or protective order;
- Applying for food stamps;
- Helping get in touch with Alaska Legal Services.

One woman said she was called and reminded when her restraining order was up. Several women listed the following services: XX Place, Community Partner 1, XX Counseling Center, Community Partner 4, Community Partner 3, XX Housing Authority, and XX economic development. Some women said Community

All the love in her (the executive director) heart has built Community Partner 1 to what it is today – Focus Group Participant

Partner 1 showed cultural respect by asking what type of food they preferred and then providing moose meat and fish. Community Partner 1 also encouraged people to participate in traditional food gathering activities such as berry picking. One woman said she wished there were more people like Community Partner 1 staff and its executive director. She said the executive director was the backbone of the organization. Another said Community Partner 1 was a long time coming, that in the past people were taught to stay quiet about sexual and physical abuse.

Participants also listed some ways Community Partner 1 could do better, including: Staff could be more informed on resources; provide a Yupik speaking advocate to talk about Community Partner 1 services especially to surrounding villages; and have an on-site attorney. One woman wanted them to advocate for counseling in surrounding villages. She described how her child needed services, but these were not available because “The mental health counseling center is packed with kids” and how in the past there was no place for troubled kids to go, “they got sent out of state.” Another woman said, “It would be nice if there were money in the budget for appliance repairs. This would mean less worry for the advocates.”



Site B People with disabilities

One participant indicated she received help her with environmental modifications, but she also needed further modifications.

Implications

Site B's outstanding strength was the collaborations built by Community Partner 1 with many of the other provider agencies and businesses in the community. These collaborations appear to provide the flexibility for Community Partner 1 staff to make a few phone calls, when presented with a survivor with a disability, to secure Community Partner 1, appropriate services for that individual. Conversely, disability providers in Site B appear to have a much lower level of awareness and utilization of potential collaborative resources when a survivor is encountered. Focus group participants were generally positive about DV/SA partners finding them needed outside help, another strength. This is less clear on the disability side given the limited input. Focus group participants did list some areas in which additional assistance would be valuable.

In order to address these implications, the community should devote attention to cataloging resources: developing memorandums of agreement on collaboration, and facilitating access to those resources for survivors with disabilities. Partners should review the areas focus group participants identified where assistance could be improved and determine ways to address concerns. Current resource lists for survivors with disabilities should be available at all ASPEN partners and collaborators.

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 ASPEN Needs Assessment goals:

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

We try to provide individualized services to the individual -
Manager

As we discuss elsewhere in this report, partners from both sectors served survivors with disabilities on a routine basis, but did not recognize they were providing some accessibility and other services to 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. An Community Partner 2 board member noted that in Site B they would not turn away a victim with a disability if they were to disclose allegations of abuse. Further, although their mission didn't state so directly, the board member felt the agency would respond and refer victims to appropriate services.

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 and 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 their core duties as disability providers.

All our partners had board members with DV/SA or victimization experience, although it was not recruited.

Perception of Disability by DV/SA Partners

Victim advocacy organizations focus on legal and system advocacy, shelter services, and support targeted on Community Partner safety, autonomy, confidentiality, and other relevant concerns of the people they serve. A Community Partner 1 board member noted that while their mission did not expressly hone in on disabilities, its goal was to enhance the safety of all people served.

Community Partner 1 interviewees expressed pride their facility was one of the only accessible buildings in the area. They added, because Community Partner 1 has an accessible building and the agency is so well connected, they perceived being a sort of “drop off” agency for people with mobility impairments who may not be survivors. They also said they strove to meet the needs of survivors with disabilities in a variety of creative ways (developing the XX program for women with substance use disorders, using visual communication formats with program participants with Fetal Alcohol Spectrum Disorder, and providing child care for program participants who experience substance use disorders). Interviewees perceived themselves as the point of referral when other providers are unsure how to work with or assist a person with a disability.

The inclusion (of board members with disabilities or expertise in disabilities) represents the life experience of our people -
Executive Director

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. We also asked



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, Community Partner 4 had board members with experience. Community Partner 4 line staff/manager seemed to focus on the need of individuals with physical mobility issues (citing the need for ramps).

Implications

Site B's non-behavioral health disability services tend to be itinerant or have a high vacancy factor, which impacts community perception of whether these services exist. Interviewees were more familiar (and comfortable) with services from XX Area Health Corporation, which has full-time staff located in Site B to provide behavioral health and senior services. Community Partner 1 has a very strong presence and community identity and is seen as the local go-to agency for FASD issues.

There is a broad range of perceptions of whom people with disabilities and survivors are and what is done to serve them in all but one of our partners. The exception is Community Partner 1, which has extensive experience with people with disabilities. Basic education on awareness, philosophy, and service delivery approaches of both the disability and DV/SA sectors should be developed and provided to all staff.

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 community 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

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, particularly in Site B; we nearly lost one of our partners before we could begin the needs assessment over the issue of exclusion of behavioral health providers. During the assessment itself, interviewees from all our partners said local behavioral health providers should be part of the ASPEN project.

XX Area Health Corporation
(has) policies and procedures
specifically related to serving
individuals with disabilities and
should be included - Executive
Director

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. Community Partner 1 interviewees noted they encountered individuals with mental health and substance abuse issues frequently. Community Partner 1 indicated they also saw many women who experienced mental illness or Fetal Alcohol Spectrum Disorders (FASD). The agency has been creative in serving these individuals in an isolated area that offers few resources for people with disabilities in general. For example, in Site B, Community Partner 1 created the XX program, collaborating with the local substance abuse program, to allow women to stay at the shelter while in treatment, providing childcare and other support. Community Partner 1 also developed a graphic communication system for survivors with FASD.

Site B interviewees said was some discussion whether the XX Area Native Association was going to assume some of the functions of a center for independent living for elders and people with disabilities. Community Partner 4’s Executive Director stated that the local organizations serving people with behavioral health issues should be included in the ASPEN project.

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 B already have some sort of relationship with local behavioral health providers. Community Partner 1’s collaboration with behavioral providers is especially strong and provides a model for improving service delivery.

Finding 5

Processes for change within ASPEN’S four 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 have a formal development process for those plans. Neither disability agencies nor victim advocates specifically addressed the needs of survivors with disabilities in their plans. The strategic plans at the four agencies are primarily developed through processes driven by the board or tribal council. In some



cases, the executive directors or program managers oversee plan development. It appears all request staff input. Community Partner 4 uses a formal process in which the executive director works with the Tribal Council to develop the plan. Community Partner 2's formal process is apparently mostly internal, without outside involvement.

All four 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, such as Community Partner 2, reported substantial funding is tied to grants with specific scopes of work.

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

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.

In this section, ASPEN 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 B has some history in training across disciplines. Disability Abuse Response Team (DART) protocols are in place for the region and Community Partner 1 is a team member. In addition, Community Partner 1 has had trainings specific to working with people with disabilities. Six to eight staff in the past six months has attended several ADA national and statewide trainings. Line staff, however, felt they needed some help to become aware of opportunities for training on working with people with disabilities. Community Partner 2 trainings are driven by the needs of the individuals they are working with and staff relies on existing community



resources to address issues affecting clients. Community Partner 3 provided no training specific to working with survivors with disabilities, but is open to doing so.

Isolated areas such as Site B face significant barriers staging trainings in the community. Community Partner 1 recruits trainers for staff and board development, striving to get the best training possible, but it is often difficult to find trainers willing to travel to Site B. They have had to send staff out of town for disability specific training, both in the contiguous U.S. and elsewhere in Alaska. Community Partner 1 has hosted a conference in Site B on FASD, with national and statewide presenters and invited community providers to attend.

Another significant barrier common to both communities and 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

In Site B, Community Partner 1 again provides an excellent model for what an individual agency that values focused training can do in a small community. Community Partner 1's leadership and role as a builder of collaborations with DART and other local providers are strengths to build upon in broadening the scope of cross-training in Site B.

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 of the 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

Community Partner 4 interviewees 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 both Site B 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 culture. Subsistence activities including opportunities to learn how to gather and process traditional foods were described as critical.

In Site B an elder survivor shared how she was able to achieve Community Partner safety and economic security during the winter by making kuspuk patterns with ulu pockets during her shelter stay. Staff support of these activities made her feel safe and welcome as well did their willingness to let her, “come and go” as needed. The elder shared with us that the Yup’ik people living in Site B and the XX area still depend upon subsistence fishing, hunting, and gathering for food (as is confirmed in the XX Native Association’s 2004 Regional Economic Development Plan)

Historically the Yup’ik people are very mobile, traveling with the migration of game, fish and plants. During the summer months everyone from the small villages works together at seasonal fish camps throughout the XX region. Focus group respondents shared, “Our lives are closely interwoven.” “They (Community Partner 1) don’t make us stay in one place. We can come here if we need help and they let us come back if we have to go.” Due to the remote location and harsh climate of the XX area, life is geared toward survival and cooperation. Culturally relevant services ensuring these realities are addressed help program participants feel safe, welcome and valued.

Focus group participants for survivors in Site B described “potlatches,” and communal food sharing as activities that help them feel safe, welcome and connected. While Site B participants also described the shelter’s provision of a “steam,” as making them feel welcome. These traditional activities also 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 (non-local).”

Implications

Traditional cultural values remain strong in Site B and 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 is needed to address historical trauma, DV/SA trauma, and disability trauma. For culturally relevant 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 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 community 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.
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 have chosen to honor the contribution 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 how they viewed their own 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 believe this was necessary 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. Elsewhere in this report, we noted the small number of participants identified as people with disabilities in Site B. However, given that so many of the focus group participant’s self-disclosed experience with disabilities (mostly behavioral and cognitive in nature), we believe we have strong representation of that perspective as well.

We want to 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 thoughts concerning how services could be made safer, more welcoming, and more comfortable.

If someone calls here they can’t say that I am staying here - that made me feel Community Partner 1.

A number related specific experiences that could be accurately described as unsatisfying.



Finally, several addressed issues were beyond the stated focus of our needs assessment; we elected to include some of these in our narrative.

Helpful Aspects vs. Unhelpful Aspects

When participants were asked about what partners do to help, there were a variety of answers. Many women described how thankful they were for Community Partner 1 and said it had been a really good program for the region—“Before Community Partner 1 there was nowhere to go.” They also said they received sufficient support from staff. One woman said, “Community Partner 1 helped me get out of a situation that would have taken my life.”

Many of the women described Community Partner 1’s XX program as very accepting, a place not just for anxiety/alcoholism, but a place to visit, network, and talk without judgment. They also said the groups for “ladies only are very helpful.” Other women were thankful they had somewhere to go, instead of the streets or jail. One said childcare is important – “It is nice to have someone help you with children.” Women also received help with protective custody, housing, food stamps, and jobs. Community Partner 1 helped pay for some to come back home.

A few women also described the thrift store Community Partner 1 runs as very useful. The steam house at Community Partner 1 was especially popular. Many women said it was helpful especially when they were feeling tense. One woman described how they stay in the steam until late, just talking and relaxing and how helpful and healing that was.

One woman said Community Partner 1 allowed people to leave to handle personal business (in her case an elderly relative) and, “When you return, your things are safe, and you are welcomed back with open arms.” She said staff brought children to work and once a staff member’s child asked her, “Are you safe?” It touched her - she realized how sincere staff was.

Community Partner 2 helped a woman with a disability put in a ramp to her house for better accessibility. She said she would like additional accessibility work in her house (rehabbing her bathroom, an additional exit).

Some of us will take longer to heal, but...there is real potential for healing.

Asked about unhelpful circumstances participants had encountered, we heard several responses. One woman said she felt there was no follow-through and they need one person to walk you through the process. Another felt they didn’t point her in the directions she needed which were housing and custody and that she really wanted them to tell her what to do. Some women felt the advocates needed more training, especially on alcoholism—they needed to understand what it is like to be coming off of alcohol, including DTs. They also need training on depression. Another woman said advocates needed to understand the dynamic array of violence in the villages.



How Providers show they can be trusted to help

Participants emphasized how important trust was in a community as small as Site B. One woman said she was more comfortable when she knew the workers than when she didn't. Another said that trust is equivalent to a confidentiality agreement—knowing that what is said in the room stays in the room. One participant said when people try to call, the advocates and other staff members don't let the callers know she is there. Another said she knows that confidentiality cannot be broken or staff will be fired, which lets her know they take confidentiality very seriously. Participants mentioned a number of other ways staff showed they can be trusted to help including:

- Being calm and confident;
- Calling to see if you need help;
- Helping you with paperwork;
- Allowing you to stay with your intake person as long as needed;
- Helping with doctor and other appointments;
- Having closed walls and privacy;
- Helping with Community Partner safety plans;
- Helping with court stuff; and
- Providing clothing and meals.

Some women said they were not comfortable seeking services at first, but after they stayed, they felt more comfortable with it. Hearing from staff that domestic violence is not something to be ashamed of and that you are there to grow, showed they could be trusted.

Other things Providers can do to help

Advertise XX program and Community Partner 1 more, especially in the villages. A back-up Yupik interpreter would be helpful, especially in the courts. Other helpful things would be:

- More parenting classes;
- More support in the schools;
- Education on intergenerational grief;
- Support for younger boys;
- Support group options for couples;
- Anger management for men; and
- An exercise room and more focus on healthy living.

Confidentiality

Confidentiality is important for Site B survivors and it appears, from their responses, that confidentiality is honored in most cases. A number of women who use Community Partner 1 services said they feel safe there and know confidentiality is maintained. One woman said “maintaining confidentiality” is in their policies and bylaws so she trusts it. Another said confidentiality is held as top priority, at the XX group

Still, women noted instances of confidentiality breaches. In one case, a woman described how an employee approached her in a public place and asked questions without ensuring



no one could overhear. She also said that if she ever heard things she said while at Community Partner 1 from someone who wasn't there, she would know confidentiality had been breached. Another said she wouldn't tell some advocates anything because "they are too nosy."

In response to what makes one feel safe enough to disclose personal information, a number of women mentioned signing of the confidentiality agreement. One woman said when the advocates gave her the confidentiality agreement she realized everybody who went to Community Partner 1 had to sign it, which gave her a feeling of trust. She went on to say she never heard anything about her situation in the community so she knew she could say anything and it would not go out.

Spread these buildings and facilities out to other rural areas for other women who can't afford to travel to Community Partner 1.

When asked how to better protect confidentiality one woman said providers should remind everyone that "everything said here is going to stay here." Another said she felt more trusting if an advocate shared with her, because then "I can tell about her, if she talks about me." Another said she protected herself by keeping things to herself. Other women had a different take on confidentiality. One did not regard confidentiality issues as a major problem - she has four sisters and the abuse was never confidential. Another said she trusts everybody, unless trust is broken. After trust is broken, it has to be earned back.

Two women suggested the need for Community Partner 1 services in rural areas. Another said they could work with Village Public Safety Officers (VPSO) to form a group of women in domestic violence situations and provide a safe place until they can get to Site B. She went on to say that village domestic violence was out of hand and women can't tell anybody.

Who do they call?

As Figure 5 shows, over 40% of Site B focus group participants said they would call a friend if they needed help. Others would call or talk to family members, medical professionals, a pastor or preacher, a neighbor, the police, former bosses, children's services, counselors, therapists, advocates, or support groups. One said she would look through the phone book. Another said she hadn't known she could get help, though she saw Community Partner 1 posters at the hospital, she didn't understand what Community Partner 1 was. Also her husband made her feel like "don't you shame me or embarrass me" by going there. Another woman said she had been everywhere, to the doctor, the native health clinic, to elders asking what she should do. Many women (8 out of 19) found out about the agency through some sort of law enforcement officer (Public Safety Officer, VPSO, Police).



Figure 5

	Agency	People talk to or call	Found out about agency
1	CP 1/CP 4	The authorities	Police, VPSO
2	CP 1/CP 4	CP 1 (for shelter); XX Place; Churches; friends	Word of mouth
3	CP 1/CP 4	Police, next door neighbor	Police
4	CP 1/CP 4	Village counselor; friends; preacher; on-call counselor	Law enforcement officer
5	CP 1/CP 4	friend	Police
6	CP 1/CP 4	Female and male relatives; police	Police (was forced to go there)
7	CP 1/CP 4	Pastor; friends; ambulance; look through phone book and start searching	Saw job openings at CP 1
8	CP 1/CP 4	unclear	VPSO; hospital
9	CP 2	unclear	Female relative
10	CP 1/CP 4	unclear	Friend; saw CP 1 poster at hospital, but didn't understand it
11	CP 1/CP 4	Friends, kids, former bosses, CP 1 staff, male relative,	Can't remember
12	CP 1/CP 4	Female relatives, CP 1 staff, Children's services	I remember when it opened
13	CP 1/CP 4	Friend	Police
14	CP 1/CP 4	Friend	Can't remember
15	CP 1/CP 4	unclear	Family member working at the hospital; female relative
16	CP 1/CP 4	Female relative; CP 1 counselors	XX Place, XX group
17	CP 1/CP 4	Female relatives; friends	VPSO handed out cards; hospital gave information
18	CP 1/CP 4	CP 1 staff	Referred by hospital
19	CP 1/CP 4	XX meetings	Heard about it in court
	CP = Community Partner		

Feeling Welcome, Comfortable and Safe vs. Unwelcome, Uncomfortable and Unsafe

Survivors

Although questions asked focus group participants what makes one feel welcome, comfortable and safe, or conversely, unwelcome, uncomfortable, or unsafe, when seeking services for the first time, many described their experiences in addition to hypothetical situations. Many did not just receive services through DV/SA or disability providers, but were referred to or sought assistance from other services, such as mental health, substance abuse, medical, etc.



Staff: For survivors of domestic violence/sexual assault, the attitude of staff was critical. Several women described a place where they felt welcome, where someone greeted them, accepted them with open arms, and allowed them to sit down and talk. Staff would tell them about available services, honor confidentiality, act respectful, wear a warm smile, not be fake, and were nice, not grumpy. Finally, they liked staff that wouldn't open the door for just anyone, who would allow you your privacy and who asked for a list of visitors who could contact you. One woman said she could sleep and not have headaches, knowing she is safe.

The courts, the cops, not even lawyers are allowed to touch us in here—that's how safe we are here.

When you first arrive they keep repeating what you need to hear, so it gets in your head that you are safe.

For survivors, a negative attitude by staff could cause to them feel unwelcome, uncomfortable and unsafe. Many comments were related to the first person encountered, the receptionist. Two women said they felt uncomfortable when that person didn't know answers to questions or turned away and avoided answering. Others said when a receptionist is unfriendly, unpleasant, or curt, they felt unwelcome. Other women described that as being bossy, controlling, rude, uncompassionate, not understanding or waiting to hear you out, poor eye contact, or not listening. Another said workers who don't honor confidentiality made her feel uncomfortable. In one case someone found out about her medical condition from a relative who worked at the hospital. Another said she wouldn't feel safe to open up if the person wasn't culturally sensitive. Finally, a couple of women said they would feel unwelcome if staff neglected them.

Service Location: Women talked about DV/SA services delivered in both shelter and community settings. In a shelters, they wanted a place that looked like a home, was comfortable, had food, and was clean. One would ban alcohol, drugs, and violence. She said it should be a place where you can reflect on what needs to be changed. Many women described a safe place where their perpetrator could not get to them. Others said they would like a tour of the place, or an open house to let women know what type of services they provide. Others cited the steam house at Community Partner 1 as important, but were concerned about the security of the building, which is separate from the main building. One woman said she liked having other kids there and that she could go to the store to get things for her kids.

Focus group participants said an unwelcoming, unsafe, and uncomfortable shelter was a place that wasn't secure, where policies and procedures weren't clear, or was unsanitary—with trash everywhere. A convenient location and or accessibility were also important. One woman said she felt unsafe in a dark place. Two women said there were three doors into the shelter and felt one door could be more secure. Others said, "When you go outside, you get locked out," but they were

(People who) encourage you, make you want to finish your exercises, are helpful and don't treat you bum or rude (make one want to return to a place).



torn on how to resolve that. As mentioned above, the steam house is very important, but there were concerns about its security, about who was watching it. One woman thought a guard at the front door would help her feel safer.

Returning to a Service Location: When asked about what would make one feel welcome, comfortable, and safe enough to return to a place, a welcoming, respectful attitude by staff was paramount: “We’re here for you if you need our services again.” Many said knowing they were welcome back anytime was important. Several said follow-up phone calls were important to her.

People with Disabilities

Staff: For women with disabilities, as with survivors, staff attitude was critical to feeling welcome, comfortable and safe. Our respondent described it succinctly as “really nice” when staff made her feel that way. Alternatively negative staff attitudes could lead to feeling unwelcome, uncomfortable and unsafe. One woman described “negative staff” as those who were “sassy,” didn’t believe her, or told her nothing is medically wrong when she knew something was wrong.

(Attitudes that) make you feel bum, some people can make you feel miserable, like you don’t belong—like they are better than you and they don’t want to help you

Service Location: For a place that was welcoming, safe, and comfortable, the participant described it as place that is accessible. When asked what makes a place unsafe, uncomfortable or unwelcoming, she didn’t like it when people used the “handicapped bathroom or parking spaces.”

Returning to Service Location: When asked what would make one feel welcome, comfortable, and safe enough to return to a place, the woman identified, “kind people.” When asked about what unsafe Partner 1 that they wouldn’t go back, she described people who are very rude or mean.

Understanding and respecting needs, choices, and culture

Survivors

In general, survivors indicated staff showed understanding and respect for individual needs and choices by “greeting you, asking you how you were doing, giving you insight, helping you set up goals, not passing judgment, offering guidance and encouraging you.” One woman also said it was good when staff encouraged program participants to speak up - when she was able to say, “I think we need a house meeting” and her request was honored.

Actions or words that show staff respect them as individuals

Participants said staff showed respect for them as individuals by being patient and letting them take your time. One described respect as valuing choices. Another woman described respect as asking, not telling. Calling to check in with survivors no longer in residence at the shelter also demonstrated respect. Another said telling one who is new to staff was



important, so she could be more patient with staff just learning. An elder survivor said Community Partner 1 staff valued her status as a grandmother whose patience and common sense provided a different perspective.

Participants saw hiring staff “who had been there, who can understand your situation, and can share their story” as demonstrating respect. Staff with lived experience “can provide a listening ear and not just a big pile of advice.” One woman said she would stay longer if staff would give her rides to church so she could attend services. Another participant replied staff would find someone to provide rides if asked.

How a service provider shows they understand their situation

Focus group/interview participants described several ways a service provider can show they understand their situation including listening and informing staff what they value, so they learn from program participants too.

People with disabilities

In general, this interviewee indicated staff showed they understood and respected her individual needs and choices by being kind, helpful and not looking down on her. She also said they can show they understood her disability by not making fun of her or her disability.

Implications

DV/SA program participants stressed physical safety. e.g. locks, lighting, cameras, etc. Similarly recipients of tribal services talked about security issues as well. Both groups stressed the need for privacy and confidentiality.

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, etc. 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.

Both groups talked about safety in terms of how people made them feel and whom they could trust; indicating a friendly attitude by staff is critical. Both survivors and consumers described in detail barriers stemming from messages provided through 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.



Confidentiality concerns existed in both groups although DV/SA program participants appeared more anxious about physical Community Partner safety as well as emotional harm if confidentiality was breached. Disability service consumers also expressed concerns about physical and emotional Community Partner safety yet often 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 sections, 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:

- Some disability sector staff appeared to believe a focus on individualized services was sufficient to ensure that necessary services are competently delivered to survivors with disabilities. At the same time, most staff interviewed believed that targeted training and cross-training was necessary in order to collaboratively serve survivors with disabilities adequately.
- There appeared to be differences in perception between management and line staff. 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 Community Partner 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 significant basis for change to local service systems exists. Site B has a historical focus on behavioral health, but less on other forms of disability. Our DV/SA partner has, in fact, been a leader, in this regard. The community is open to training and collaboration across disciplines, the need for which is a major finding of this needs assessment.

Our DV/SA partner appeared to believe that collaborative training and cross-training are crucial to their ability to appropriately serve people with disabilities. This belief has led it 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. Site B's victim advocacy organization has a very strong presence and is perceived as the local provider to go to for FASD concerns.

Disability services, other than behavioral health, in Site B are often itinerant or experience high turnover and thus have a different presence and image compared to services headquartered there; the community is more familiar and comfortable with services provided by XX Area Health Corporation. All our community partners work closely with them; engaging them in should be a long-term goal for the community.



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 suitable local planning model.
- 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 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, 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 training.

Conclusion

Site B and awaits our return to share needs assessment results and are excited at that prospect and the opportunity for us to facilitate development of a plan geared to meet local needs. Although it would be simpler to develop a plan without their input, long experience in Alaska's smaller communities has taught us that they do not react positively to being told what to do. Because ASPEN members don't live or work in the selected communities, it is imperative ASPEN works collaboratively with its local partners when suggesting change to local systems.

Key Findings And Opportunities For Change

- Policies and procedures at ASPEN's partners in Site B 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.
- 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.



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- 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.
 - 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 B identified positive, respectful, and supportive attitudes and actions as keys to making them feel safe, welcome, and comfortable.

Next Steps

We will share the results of the needs assessment with our partners. 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 to implement these initiatives. We will involve individuals with disabilities and survivors of DV/SA in this planning work.