

A Project of



and



“Partnering to Increase Service Access”

Needs Assessment Report Part 2

Disability Community

January 2009

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Partnering to Increase Service Access:

A Project of Advocacy, Inc. and SafePlace in Austin, Texas

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Part 2 – Disability Community

Overview of the Collaboration

Introduction

In October, 2006, the “Partnering to Increase Service Access” initiative was funded by the U.S. Department of Justice, Office on Violence Against Women (OVW).¹ The three agencies who first initiated this collaborative were *Advocacy, Inc. (AI)*, Deaf Abused Women and Children Advocacy Services (*DAWCAS*), and *SafePlace*. *Advocacy, Inc.* is the Texas protection and advocacy agency, *DAWCAS* was the local domestic violence service provider catering to the D/deaf² community, and *SafePlace* is the local domestic violence and sexual assault service provider. *Advocacy, Inc.* has regional or satellite offices in fourteen (14) communities across Texas and partnering agencies have offices located in Austin, Texas.

During Year I of this project, the partnering agency *DAWCAS* was dissolved.³ In response to the gap in services left by the closing of *DAWCAS*, *SafePlace* initiated expansion of its domestic violence and sexual assault services to the D/deaf community through establishment of a new Deaf Services program. The primary goal of the program is to increase the availability of domestic violence and sexual assault services to the local Deaf, hard of hearing and Deaf/blind community.

Staff hired within the new Deaf Services program at *SafePlace* participated in conducting Part I of these needs assessment activities and will take active roles in developing and implementing the collaboration’s strategic plan, as will other

¹ The “Partnering to Increase Service Access” initiative was funded in 2006 by the U.S. Department of Justice, Office on Violence Against Women through an Education and Technical Assistance Grant to End Violence Against Women with Disabilities grant program.

² Within this report, and similar to other documents produced by the Partnering to Increase Service Access project, the term Deaf with an upper case D is used when referring to individuals who are Deaf and identify as a member of a Deaf community. Individuals who identify as “Deaf” consider themselves as culturally deaf and have a strong Deaf identity. Deaf individuals tend to have attended schools/programs for the Deaf, while individuals who are deaf tend to have been mainstreamed and never attended a school for the deaf. In respect for both groups, we will use the following term throughout this report: D/deaf.

³ Before *DAWCAS* closed, staff contributed significantly to development of the collaboration’s vision, mission, charter and needs assessment plan.

collaborative members. The additional staff participating in the project is part of *Advocacy, Inc.*, the Texas protection and advocacy agency, and the Disability Services ASAP program at SafePlace. Staff of these agencies participated in conducting Part I and Part 2 of the needs assessment and will have active roles in developing and implementing the collaboration's strategic plans.

Separate needs assessment activities were planned and implemented which focused on the needs of the D/deaf, hard of hearing and Deaf/blind community. A report (Part 1 Needs Assessment Report) detailing those activities was previously submitted to and approved by OVW. This Part 2 needs assessment report identifies barriers, gaps, and needs for domestic violence and sexual assault services within Austin relating to people with disabilities.

During the first year and a half of this project, the partners met regularly to identify overarching goals for the collaboration, and to determine how they would assess the needs of abuse survivors with disabilities or who are D/deaf, hard of hearing or D/deaf/blind in Austin, Texas. During this process, partners increased knowledge of each other's missions, vocabulary, philosophies and both unique and shared visions and goals for addressing violence in the lives of people with disabilities. Each partner contributed to the development of a concrete work plan, project timeline, and the process for initiating, developing and maturing working relationships and the project.

The following activities were undertaken and completed by the partners during the initial phase of designing this needs assessment:

- Formalized and deepened existing relationships among partners and began building on past initiatives in responding to individual survivors who are D/deaf or who have disabilities.
- Participation in all-site meetings facilitated by OVW and Vera Institute of Justice (the project's technical assistance provider).
- Development of a vision and mission statement, collaboration charter, project timeline, and goals for needs assessment activities.
- Conceptualized and designed methods and protocols for conducting a needs assessment within the partner's community.
- Identified focus groups and key informant interviews as primary methods for gathering information/data.
- Organized, reviewed and presented the information gathered from focus groups and interview participants in the form of this needs assessment report.

Vision

The shared vision of the "Partnering to Increase Service Access" partners is that people with disabilities and people who are D/deaf will live as they choose without experiencing violence in the everyday course of their lives. To reflect this vision, the following guiding statement was adopted for this collaboration effort.

“We envision that people who are D/deaf or have disabilities live free from domestic and sexual violence and other forms of abuse.”⁴

Mission

The mission of the partners is to work to advance change within our own agencies and communities to ensure that disability, D/deaf and victim services are available to all people with disabilities and D/deaf community members. The following statement was adopted to guide our planning, needs assessment, and implementation activities:

Our mission is “to advance policies, practices and services that ensure culturally aware, sensitive and fully accessible responses to members of the disability and D/deaf communities regarding domestic, caregiver and sexual violence.”

Project Scope

After a lengthy period of discussion and deliberation among the partner agencies, Vera Institute of Justice (Vera), and OVW, the geographical scope of this project was limited to Austin, Texas and surrounding areas (Travis County). All Part 2 needs assessment activities were conducted within the partners’ own agencies (Advocacy, Inc. and SafePlace) and among disability community members and disability service providers.

Workgroups were formed to select and propose assessment goals representative of the partnering agencies’ internal and community-based interests. The selected goals were presented and reviewed by the full project team, Vera Institute of Justice, and OVW. A final set of project goals were selected based on the overarching purpose in developing this needs assessment.

Overarching Purposes and Goals

In developing the needs assessment plan, our purpose was to discover what is needed within our own agencies and community so that people with disabilities living in Austin and Travis County, are consistently welcomed and gain access to needed domestic violence and sexual assault services.

⁴ The project partners recognize that “this statement does not reflect the world as it is, but rather our values and beliefs about the world as it should be, and our work leads us closer to this...our dream. Our work is about believing in the vision and living the dream.”

Conducting the needs assessment provided the partnering agencies with an opportunity to update our understanding of the service barriers and needs of survivors with disabilities in Austin. In a less formal way, the methods of data collection (i.e., focus groups and interviews) generated dialogue and sparked the curiosity and interest of co-workers about working with survivors who have disabilities in their own areas of accountability. Subsequent to the approval of this report, the information detailed in this report will be used to develop a strategic plan for responding to the gaps and access barriers identified.

This needs assessment was designed and implemented according to the following purposes and goals:

1. Identify Service Gaps, Barriers and Needs

What are the areas of need by people with disabilities related to domestic violence and sexual assault?

What are the service gaps and barriers experienced by disability service providers when working with survivors of violence?

2. Build Internal Capacity for Providing Services

What do SafePlace staff members need to increase their own capacity for providing sensitive and accessible domestic violence and sexual assault services to survivors who have disabilities?

What do disability service providers (including Advocacy, Inc.) need to increase their capacity for responding in a knowledgeable and sensitive way to domestic and sexual violence survivors who have disabilities?

What is the role of disability service providers (including Advocacy, Inc.) in responding to survivors of domestic and violence that they serve?

3. Expand Outreach and Provision of Services

How can the SafePlace and Advocacy, Inc. outreach to people with disabilities in order to increase their access to domestic violence and sexual assault services?

4. Build Collaborative Responses

What Austin-based disability service organizations are interested in building a more collaborative response to abuse survivors who have disabilities through partnering or increased service referral?

In what ways can Advocacy, Inc. and SafePlace coordinate their own services to better respond to domestic and sexual violence when working with survivors who have disabilities?

5. Sustain Outreach and Provision of Services

In what ways can we institutionalize policies, practices, and other strategies that ensure welcoming, knowledgeable, and accessible responses to individuals with disabilities living in Travis County?

Methodology

This Part 2 of the needs assessment was intended to gather information about the domestic, caregiver and sexual violence service and support needs of people with disabilities. To accomplish this goal, we wanted to learn from a variety of sources and most directly from individuals with disabilities, disability service providers, and the partnering agencies (SafePlace and Advocacy, Inc.). Part 2 needs assessment activities were conducted between July and November of 2008 in Austin/Travis County, Texas.

The primary methods for gathering information from stakeholders were focus groups and individual face-to-face interviews. The partnering agencies recruited participants, moderated or co-moderated focus groups and interviews, and debriefed data collection activities. As lead agency, SafePlace agreed to manage the logistics and provide note-takers for each focus group and interview. Project staff from both agencies shared in the process of developing and revising a set of focus group/interview questions until they clearly reflected the interests of each partnering agency and the overarching purposes and goals for this needs assessment.

The project's technical assistance provider, Vera Institute of Justice, and OWW staff provided assistance to ensure focus group and interview questions and necessary prompts reflected the purpose and goals of this grant initiative. All focus groups and interviews were conducted at Advocacy, Inc. or SafePlace.

Focus groups and interviews were conducted according to a structured protocol where all participants received the same instructions and responded to the same pre-determined set of questions. Focus group moderators and the interviewers exercised flexibility in the use of prompts and queries but overall, information was gathered in a similar manner for all participants.

In preparation for conducting the focus groups and interviews assessment activities, Vera Institute of Justice arranged for Mary Oschwald of the Regional Institute of Portland State University to provide training on tips and strategies for collecting data through focus groups and interviews. The training provided

project staff with information on the current practices in the design of focus group and interview protocols and design of consistent approaches for moderating focus groups and face-to-face interviews. Staff from the partnering agencies participated in the training.

Accessibility

The sites where focus groups and interviews were conducted were accessible. Several participants asked about the physical access of the locations and were assured of the access into and throughout the buildings. In one case, participants' access to the reception area was affected by insufficient delay time on the automatic door opener. This information was immediately submitted to the facilities management staff at SafePlace for repairs. There were no other specific accessibility accommodations or modifications requested during the collection of data in these needs assessment activities. No reimbursements for transportation and child care services were requested.

Data Collection

Tools

Partnering staff generated four (4) sets of focus group questions and one (1) set of individual interview questions to conduct the Part 2 need assessment. Each question set was designed to reflect the key areas of interest outlined earlier in this report. The five (5) sets of questions can be found in Appendix A of this document.

Sources of information

Focus groups and individual interviews with people with disabilities were used to gather information about the access gaps, barriers and needs for domestic and sexual violence services. These same methods were used to assess the needs of disability service providers, Advocacy, Inc. staff, and SafePlace staff for education, training, technical assistance, policy/protocol development to improve supports and services to abuse survivors in Austin.

SafePlace and Advocacy, Inc. looked first within their own agencies to assess gaps and needs, make improvements, and identify opportunities to formalize the coordination of services between the partners. Staff were asked to identify their needs for information, education, training, technical assistance and agency changes to support work with abuse survivors who have disabilities. Staff members were also asked to identify gaps and needs to ensure effective coordination of services between other direct service staff, disability service providers, and the partner agency.

Disability service providers were also engaged in this needs assessment. Project staff hoped to identify providers interested in expanding their network of

available resources and supports for serving their clients who are at risk or have already experienced violence.

A total of twenty-six (26) needs assessment activities were conducted with a total of ninety-three (93) participants. The sources of information for this needs assessment are summarized in a table on the next page.

Table 1: Needs Assessment Participant Groups

Community Members	Project Partners	Service Provider Agencies
<p>People with Disabilities</p> <ul style="list-style-type: none"> • Types of disabilities represented <ul style="list-style-type: none"> ○ Physical ○ Cognitive ○ Mental Health ○ HIV + ○ Sensory (blind or low vision) 	<p>SafePlace Staff</p> <ul style="list-style-type: none"> • Counseling staff • Crisis Intervention staff • Hospital advocacy staff • Legal services staff • Program Directors • Resource advocates • Shelter staff • Transitional housing staff <p>Advocacy, Inc.</p> <ul style="list-style-type: none"> • Community Integration team • Protection and Civil Rights team 	<p>Disability Services</p> <ul style="list-style-type: none"> • Administrators • Direct service staff • Agencies Represented: <ul style="list-style-type: none"> ○ Texas Department of Family and Protective Services - Adult Protective Services (APS) (Austin regional office) ○ Austin Resource Center for Independent Living (ARCIL) ○ Austin Travis County Mental Health Mental Retardation (ATCMHMR) ○ Capital Metro ○ Easter Seals ○ Empowerment Options ○ Family Eldercare ○ Goodwill Industries ○ Texas Department of Assistive and Rehabilitation Services (DARS) -- Division of Blind Services ○ Texas Department of Family & Protective Services ○ The Arc of the Capital Area

Participant Recruitment

SafePlace staff: Focus groups were scheduled and conducted with SafePlace's direct service staff from these service areas: shelter, transitional housing, counseling, hotline, hospital advocacy, crisis intervention, advocacy/case management and legal services. Staff members were invited to participate by project staff through directors, managers, flyers, emails and face to face invitations.

Advocacy, Inc. staff: Focus groups were conducted with the Community Integration and Protection and the Civil Rights teams.

Disability service providers: Project staff contacted and invited staff to participate from organizations providing services to or who have contact with people with disabilities within Austin/Travis County. These organizations included: The Arc of the Capital Area, Austin Resource Center for Independent Living (ARCIL), Austin Travis County Mental Health Mental Retardation (ATCMHMR), Capital Metro, Easter Seals, Empowerment Options, Family Eldercare, Goodwill Industries, Texas Department of Family and Protective Services - Adult Protective Services (APS) and Texas Department of Assistive and Rehabilitation Services (DARS) - Division of Blind Services.

Community members with disabilities: Participants for focus groups and individual interviews were recruited by contacting local disability service agencies and other community groups in contact with people who have disabilities and live in Austin. Methods of contact included email, in person, word-of-mouth, and various listservs.

The emails, letters and flyers used to invite all participants outlined the purpose and voluntary nature of the interviews and focus groups, how to contact project staff, and group dates and times.

Confidentiality

Every effort was made to maintain participant confidentiality within the limits of the law. All participants were informed that no personally identifying information would be recorded unless the participant gave us their signed consent for the purposes of: 1) contacting them with follow up information or 2) contacting them for further needs assessment information. Even in those two cases, the contact information is kept separate from the data gathered. Participants in focus groups were also asked to agree to maintain confidentiality about each other's participation, names, comments or answers to questions.

Participants were informed of two exceptions to our consent and confidentiality agreements. These exceptions would be: 1) if a participant disclosed current

abuse, and 2) if a participant disclosed plans to harm themselves or someone else. Texas is a mandatory reporting state and information in these cases must be reported to Adult Protective Services (APS). In these assessment activities, no reports were made to APS.

Informed Consent to Participate

Disability community members: Participants with disabilities were asked to sign an *informed consent to participate* document. The interviewer or focus group moderator reviewed the contents of the consent form with participants and answered any questions. All consent forms were signed and collected before the interview or focus group began. A copy of the *consent to participate* form, developed by SafePlace and Advocacy, Inc., can be found in Appendix B.

It was important to project staff that participants were informed that the focus group / interview was going to focus on issues related to abuse and that they may feel uncomfortable or upset in discussing these issues. Participants were also told that they could leave the room and talk to a safe person. The following key elements covered in the informed consent process were detailed and discussed with participants:

- The state law about mandatory reporting of abuse or intention to harm to self or others.
- The voluntary nature of their participation.
- Right to pass on any question.
- Right to stop participation at any time and still be given the stipend.
- Access to a safe person and immediate supports if requested.
- The potentially upsetting nature of the topics under discussion.
- Resources available after the focus group or interview.
- Information about the note-taker and what would be recorded.
- The offer to provide a copy of the notes immediately following the group or interview.

Disability service providers, SafePlace staff, and Advocacy, Inc.: Passive voluntary consent was considered evidenced when a provider or staff member participated in a focus group or interview.

Participant Compensation

Gift Cards: Participants in focus groups for disability service providers were given a \$5.00 gift card to a local ice cream store or coffee shop for their participation in the focus groups. These \$5.00 gift cards were not advertised prior to the focus groups and were distributed at the conclusion of the service provider focus groups in appreciation of their participation.

Stipend: Participants from the disability community received a \$35.00 stipend for their participation in needs assessment activities.

In addition, snacks and beverages were offered to focus group participants and individual interview participants were offered their choice of beverages during the interview.

Focus Groups

A total of thirteen (13) focus groups were held with approximately eighty-four (84) participants in this needs assessment with an average of six (6) participants per focus group. Targeted outreach to potential focus group participants was made to people with disabilities in Austin, Texas.⁵ In addition, project staff engaged local disability service providers, domestic violence and sexual assault agency staff (SafePlace) and Advocacy, Inc. staff. Focus groups were held at SafePlace or the Advocacy, Inc. offices.

Individual Interviews

A total of thirteen (13) individual interviews were conducted as means of gathering information to help improve domestic and sexual violence services and supports to people with disabilities.

Targeted outreach for individual interviews was made to people with disabilities in Austin/Travis County. No specific recruitment of survivors was conducted. One individual community member interview was held at the Advocacy, Inc. office, while the remaining ten were held at SafePlace. Key informant interviews were also conducted with Program Directors within SafePlace's shelter and crisis intervention/hotline programs. Project staff sought to conduct key informant interviews with the Program Directors of the Counseling and Legal Services departments but due to varying reasons, these SafePlace staff were not able to participate in an interview.

⁵Specific attention was given to recruit individuals with a wide range of disabilities for these focus groups. Individuals with cognitive/developmental disabilities, mental health disabilities, physical disabilities and individuals with sensory disabilities were recruited and participated in interviews and focus groups.

Focus Group and Key Informant Interview Participation

Target Group	Number of Focus Groups Conducted	Number of Focus Group Participants	Number of Individual Interviews Conducted	Number of Interview Participants	Total
Disability Service Providers	2	10	0	0	
Partner Agency					
Advocacy, Inc.	2	19	0	0	
Disability Community Members	4	16	11	11	
SafePlace Staff					
Transitional Housing	2	13	0	0	
Non-residential Counseling	1	13	0	0	
Legal Services/hospital accompaniment	1	3	0	0	
Shelter Advocates and Counselors	1	10	1	1	
Crisis Intervention Providers	0	0	1	1	
TOTAL	13 focus groups	84 FG participants	13 individual interviews	13 interview participants	26 Activities 97 Total Participants

Future Contact with Participants

Throughout the course of conducting the needs assessment, participants' interest in follow up contact was explored by moderators and interviewers. Individuals wanting future contact with the project staff gave us information about how and when they could be safely contacted. Some of the participants wanted to know about the assessment outcomes and any changes that we made as a result. The follow up contact information is stored as confidential material in a locked file cabinet at the lead agency.

Data Recording

Project staff served as note-taker(s) to record the information shared by participants during the focus groups and interviews. Paper and pen and laptops were the methods used to record information shared by participants. The transitional housing team was quite large and split into two focus groups held concurrently during their weekly staff meeting. For these groups, only one note-taker was available for each group. For all but one of the individual interviews conducted, one note-taker was used to record information shared by the key informants (Program Directors). For one interview, no note-taker was available due to a last minute emergent situation. In this case, the interviewer took notes while simultaneously conducting the interview.

The decision to employ one note-taker was strategic to reduce the number of unknown persons who were in the room during the individual interviews. Interviews comprised of the individual with a disability, one interviewer and one note-taker or— one Program Director, one interviewer, and one note-taker.

Offer of focus group / individual interview notes to participants

Project staff worked to ensure that that all needs assessment activities were transparent to individual participants in this project. Although offered, no participants requested a copy of information gathered during their interview or focus group. Participants did express general interest in learning about the project outcomes and any changes that would be implemented within the community. These requests were noted by project staff and will be honored once a Strategic Plan is created and approved.

Transcription of Notes

Note-takers were responsible for transcribing their notes immediately following an interview or focus group and submitting to the project manager. The note-takers documented the method of data gathering (individual interview or focus

group), date, note-taker and interpreter name(s), and the total number of participants.

The information gathered was organized according to the individual questions and based on the thematic content of responses. Individual responses were not linked with participant names as was discussed earlier in the confidentiality section of this document. The original notes are stored in a locked file cabinet in the project manager's office. Electronic copies of this data are stored at the lead agency where access is limited to project staff only. The information will be stored according to federal guidelines governing the collection and storage of data.

Following transcription of the notes taken during each focus group and interview, project staff organized the information to facilitate identification of key issues and areas of need revealed by individual and collective participants. Participant responses were cross referenced according to the population represented (i.e., survivor, service provider, direct service staff, etc.), individual questions asked, and the core themes and requests. Responses are organized in the results section of this report according to: 1) populations represented, 2) issue areas, and 3) the project's purposes and goals.

Needs Assessment Time Line

The information gathered in the needs assessment will be essential to the development of a strategic plan that accurately reflects the resources, barriers and opportunities for increasing accessibility to victim and disability services and safety options for people who have disabilities.

Workgroups within the collaborative team were tasked with developing needs assessment goals that represented each of the partner agencies internal and community based self-interests. These goals were presented and reviewed by the full project team and a final set of goals were selected which are summarized earlier in this document. The focus group and interview questions were developed according to these goals (see p. 2-3).

Following selection of our goals, the project team outlined a plan for completion of the various activities necessary for conducting the focus groups and individual interviews. A strategic plan will be developed and proposed to OVW for approval based on results presented in this report. The approved plan will reflect the partners recommendations and will guide the remaining project activities. The following chart details our estimated timeline for completing the needs assessment activities.

Month	Needs Assessment Plan – Development Timeline Major Activities and Milestones
June 2007	Develop needs assessment goals representing each partner agencies goals and community based self-interests.
July - August 2007	<p>Select teams to develop needs assessment goals. Draft protocol for conducting needs assessment activities and develop focus group and interview questions based on needs assessment goals.</p> <p>Continue meeting as collaborative.</p> <p>Participate in training by Vera Associate on “Best Practices in Moderating Focus Groups.”</p>
September – November 2007	<p>Develop the needs assessment plan and submit to Vera Institute of Justice for review and OVW for approval.</p> <p>Finalize informed consent documents and stipend plan for participants.</p> <p>Continue meeting as collaborative.</p> <p>Attend OVW/Vera all-site meeting in St. Louis, Missouri.</p>
December 2007 – January 2008	Pending OVW approval of the needs assessment plan – recruit participants and provide informed consent information.
January – November 2008	<p>Develop needs assessment protocol; conduct focus groups and individual interviews.</p> <p>Continue meeting as collaborative.</p> <p>Attend OVW/Vera all site meeting in Louisville, Kentucky.</p>
<p>November 2008 – January 2009</p> <p>February 2- March 2009</p> <p>March 2009</p>	<p>Organize and compile needs assessment data. Develop findings and integrate with other sources of information (census, agency self-interests, priority setting by collaboration, etc.). Submit needs assessment report to OVW for approval.</p> <p>Hold strategic planning session with partners, Vera Institute of Justice and OVW. Develop strategic plan based on results of needs assessment data. Submit strategic plan to OVW for approval.</p> <p>Pending approval of strategic plan - begin implementation of strategic plan.</p>

Strengths and Limitations

Strengths

A strength of this collaborative and needs assessment is the relationship among project partners. In 2005, Advocacy, Inc. and SafePlace worked together on a joint project related to advocacy, disability rights, and accessible services to

individuals with disabilities or who are D/deaf. Through that project, AI closed its offices for two days so that agency staff could participate in an introductory training on domestic violence which was offered by SafePlace and DAWCAS. Additionally, Advocacy, Inc. and SafePlace held a two day meeting with disability rights advocates to discuss domestic and caregiver abuse related issues.

This OVW funded project has allowed Advocacy, Inc. and SafePlace to deepen their existing relationships, learn more about each other's work, agency culture, and roles in serving our community. Project team members are committed to continuing this work to ensure that women who have disabilities or who are D/deaf in Austin or Travis County can increase their personal safety and get the help and supports they need when domestic / sexual violence occurs.

An additional strength has been leadership within Advocacy, Inc. and SafePlace who are committed to providing accessible services to individuals who have disabilities. In the course of conducting this needs assessment, co-workers, direct services staff, and program leadership readily contributed to identify service gaps and barriers and how our agencies can better coordinate services and reach out to other providers in our community to better serve people with disabilities in our community.

This needs assessment also provided an opportunity to communicate face-to-face with community members with disabilities and local disability service providers, to further build relationships. A number of participants with disabilities shared that their participation was a first time to gather specifically to talk about abuse and violence, victim service needs and some of their fears, experiences and barriers to seeking help.

Limitations

We also note several weaknesses regarding our data collection methods. First, we relied heavily on self-reporting which yields a subjective and biased data set. Yet, for our purposes, this method served well. We listened, face-to-face, and took note directly from people with disabilities, disability service professionals and SafePlace and Advocacy, Inc. staff. These individuals spoke with us about the service gaps, barriers and needs related to domestic and sexual violence, from a personal and experienced perspective.

Second, we recorded participant responses during focus groups and interviews by taking notes. This method of data collection is likely to yield results influenced by our human tendency to pay attention to what is more personally interesting or relevant. For some measure of control related to this bias, we provided training to note-takers and initiated the standard of using two (2) note-takers and transcribers for each group.

Third, in consideration of weaknesses associated with reviewing the data, at least three (3) staff members independently identified and summarized the key gaps, barriers, needs and requests detailed in the recorded data. These sets of data were then compared to identify the similarities and differences. Findings with higher levels of agreement were included in the final needs assessment report.

And finally, the information we gathered is limited to one geographic area and collected one-time during focus groups and interviews. Generalization of findings, implications and recommendations can only be limited to the single geographic area under study (Austin and Travis County, Texas).

Despite these limitations and challenges, the methods utilized and the geographic restrictions allowed us to: 1) focus intensively on engaging and identifying our own agencies needs, 2) learn directly from the key beneficiaries of our efforts, and 3) focus attention on how we can increase the accessibility of domestic and sexual violence services and outreach to people with disabilities in our community.

Results and Key Findings

Gaps, Barriers and Needs

The results and findings detailed in this section are intended to guide the partnering agencies to make short and long term plans for improving our own services to people with disabilities in relation to domestic, caregiver and sexual violence. Results of the assessment will also guide efforts to increase the community's awareness of the services that are available to survivors with disabilities and aid in identifying gaps, barriers and needs to provide accessible and sustainable victim services to people with disabilities. The following stakeholder groups are represented in these assessment activities:

- Advocacy, Inc. staff,
- Disability service providers,
- People with disabilities, and
- SafePlace staff.

For detailed tables of the compiled information provided by focus group and interview participants see Appendix C.

When participants were asked why many people with disabilities don't ask for help when abused, a range of barriers to speaking out were named. For the most part, responses were related to retaliation, being disbelieved, loss of social connections and loss of independence. One person said the abuse would be interpreted as a delusion or that the person didn't understand what they were

saying (cognitive disability). A main barrier to asking for help was the fear of losing independence—a core value for the majority of people with disabilities. Another major concern about speaking out was a loss of supports and especially if the abuser is also the care provider. For many people with disabilities, loss of a caregiver can result a nursing home placement or institutionalization.

Individuals with disabilities also expressed concern that asking for help from others would only result in being blamed for the abuse. Specifically one participant said that a person might have their counselor ask them directly what they had done to cause the abuse. Closely related to blame is the experience of feeling shamed. Participants also said that a survivor may not speak out because s/he feels embarrassed or somehow responsible for the abuse that has been perpetrated. Other individuals with disabilities stated that the aftermath of a disclosure or request for help is likely to result in Adult Protective Services (APS) involvement.

One of the most basic concerns that people with disabilities expressed was the risks for retaliation. This very real concern is a barrier for any survivor and can be heightened if the survivor has a disability. Any efforts to address barriers and gaps in service systems need to include a comprehensive and thoughtful review of the possible risks for further violence and safety planning. First, we must do no harm.

Building Internal Capacities for Providing Services

Participant groups identified the following areas of need and suggestions for how SafePlace, Advocacy, Inc., and disability service providers can increase capacity for providing knowledgeable and sensitive domestic and sexual violence response and services to people with disabilities in our community:

Accessibility

Each of the stakeholder groups identified barriers specific to accessibility of services at SafePlace as potential focus areas of the forthcoming Strategic Plan.

Attitudinal Accessibility – People with disabilities told us that attitude is a critical aspect of accessibility. One participant with a disability thought SafePlace should orient new employees so that they know staff is expected to have attitudes that remove barriers to serving people with disabilities. SafePlace direct services staff pointed out that new employees may bring negative experiences, fears or a lack of knowledge that results in biases toward clients who have mental health or substance abuse issues. People with disabilities shared that friendly staff at the front reception area is important in showing a welcoming attitude toward people with disabilities.

Programmatic Accessibility – Most participants talked about barriers to getting in for services that people with disabilities experience if they live in restrictive settings (e.g., staffed group homes, state schools and hospitals, etc.). For example, limits may be placed on telephone access, access to computers, transportation, or connection with people other than caregivers or roommates. These limitations are likely to prevent a person being abused from reaching out for help. Advocacy, Inc. is interested in partnering with SafePlace to explore ways that screening and service entry for people with disabilities who live in these restrictive settings can be facilitated.

Several participants with disabilities asked if case managers could accompany them to appointments at SafePlace. Disability service providers recommended that SafePlace set up a voice mail for requests for services and follow-up with individuals who may have limited or sporadic access to a telephone.

Participants with disabilities pointed out that they wanted staff to know that time delays in showing up for appointments may be result of transportation or other supports they rely on others to provide. Participants asked SafePlace, Advocacy, Inc. staff and disability service providers to make sure they disclose the mandatory reporting requirements to clients with disabilities and to first inform survivors if an APS report is going to be made.

When asked what SafePlace and Advocacy, Inc. could do to improve services to people with disabilities, participants made some of the following observations and suggestions: review the intake process and paperwork to make sure we use People First Language; simplify intake paperwork for survivors with sensory and cognitive disabilities; walk-in group orientation at SafePlace may be stigmatizing or isolating for survivors with cognitive disabilities; explore ways to format and conduct the parenting classes and support groups (e.g., simplified language, shorter sessions over longer periods of time, etc.) to increase access to survivors with cognitive disabilities or who use communication devices; and extend the number of allowable sessions or time limits in shelter as a reasonable modification that increases access and the effectiveness of our counseling and advocacy services.

SafePlace staff shared concerns that law enforcement may not respond well to survivors who are having a mental health crisis. SafePlace staff expressed interest in developing more of a relationship with the Austin Police Department and Travis County Sheriff's office and to develop a formal protocol with trained and experienced mental health officers when a client requires crisis intervention.

Disability service providers indicated that it can be confusing and seem inconsistent when we conduct outreach and then they or their clients are told that shelter is full. This situation could better be addressed by providing more clarity about the 'intake' protocol and how shelter admissions are prioritized. The demand for shelter services is high in our community. Service providers thought

it might help if SafePlace developed a “universal script” for use when shelter is denied.

Physical Accessibility - Stakeholders expressed significant concern at the current entry system on the SafePlace campus. Two aspects of the system were highlighted as barriers. The doors (that open out) create a barrier to access for individuals who are blind or have low vision and create potential risk for injury during the entry process. Also, the current buzzer and audible entry system both at the main reception entrance as well as the walk-in gate were identified as confusing and inaccessible at times for individuals with disabilities.

Other physical accessibility barriers identified include:

- The glass door in the reception area creates a risk if it closes too quickly.
- The time delay is too short on the automatic door openers and can close on clients using a wheelchair,
- The bathroom door in the reception area bathroom is too heavy and is difficult for some people with disabilities to open.
- The walk in gate at the shelter needs a ramp.
- The latch on the walk-in gate in front of the Resource Center is too high for someone using a wheelchair to reach.
- The two-door security system in the entry to the Resource Center can be confusing to clients. Participants with disabilities recommended that staff meet clients in the atrium.
- Despite the fact that 20% of showers in shelter are roll-in for wheelchair access, some people with disabilities thought that number is too limited.
- Occasionally, a client will need a wheelchair and it can be difficult to find the resource.

Participants with disabilities also identified a need to make the website more accessible such as using simple language, large bold wording and using links to navigate to other parts of the site.

Building Collaborative Responses

Coordination of Services

Most participants identified that service coordination needs to be improved when serving individuals with disabilities. This section will outline some of the gaps, barriers and needs identified by participants as related to the coordination of community based disability and domestic, caregiver and sexual violence services.

Range of services and referral information: All stakeholders shared that many people with disabilities, community members and service providers need more information about SafePlace and may not know the range of services that SafePlace offers to people with disabilities. Service providers asked that we

consider ways to make sure area disability service and advocacy agencies are clear on what we do and what we do not offer, and the protocol for making a referrals to SafePlace. People with disabilities asked that we identify back up contacts should the primary contact (when given a referral) is not available.

Peer mentoring: Two stakeholder groups suggested we have peer mentors for people with disabilities at SafePlace. For example, staff thought that clients with cognitive disabilities get bored or feel neglected when staying in shelter. In addition, more frequent supports are needed for survivors with cognitive disabilities staying at shelter with day-to-day activities like cooking, cleaning and caring for children. Some shelter clients with cognitive disabilities came from more structured environments with fewer opportunities to make everyday decisions about their activities or schedule. A peer mentor might help address any sense of isolation in shelter while supporting the individual to build more independent living skills.

Mental health services: Participants thought that SafePlace and Advocacy, Inc. could increase and formalize service coordination with MHMR (Mental Health and Mental Retardation) and APS (Adult Protective Services). Advocacy, Inc. staff is interested in helping SafePlace staff work more effectively with MHMR. It would be helpful to SafePlace staff to identify a person or formalize a liaison at MHMR to streamline referrals to clients wanting mental health services. Disability service providers recommended that SafePlace develop a collaborative relationship with the staff of the MHMR East 2nd Street Clinic. The ADAPT advocacy office is across the street from the East 2nd Street Clinic and service providers recommend SafePlace work to coordinate services and outreach between those two agencies.

SafePlace staff also indicated a need to improve our relationships with other developmental disability and mental health service providers – the Austin State School, Austin State Hospital, and Psychiatric Emergency Services (PES). Related to this need, SafePlace leadership discussed the delayed response from the Austin State Hospital as an area where more coordinated services may improve the experiences of SafePlace clients who need psychological and emotional support during a crisis.

SafePlace participants shared that it is quite difficult to find trauma-informed therapists in Austin who accept Medicare or Medicaid. As a result, some clients must depend on the MHMR system for mental health services and MHMR has extended waiting lists. SafePlace staff said that clients with mental health needs would benefit from an on-staff or on-site mental health provider (e.g., psychiatrist, psychiatric nurse, psychologist, etc.). Staff also asked for more up to date information about how and where clients might better access routine and emergency mental health care from MHMR.

Adult Protective Services: Advocacy, Inc. staff is interested in working more closely with SafePlace and APS (Adult Protective Services). Advocacy, Inc. staff believes that APS workers need additional legal supports in making their cases stronger regarding people with disabilities who are experiencing abuse. At the same time, SafePlace participants talked about needing more supports when Child Protective Services (CPS) workers are not allowing modifications that would support parents who have disabilities in accomplishing their parenting goals. In addition, SafePlace staff noted that APS workers tend to close cases when a client comes into shelter rather than continuing to support the client in preparation for the client's exit. When clients with disabilities leave shelter but are not returning to their families, it can be difficult to know where the survivors can find long term and safe housing options. Advocacy, Inc. staff would like to institute an agreement or plan developed with SafePlace and APS to provide safety planning, and follow up and follow-along services when someone returns to their perpetrator or is transitioned into the community. People with disabilities asked for some degree of follow up with survivors who have disabilities during and after they receive services at SafePlace.

Guardianship: Participants with disabilities talked about their risks for future violence if they have a guardian who is also their abuser. For example, a guardian may use their power to retaliate against a person if they ask for help. In these cases, the survivor will need to take extra time and caution to decide and take steps to leave their perpetrator and change guardianship.

Resource advocacy: SafePlace participants need support in developing a more streamlined process for obtaining resources or negotiating waiting lists for clients with disabilities (e.g., Home and Community Based Services, accessible housing, guardianship issues, etc.). They are also interested in having more face-to-face contact with staff from disability service and advocacy agencies and they want to increase their knowledge about resources/services, and streamline the referral process for clients with disabilities.

State institutions: Advocacy, Inc. focuses on the needs of people with disabilities living in Texas state institutions. Staff said they would like to partner with SafePlace to reach out to institutional treatment teams who could provide options for trauma informed supports to abuse survivors living in those institutions. Although beyond the scope of this project, SafePlace and Advocacy, Inc. staff also talked about their commitments to research and development of how they can work with state entities to integrate personal safety and healthy relationship education into the transition plans of individuals with disabilities transitioning from institutional to community based settings. We are hopeful these transitions will increase as directives are issued to close Texas institutions.

Screening for domestic violence: Advocacy, Inc. leadership wants their own staff to receive additional training from SafePlace about domestic and sexual violence, screening for abuse, responding to disclosures, supporting survivors after

disclosure, and how to make more referrals for local domestic and sexual violence services. While Advocacy, Inc. staff report they take few calls related specifically to domestic violence, they also recognize that these calls may be identified or prioritized in other ways. Advocacy, Inc.'s intake protocol does not include specific questions about domestic violence or sexual assault. One initiative suggested is to explore how Advocacy, Inc. could modify their current intake to screen specifically for domestic and sexual violence cases. At the same time, both agencies recognize this initiative should be carefully balanced so that workers have information for responding to disclosures during intake, options for assistance in safety planning, and an effective referral protocol so that clients who disclose are not further harmed as result of that disclosure. Advocacy, Inc. staff also expressed an interest in continuing to work with SafePlace and some of the following initiatives: providing a forum so that staff can explore the legal and ethical obligations of reporting abuse; development of a formal protocol on reporting abuse; and partnering on a healthy relationships initiative.

Attendant care: Disability service providers suggested that SafePlace review and update the process or policy around supporting clients to utilize attendant care services. People with disabilities recommended that SafePlace develop good relationships with staff from a home health agency to streamline obtaining these services when needed. Disability service providers shared that there may be services in the community that SafePlace is not currently utilizing such as a consumer abuse and neglect reporting system administered by Mental Health Mental Retardation (MHMR). Advocacy, Inc. and SafePlace are interested in working on a protocol so that people with physical disabilities have needed attendant care in shelter or transitional housing.

Transportation

People with disabilities and disability service providers identified limited or no accessible transportation (and especially after hours) as a significant barrier to some survivors with disabilities. Private transportation may be controlled by a person's care provider or abuser. And public transportation may not be an option for survivors who do not have access to telephones or money. The Austin Police Department, Capital Metro Transit Authority and Medicaid were identified as community based resources available to support someone who needs accessible transportation. Participants with disabilities said that even if a person could privately pay for a taxi cab, there are only 3-4 accessible cabs in Austin. Given these and other transportation barriers, community members with disabilities suggested that SafePlace have alternate locations in Austin to meet with survivors who want to pursue services.

Durable medical equipment: When seeking safety or emergency shelter or services at Advocacy, Inc., people with disabilities need to be able to transport their Durable Medical Equipment (DME) (e.g., wheelchairs, walkers, cane

crutches, communication devices, prosthetics, etc.). Some participants stated that they would probably not come to shelter if they had to leave these supports behind or if they knew they would have to wait for many hours or days to get replacements. Obtaining durable medical equipment is often difficult for people with disabilities. The equipment is expensive and insurance companies may not cover DME or that coverage is limited. Pre-approval wait times can be months long and getting the equipment after placing an order can also take months. People with disabilities were concerned that use of durable medical equipment might present a barrier to services if the equipment is interpreted as evidence of a person's medical fragility or as indicator of the seriousness of a person's disability. A more realistic interpretation of durable medical equipment is as a sign of increased independence.

Legal Advocacy

SafePlace direct services staff asked for information (format could be a one-page fact sheet) detailing the kinds of legal services Advocacy, Inc. could provide to clients with disabilities. Staff reported that legal issues that SafePlace clients tend to encounter are housing discrimination, guardianship issues, changing payees for incomes, and denial of SSI or SSDI benefits. Participants also discussed that many SafePlace clients attend "*Project Options*" classes to learn about the complex decisions that must be made when survivors of family violence are deciding whether or not to press charges against their abuser/perpetrator

Child Protective Services: Several stakeholder groups brought up that when Child Protective Services (CPS) is involved with parents who have disabilities, for whatever reasons, an additional burden is placed on the abused parent who is battling for child custody. The example shared is when parents with mental health disabilities must take psychotropic medications to be compliant with mandated plans related to child custody. SafePlace direct service staff asked if Advocacy, Inc. could work with them and survivors with disabilities who are experiencing difficulties completing mandated CPS plans.

Expanding and Sustaining Outreach and Provision of Services

Targeted Outreach

Participants in this needs assessment told the partnering agencies that we need to conduct more intensive outreach to Austin's disability community and disability service organizations about the range of services and supports we provide. Participants discussed what they identified as an overlooked group of citizens who have disabilities and could benefit from our services. For example, there are many people who do not identify as a person with a disability and they are not linked with social or disability service systems. Since there is a group of people with disabilities who choose to not identify as such, they would best get

information about SafePlace services in general campaigns or through information shared in public places like grocery stores, public transportation systems, radio spots, posters placed in public buildings, bingo halls, and through community presentations.

Service provider groups also discussed the importance of considering unintended consequences of outreach efforts and whether or not we will be putting individuals with disabilities at a higher risk of violence. These cautions were welcomed and consistent with SafePlace's outreach to people with disabilities. Decisions about outreach initiatives will be made based on the first principal— do no harm.

One participant with disabilities recommended that disability service providers routinely screen "all" clients by asking about experiences of abuse. In this way, questions about abuse are less likely to become a red flag or alert a perpetrator and that could help reduce the risk with a perpetrator.

Participants asked SafePlace to make sure they are including images of people with disabilities in brochures and other printed materials to increase community awareness that SafePlace also serves people with disabilities. Participants with disabilities thought that information about SafePlace does not consistently trickle down to many people with disabilities despite communication with providers by SafePlace and Advocacy, Inc. Another suggestion to increase communication about our access is to post the universal disability symbol on our website, doors and front gates.

Stakeholders said that the following general knowledge about SafePlace and Advocacy, Inc. is not as well known as we might think:

- SafePlace services are free.
- SafePlace location is no longer confidential.
- Locations of SafePlace and Advocacy, Inc.
- Bus lines located near SafePlace and Advocacy, Inc.
- SafePlace also provides services to survivors of caregiver violence and sexual assault
- Whether SafePlace makes attendant care services available if a person in shelter needs those services

Other Ideas: Participants were energetic in offering the following thoughts and ideas about how SafePlace and Advocacy, Inc. could increase the community's knowledge about our services and supports.

- Advertise the issue and services through television spots.
- Conduct outreach to people in day program activities.
- Design key chains and magnets with hotline information.
- Develop and distribute t-shirts with SafePlace information on them.

- Develop handouts in Spanish and simplified language
- Develop posters and brochures about sexual assault to communicate that rape and sexual assault does happen to people with disabilities.
- Develop posters and brochures detailing various forms of abuse and the services available for survivors.
- Distribute emails or submit articles to newsletters about the issue of violence against individuals with disabilities and SafePlace services.
- Increase APS workers knowledge about how to access SafePlace services.
- Partner with Goodwill Industries to target outreach to Goodwill program participants.
- Produce a PSA that targets individuals with cognitive disabilities and the specific types of violence that may be experienced.
- Produce small palm or business cards with contact information.
- Recruit survivors to tell their stories.
- Update 211 information about SafePlace to focus on services available to people with disabilities.
- Use the SafePlace and Advocacy, Inc. logo as an easily recognizable contact point for individuals who do not read.

Some of the specific locations stakeholders identified for outreach efforts are listed next:

- Attendant care networks on the internet
- Austin Mayor's Committee for People with Disabilities
- Chamber of Commerce
- Faith communities (e.g., churches, synagogues, etc.)
- Disability service providers and events (e.g., day programs, group homes, MHMR, Muscular Dystrophy Association, Respite Care providers, Austin Resource Center on Independent Living, etc.)
- Durable Medical Equipment (DME) providers
- Waterloo Counseling Center
- Home health agencies
- Job, health and other disability fairs
- Libraries
- Narcotics Anonymous, Alcoholics Anonymous
- Physicians, therapists and rehabilitation centers
- Planned Parenthood
- Public Access TV
- Retail stores
- Social Security and Medicaid offices
- Apartment complexes where large numbers of people with disabilities live (e.g., Stony Ridge)
- Students with disabilities offices at local colleges and universities
- United Way

Durable Medical Equipment providers: A particularly innovative outreach idea was identified by people with disabilities. SafePlace and Advocacy, Inc. could partner with local DME providers like Travis Medical, to include SafePlace hotline and Advocacy, Inc. intake number listed on the emergency number sticker included on the equipment. These numbers would become part of the universal number set on all equipment. The numbers would be accessible to a person when and if they should need them without arousing any particular suspicions on the part of a perpetrator.

Group homes: SafePlace staff also discussed the gap in services for sexual assault survivors who are living in group homes. Since the mid-90's, SafePlace staff have provided personal safety education to group homes and group home residents in Austin and surrounding areas. And yet, there are still a significant number of group home providers who do not respond to outreach related to sexual assault services. Despite the incidence of sexual abuse experienced by women and men in group homes, disability service providers do not routinely provide supportive responses or seek access to healing services for those survivors. SafePlace and Advocacy, Inc. were encouraged to explore how we might better reach out to these underserved survivors.

Public transportation: Service providers also recommended that we make SafePlace and Advocacy Inc.'s contact information available on placards in city buses to increase access and the community's knowledge about our services to individuals with disabilities.

Education and Training

All participant groups identified gaps and needs for Education and Training.

Disability Service Providers: Advocacy, Inc. intake workers and other disability service provider staff requested additional education on screening for abuse and responding to disclosure of abuse within the time constraints of a screening call or intake interview.

Service providers pointed out a continued need for training on methods of identifying when abuse is happening to their clients and basic knowledge about the dynamics of violence perpetrated against individuals with disabilities, the different types of abuse that violence can take, and the long-term effects of abuse (including sexual violence) in the lives of people with disabilities.

Disability service providers indicated needs for education on responding to disclosures their clients make after participating in educational programs on personal safety or healthy relationships. Stakeholders also indicated that service providers need to continue client education that it is OK to speak out and ask for help if they have been abused.

First responders (including police and sheriff's departments) need continuing education on the issue of violence against individuals with disabilities.

People with disabilities stated that disability service providers need up to date information so they can clearly identify what resources are available for survivors with disabilities. In addition, service providers need continuing education on how to safety plan with individuals when their abuser is also their caregiver, parent or guardian.

Individuals with disabilities also want staff of disability services agencies to know how to give their clients information about abuse and what they could do to support clients who are survivors.

In addition, the disability community members thought that service providers should do a better job of screening new employees [presumably to screen out perpetrators]. In addition, participants with disabilities want service providers to provide more training to their staff on the issue of appropriate boundaries with clients they are serving.

Service providers also thought it was more likely that they would identify domestic violence than sexual assault among their clients. One response to sexual abuse may be acting out which can result in being identified / prosecuted as an offender. In these cases, a survivor is even less likely to be provided with needed support and healing services. Service providers in congregate or institutional facilities also need education and training on the differences between sexual abuse and sexual activity between consenting adults.

Disability service providers who participated point out that the following service systems need continuing education on issues related to domestic, caregiver and sexual violence:

- Adult Protective Services (facility and in-home workers)
- The Arc of the Capital Area
- Austin Police Department
- Austin State Hospital
- Austin State School
- Capital Metro Transit
- Department of Assistive and Rehabilitative Services (DARS)
- Easter Seals
- Educare
- Empowerment Options
- Family Eldercare
- Home and Community Services (HCS) Group Homes
- Kenmar Residential
- MacBeth Recreation Center
- Marbridge
- Mary Lee Foundation

- Medical providers
- Travis County Sheriffs Department
- Rescare
- Volunteers of America

In addition to the organizations listed above, participants identified specific training gaps for several organizations. Home health agencies need education about when to report abuse to Adult Protective Service or DADS as appropriate. Adult Protective Services facility workers need information on the dynamics of rape, molestation and the St. David's Hospital rape exam protocol. Participants recommended that SafePlace offer Austin Travis County Mental Health Mental Retardation (ATCMHMR) and BlueBonnet Trails MHMR agencies training that could be integrated into their annual mandatory trainings. Finally, Capital Metro drivers need to be specifically trained on HIPAA relative to their riders with disabilities.

Service providers identified needs for information on how to stay safe when they enter someone's home and what to do if an allegation is made against one of their staff. Providers would also like to see more training in the community about the intersection of domestic/caregiver violence, Post Traumatic Stress Disorder (PTSD) and employment.

The Austin Police Department and the Travis County Sheriff's office's mental health officers could benefit from continuing education on how to better manage a family violence scene. Program staff at SafePlace said that critical conversations are needed with the Austin Police Department detectives specific to their services provided to survivors with disabilities.

SafePlace direct services staff: Participants indicated that SafePlace staff needs continuing education for a general familiarity, comfort and sensitivity in working with individuals who have a range of disabilities.

Some staff at SafePlace indicated they feel overwhelmed and intimidated when working with clients who have disabilities. For many disability groups, services are limited, waiting lists are incredibly long, programs or budgets continue to be cut or frozen, and financial resources are limited if non-existent. The resource needs and the lack of available resources are so great that staff can feel drained when working with clients with disabilities.

SafePlace staff members feel they need more ongoing education and information in working with individuals with mental health disabilities (including PTSD), hidden disabilities, seizure disorders / cognitive disabilities, and substance abuse issues. Staff also said that it would help to have more information on how various disabilities might impact their interactions with staff. Staff would like continuing education on mental illness, treatment options and how symptoms

affect an individual. Staff also expressed the difficulty in prioritizing clients with mental health disabilities and serving sexual assault survivors with mental illness.

Given experiences in serving people with disabilities, SafePlace staff requested information and training in answer to the following questions:

- How can SafePlace staff better serve clients with cognitive disabilities?
- How can SafePlace staff learn more about taking calls from people with substance abuse issues, as these are difficult calls for workers?
- What are the recent changes in the ADA and how do we apply those changes?
- How much information can we give to a resident about another person's disability?
- Can Disability Services staff provide training at our monthly advocates meeting?
- What can Advocacy, Inc. offer our clients?
- Given recent changes in governmental agencies, what services are provided by Department of Assistive and Rehabilitative Services (DARS) and the Department of Aging and Disability Services (DADS)?
- What are accessible/affordable housing options in the community for people with disabilities?

Advocacy, Inc. staff: Staff of Advocacy, Inc. identified a need to know more about how they can work with SafePlace to better support their clients. And, SafePlace staff would like to know how they can work with Advocacy, Inc. to support their clients and work. Advocacy, Inc. staff asked to learn more specifically what resources are available in the community for clients whose cases of abuse were determined to be unfounded. Staff also indicated a need for Advocacy, Inc. intake workers and managers to know more about domestic violence and sexual assault and would like more training from SafePlace. Advocacy, Inc. staff reported that the trainings SafePlace provided several years back were helpful, but more advanced training is necessary to make changes in how business is conducted. All staff also requested to have access to the SafePlace Disability Services' fact sheets on their internal server. Advocacy, Inc. staff also indicated a need to know more about assessments of survivors to ensure that the assessments their clients receive from institutional staff are complete and include the client's trauma history.

People with Disabilities: Community members with disabilities would like to have continuing education on the following core topics:

- What is abuse?
- How to recognize abusive relationships.
- How to ask for help.
- Where to find help.

People with disabilities want information about where they can get counseling and support related to abuse. Additionally, individuals with disabilities asked for

information on sexuality, boundaries, respect and definitions of sexual assault. If people with disabilities were to experience sexual assault, individuals with disabilities want survivors to know that St. David's is the hospital in Austin where forensic exams are given.

SafePlace staff requested that education be provided to people with disabilities who are clients of SafePlace similar to the current community education classes offered to adults with disabilities. Service providers recommend that education currently offered to individuals with disabilities be presented through the lens of "healthy relationships" and that we add more interactive activities.

Finally, community members with disabilities indicated an interest in continued opportunities to dialogue about the issue of abuse – not in a therapeutic or clinical format. This request came as a direct result of the focus groups and individual interviews in that people with disabilities were interested in sharing more of their ideas and experiences in an informal way.

Recommendations

The following overarching recommendations represent the areas of greatest need identified by participants in this needs assessment. These will be utilized as a starting place to develop short, intermediate, and long-term plans.

Service gaps, barriers and needs:

- Develop and pilot a forum whereby people with disabilities can meet and continue to dialogue about victimization issues and provide ongoing input to SafePlace and Advocacy, Inc. for increasing service access to survivors with a range of disabilities.
- Prioritize and address physical and attitudinal accessibility concerns within SafePlace that were identified by needs assessment participants.

Building internal capacity:

- Develop and pilot a protocol within Advocacy, Inc. for screening for domestic/sexual/caregiver violence, responding sensitively, and making effective referrals.
- Create, pilot, and implement a simplified intake process within SafePlace to increase accessibility for persons with limited reading skills.
- Expand program evaluation activities within SafePlace to gather information from clients with disabilities to assess service effectiveness and use this data to continuously make service improvements.
- Develop and institutionalize training for all new SafePlace employees on sensitively working with clients with disabilities and ensure that comprehensive consultation and technical assistance is available for direct service staff when working with clients with disabilities.

- Implement strategies for increased website accessibility for Advocacy, Inc. and SafePlace.
- Develop and seek board approval for a domestic violence in the workplace policy for Advocacy, Inc.

Sustaining outreach and services:

- Develop and implement a sustainable public awareness campaign targeting people with disabilities for increased visibility about the issue of abuse and SafePlace and Advocacy, Inc. as resources.
- Design a targeted recruitment plan to engage people with disabilities as volunteers within SafePlace (including, but not limited to, a Speakers Bureau, peer mentors, board member who has a disability).

Building collaborative responses

- Develop and institutionalize an MOU for service coordination between SafePlace and Advocacy, Inc. for work with abuse survivors who have disabilities.
- Expand collaboration to add on at least one additional local disability service provider partner interested in making systemic changes and/or service coordination to address abuse/violence against people with disabilities.

Appendix A

Focus Group and Key Informant Interview Questions

Advocacy, Inc. Focus Group Questions

Advocacy, Inc. Services

1. How do issues of domestic violence or sexual abuse/assault come to AI's attention? In the context of your work, what do you do when you suspect or learn that caregiver abuse, domestic violence or sexual assault has happened?

Possible Prompts: What agency procedures, protocols and policies are in place for responding to abuse? How could policies or procedures be added or expanded for responding to abuse?

What is working well currently? What service gaps or barriers have you identified? How could these problems be resolved or addresses?

2. What have been Advocacy, Inc. staff's experiences around obtaining protective orders for people with disabilities who have experienced caregiver or domestic violence or abuse in their homes?*

Possible Prompts: What problems have come up? How do you think these problems could be addressed?

3. What type of trainings, consultation, or resources would support Advocacy, Inc.'s staff for responding to caregiver abuse, domestic violence and sexual assault?

Outreach

4. Sometimes people with disabilities who are experiencing domestic violence, caregiver violence, rape or abuse do not reach out for help. What are your thoughts about this?

Possible Prompts: What would help people reach out for help if they've been abused? How could we better notify people with disabilities of available services?

5. What are your greatest concerns about domestic and caregiver violence and sexual assault committed against persons with disabilities?

Possible Prompts: What might prevent people from accessing services if they've experienced violence? What within your agency would help eliminate barriers and promote solutions?

Collaboration

6. How could you see disability advocacy and domestic violence / sexual assault agencies working together to address abuse against people with disabilities?

How could you see SafePlace and AI working together?

***These questions will be asked to assess needs for developing a Memorandum of Understanding between Advocacy, Inc. and SafePlace for cross-referrals and service coordination.**

Disability Service Providers Focus Group Questions

SafePlace Services

1. Sometimes people with disabilities who are experiencing domestic violence, rape or abuse do not reach out for help. Why do you think this is?

Possible Prompts: What would help people reach out for help if they've been abused? What training or policies/procedures could support you/other staff to talk about suspicions that you have that a client has been abused? What training or policies/procedures could support you/other staff to respond to clients who disclose abuse? What ideas do you have for reducing barriers? What do you think would support people with disabilities in requesting support/services related to abuse?

2. What advice do you have for reaching out to the disability community about domestic violence or sexual abuse or rape?

Possible Prompts: Where and how should the outreach take place? What type of messages should be included? What types of messages would support individuals with disabilities who have been sexually abused in asking for help?

Provider / Service Agencies

3. If a client told you that their partner or spouse was being abusive, what would you do?

Possible Prompts: What is already working well in your agency when clients report abuse? What do you think is needed to do better? Is there training or technical assistance you need in order to respond?

Collaboration

4. How do you see domestic violence, sexual assault and disability service providers working together to respond to abuse against people with disabilities?

Possible Prompts: What type of service coordination do you think needs to be developed? Would your agency be interested in talking in more depth about how changes could be made for recognizing and responding to abuse your clients?

SafePlace Staff
Individual Interview Questions

SafePlace Services

1. In general, what have been your program's experiences in working with clients who have disabilities?

Possible Prompts: What went well? What are the strengths we can build on? What hasn't gone so well or is challenging? How do you think the challenges (barriers or gaps) could be addressed? What are the areas that could use more support?

Provider / Service Agencies

2. From your experience, how are disability service agencies responding to people who have disabilities who are experiencing abuse/violence?

Possible Prompts: What are the problems you or clients have identified? How could disability service provider's responses be improved for people who have experienced abuse?

3. What types of legal issues came up when working with survivors with disabilities?*

Collaboration

4. How do you see disability service providers and domestic violence / sexual assault agencies working together to address abuse against people with disabilities?

Possible Prompts: What has it been like for you when you (or staff in your department) have tried to link clients with disabilities to other community resources? What kinds of collaboration or agreements could improve options for persons who have disabilities?*

Vision

5. What does your department need to make our work successful with people with disabilities?

What do you think our agency needs?

Possible Prompts: What about people with physical disabilities [intellectual or cognitive disabilities, mental illness, people who are blind]?

***These questions will be asked to assess needs for developing a Memorandum of Understanding between Advocacy, Inc. and SafePlace for cross-referrals and service coordination.**

SafePlace Direct Service Staff - Focus Group Questions

SafePlace Services

1. What are some of your experiences working with clients with disabilities?

Follow up questions: What is working well? What does not go so well?

Possible Prompts: When do you feel strongest in working with people with disabilities? What barriers do you come up against (internally or externally)? What changes would you make in the way we do things that might better support clients with disabilities? What improvements are needed to make sure services are more effective with clients who have disabilities? Any specific challenges with safety planning related to persons with disabilities being stalked?

2. What types of changes do we need to make internally to best serve the disability community?

Possible Prompt: Do you need information/training on different technology options for working with people with disabilities?

Provider / Service Agencies

3. What has it been like when you've tried to link clients to disability related services in the community?

Possible Prompts: If you could change one thing to improve services for clients with disabilities what would that be? How could we improve coordination of services with people with disabilities?

4. What have been the legal issues that came up in your work with survivors who have disabilities?*
5. What do you think is most important for other agencies to know when helping survivors who have disabilities and have been hurt by abuse?

Possible Prompts: How can other service providers improve their response to abuse against individuals who have disabilities?

Collaboration

6. Are there any kinds of training or consultation that would support your own work with clients who have disabilities?

Vision

7. What is your vision for how we can better serve survivors who have disabilities?

Possible Prompts: What approach should SafePlace use to coordinate services between disability services and other direct service programs? What do you need from the Disability Services department to make our work successful with the disability community?

***These questions will be asked to assess needs for developing a Memorandum of Understanding between Advocacy, Inc. and SafePlace for cross-referrals and service coordination.**

People with Disabilities Focus Group Questions

1. What are your thoughts about why people with disabilities may not reach out and ask for help if they've been abused?

Possible Prompts: What do you think persons with disabilities need in order to get help (services and supports) related to abuse? How can people with disabilities get this information?

2. What suggestions do you have for reaching out to people with disabilities about abuse?

Possible Prompts: What types of messages would support people who are abused to get help? What can SafePlace do to tell people with disabilities about our services?

3. What are important things that service providers need to know to help people with disabilities hurt by abuse?

Possible Prompts: What can disability service providers do? How can disability service providers create an environment that is more responsive to the needs of people who have been abused? What can SafePlace (victim service providers) do? How can SafePlace be more welcoming to people with disabilities?

4. What do you think can help people with disabilities being abused in institutions? What about people being abused in the community?

Possible Prompts: Do you think what they need is different or the same? What advice would you have about safety for someone who is leaving a state school or hospital and moving into the community? How can people get this information? What could help people with disabilities who are being abused (either in an institution or in the community)?

5. What kinds of information and training do staff in institutions and community based organizations need in relation to safety and abuse?

Appendix B

Consent for Participation in a Focus Group or Interview

Date: _____ **Focus group** or **Interview** (circle one) participant

I _____ (participant name) agree to be part of a focus group or individual interview and talk about ways that domestic violence and sexual assault services can be improved or made better with people who are D/deaf or people who have disabilities in Austin, Texas.

SafePlace and Advocacy, Inc. (AI) also want to make their services better and more available to any person with a disability or who is D/deaf by finding out what they could do differently.

I will be part of this project by answering questions in a small group of people (focus group) or by talking individually with someone from SafePlace or AI.

I know I will be answering questions about domestic, sexual, and caregiver abuse.

I am volunteering to participate in the focus group and interview and will be answering these questions.

I know that if I talk about abuse that is personally happening to me, the focus group leader may need to call Adult Protective Services (APS) and let them know about the abuse.

I can also make a report to APS about the abuse myself by calling the APS hotline at 1-800-252-5400.

If Adult Protective Services staff investigates or talks with me about the abuse-- they may offer me services. I have the right to refuse or accept those services or help. I understand that this is the law in Texas.

I can change my mind at any time about participating. I can also say "pass" if there is a question I do not want to answer. Even after the focus group or the interview starts, I can decide at any time to stop and leave.

If I decide to leave or 'pass' on any question, I will still receive compensation for my participation.

If I do stop answering questions or decide to leave, I can talk to a safe person at the focus group or interview. I can also still call Advocacy, Inc. or SafePlace if I need help with abuse. I also know that participation in a focus group or interview does not mean that I am a client of Advocacy, Inc. or SafePlace.

It is OK with me that a project person from SafePlace or AI will be taking notes on what everyone is talking about and the answers that everyone is giving. This person is taking notes to help project

staff remember the things we talked about until they can write a report with all of the information from everyone.

After the focus group / interview is over, SafePlace and Advocacy, Inc. are hoping to know more about what they can do to better serve people who are D/deaf or have disabilities and who have been abused.

I know the information I give will be put together with information from other people's comments and all of my comments and answers will be confidential.

This means that no one will be told that I gave any of the specific comments / information and no one will be told that I participated in the focus group or that I was interviewed.

I agree that I will keep confidential and not share names of individuals who participate in focus groups or information that other people who are in the focus groups share during the group, after leaving the focus group.

I know that SafePlace cannot guarantee that other people in the focus group will keep my name private, but everyone is being asked to keep each other's names private.

I can ask to meet with someone (a safe person) before, during, or after the focus group or interview to get support and information about where to find more support about anything hurtful or confusing that I thought about or felt during the focus group or interview.

If I have any worries or questions about the focus group or interview I can call _____ or write by email to: _____.

I _____ (my name)
agree to be part of this project called "Partnering to Increase Service Access" to help identify how SafePlace and Advocacy, Inc. can improve services in Austin for people who are D/deaf or have disabilities about issues and needs about domestic, sexual and caregiver violence and abuse.

Signature _____
(participant)

Date _____

I agree for the facilitators to contact me at the following telephone number or email address after the focus group or interview if they have any other questions.

Telephone: _____

Email address: _____

Appendix C

Tables of Results and Key Findings

The following issue areas were identified by participant groups:

1. Possible social, emotional and safety consequences for reaching out for help when abused
2. Transportation gaps, barriers and needs
3. Legal advocacy gaps and needs
4. Accessibility barriers
5. Gaps in and needs for education and training
6. Targeted outreach to the disability community
7. Coordination of services

People with Disabilities: Interviews	
Gaps, Barriers or Needs	According to Participant Group
Possible social, emotional and safety consequences for reaching out for help when abused	<ul style="list-style-type: none"> • Retaliation from family for violating family rules • Loss of financial resources • Shame, embarrassment – “People with disabilities who have lived in the community are held to a higher standard by service providers, expected to be perfect, not allowed to have mistakes.” • Don’t have a way to get help • Don’t have access to phone to get help • Escalating violence • Repercussions by the perpetrator • Loss of care provider • Blamed – “Fear that the counselor might say, <i>did you bring it on, wear clothes that would bring on the abuse?</i> I didn’t want them to look at me and say, <i>what did you do?</i>” • Feel judged • Loss of stability • May lose independence / right to self-determination • May have confidentiality broken • May be hit or injured by person they report to • May be killed • It’s hard to trust. • Will possibly be identified as the “person who got abused” • Won’t have anyone to tell • May not be other options • Staff might criticize. • Staff might break confidentiality. • Staff may violate trust. • Staff might contact the abuser. • Staff might add to the abuse. • Staff might ignore the problem. • People may not understand the extent of the abuse. • Staff might pretend to relate when they can’t. • “Scared of HIV/AIDS” • “For me, my caregiver was my abuser. I was worried that the bottom would fall out of my life.” • “Don’t want APS [involvement].”

People with Disabilities: Interviews	
Possible social, emotional and safety consequences for reaching out for help when abused (continued...)	<ul style="list-style-type: none"> • “[Might] mean a report on family members who may be perpetrating abuse. [Staff should] clarify under what circumstances the police, CPS, etc. are reported to.” • “It’s hard to say to someone that I need a type of care, what kinds [of care] I need. People may not be able to say <i>these are my needs. How can I attain them?</i>” • “Pets are important – I have cats and that was an issue too. I didn’t want to leave my cats.”
Transportation	<ul style="list-style-type: none"> • Lack of accessible, available transportation acts as a barrier to disclosure. • Service providers may not know about accessible transportation resources. • Service providers should work with SafePlace and provide accessible transportation for safety. • Speaking out about abuse might cause someone to lose their transportation.
Legal advocacy - gaps and needs	<ul style="list-style-type: none"> • None detailed
Accessibility barriers	<ul style="list-style-type: none"> • People with disabilities should be given time to arrive late, communicate with staff and still be able to participate in services at SafePlace. [Many people with disabilities do not have control over the forms of transportation available to them.] • Staff should meet clients ½ way into the building [in atrium]. • Materials should be available in alternate formats. • All areas of SafePlace should be accessible to people who use wheelchairs. • Intake process should put the person first and reflect the People First philosophy. • Use simple language, links to other pages and big bold wording on the website. • Highlight to new employees that we remove attitudinal barriers. • Be sure that individuals with disabilities are integrated (e.g., given their own space, space to move around freely but not secluded and accommodations as they need them). • Staff at SafePlace and should be more welcoming for people with disabilities by creating a space where people can watch movies, receptionists are nice, etc. • People with disabilities don’t always have access to a phone. • Time periods of service should be extended. • “I feel safe here because of that gate.” • “Address fear of reporting.” • “Let bring own caregiver to shelter.” • “Don’t make assumptions that someone who comes in a wheelchair is going to be nice.” • “Keep in mind that people [who has disabilities] may have bad days and if they’ve just had something happen to them they may be different. Be ready for that.”

People with Disabilities: Interviews	
Accessibility barriers (continued...)	<ul style="list-style-type: none"> • “Focus on the person, not disability.” • “No condescension.” • “Some people in wheelchairs may not want you to engage with them like they have a disability at all; because they are doing well and have the supports they need.” • “It may take a longer time for a person with a cognitive disability when explaining things, etc.” • “It’s important to regain their confidence – and that can be done in small conversations.” • “Stress that is a safe haven, and assure people that you are actually safe here: the fear is the person you are running away from.”
Gaps in and needs for education and training	<ul style="list-style-type: none"> • Disability service providers should know indicators, basic dynamics and long-term effects of abuse against people with disabilities. • Disability service providers should know that it’s not wrong to ask for help. • Disability service providers should know that there are a lot of different forms of abuse. • Disability service providers should know to offer services but don’t force someone to participate. • Service providers should know what resources are available in the community for survivors with disabilities. • Disability service provides should know basics of safety planning when the abuser is a caregiver, parent or a guardian. • Disability service providers should know when they are required to report to Adult Protective Services. • Train home health agencies. • Service providers need to give information about abuse to their clients. • Care providers should know to think outside of the box when it comes to thinking about abuse. • Care providers should know that verbal abuse is just as bad as physical. • Disability service providers Service providers should know to say “it’s not your fault. We want to help you. We want you to be ok.” • Educate people with disabilities that it [abuse] happens to a lot of people and there are counseling and support groups. • Educate people with disabilities on sexuality education. • Educate people with disabilities about boundaries, respect, what sexual assault is and risky behavior. • Educate people with disabilities so that they can stop it before it happens and recognize it if it happens.
Gaps in and needs for education and training (continued...)	

People with Disabilities: Interviews	
	<ul style="list-style-type: none"> • Educate people with disabilities and put the word out about sexual assault. • Train disability service providers to ask the [screening] questions for sexual assault. • Train the sheriff's office. • People may not come in because there may be an arrest. • Educate disability service providers that St. David's is the place to go if you're raped. • Educate care providers that it may take time for people to acknowledge abuse. • "Know that we didn't ask to be molested."
Targeted outreach to disability community	<ul style="list-style-type: none"> • Go to different agencies and talk to peer mentors. • Go to Alcoholics Anonymous and Narcotics Anonymous meetings. • Community is not aware that SafePlace serves people with disabilities. • People with disabilities may not be comfortable disclosing to disability service providers. • Brochures and materials should have people with disabilities in them. • Community does not know where SafePlace is located. • People should know that SafePlace covers all types of abuse (sexual assault). • Put flyers up in the community (bingo halls, doctor's offices, service providers, Wal-Mart, etc.). • "Think outside the box of victim service, non-profit, and disability services. ... <i>Think where aren't we.</i> There are people with disabilities who are experiencing abuse who may not identify as having disabilities or be connected in a service system." • Use the media. • Give out t-shirts with SafePlace logo. • Work with ADAPT and other disability community groups. • Contact Students with Disabilities offices at local colleges and universities. • Develop different brochures with different situations for people with cognitive disabilities. • Tell the community that SafePlace is accessible. • Tell the community the bus lines that someone can use to get to SafePlace. • Tell the community that there isn't a charge for services. • Tell the community if you provide attendant care services and what kind of services. • Give the hotline number out to service providers, including MHMR East 2nd Clinic. • Have a PSA specifically for people with cognitive disabilities. • Have brochures that talk about the difference between different forms of abuse. • Write a chapter in the DADS (Department of Aging and Disability Services) manual on abuse and reporting. • Partner with service providers and have them give SafePlace information at intake – universally.

People with Disabilities: Interviews	
Targeted outreach to disability community (continued...)	<ul style="list-style-type: none">• Get the word out – it may take time for the trust issue.• May be unsafe to outreach – may put people at greater risk.• Use media like newspaper, television etc.• Distribute letters community-wide that SafePlace works with people with disabilities.• Have a condensed pamphlet that says “this is what sexual assault is.”• Have a poster with someone who has been molested, raped etc.• Ask SafePlace clients at intake how they heard about SafePlace.• “[Host] open house and tour.”• “Share stories of people who got results. Would help to know how it can turn out.”• Distribute flyers to<ul style="list-style-type: none">○ Adult Protective Services (facility and in-home workers)○ The Arc of the Capital Area○ Austin Police Department○ Austin State Hospital○ Austin State School○ Capital Metro Transit○ Department of Assistive and Rehabilitative Services (DARS)○ Easter Seals○ Educare○ Empowerment Options○ Family Eldercare○ Home and Community Services (HCS) Group Homes○ Kenmar Residential○ MacBeth Recreation Center○ Marbridge○ Mary Lee Foundation○ Medical providers○ Travis County Sheriffs Department○ Rescare○ Volunteers of America

People with Disabilities: Interviews	
Coordination of services	<ul style="list-style-type: none"> • Have one contact person for incoming referrals to SafePlace from community. • Have a back-up for that staff person in case they aren't available. • People with disabilities are isolated, use peer mentor programs at SafePlace. • Have a direct line to a peer mentor on the hotline. • Offer services but don't force them on someone, ask for the individual's feedback. • Survivors may have to tell their stories to 3-4 different people. • Referrals to service providers should be current and active numbers/organizations. • ... "A lot of people will shy away from calling themselves, but if their case manager gets the ball rolling they feel more comfortable." • SafePlace staff should follow-up with survivors. • It's important to hold confidentiality. • Develop more of a partnership with APS. • Offer support groups. • Need to coordinate services with Easter Seals. • Need to coordinate with therapists in the area. • Need to partner with community organizations like the Chamber of Commerce. • Parents might have guardianship [which may compromise a person from accessing services]. • Staff may need to communicate in alternative ways such as email or text. • Communicate with clients that disclose sexual abuse that you have to report to Adult Protective Services. • MHMR needs the SafePlace crisis number. • "Encourage therapy and support groups, but keep in mind not everyone else is pro-therapy. Provide other options, like journaling, art, exercise." • "Include in the opening statement that we're here to help. <i>Let me help you get into the direction where you want to be.</i>"

People with Disabilities: Focus Groups	
Gaps, Barriers or Needs	According to Participant Group
Possible social, emotional and safety consequences for reaching out for help when abused	<ul style="list-style-type: none"> • Won't be believed • Fear • Will lose caregiver services • Lose independence / risk institutionalization • Lose financial resources • Social isolation • Retaliation • Shame, embarrassment • Poor self-esteem – "Some of us are so insecure that we feel we might deserve all of this." • No support from others • May have confidentiality broken • May be identified as a "victim" • "Not everyone feels comfortable at SafePlace" • Blame • Don't believe that things can be different • May not realize that something is abuse • "People will say that it's only a delusion and that it's not real" • "Many responders may believe that if (have a disability), you have no mental capacity. Abuser is there to say "they don't know what they're talking about." • "There is a lot of finger pointing at the victim." • "They need a place to live otherwise they'd end up on the streets. Talk to a wrong person by accident and then the perpetrator may find out." • "If you are reporting someone you need for survival; (fear that) I won't survive anymore." • "Don't want to get a bad reputation from attendants." • "It's a matter of how much you can put up with." • "Maybe the person [abuser] is at least paying attention to me and I want that."
Transportation	<ul style="list-style-type: none"> • Accessible transportation is needed overnight for people trying to get into SafePlace services. • Getting adaptive equipment to SafePlace is the main concern. • "If I need my equipment, I don't want to wait 15-24 hours." • Southeast Austin, where SafePlace is located, isn't accessible – another meeting place may be needed.

People with Disabilities: Focus Groups	
Transportation (continued...)	<ul style="list-style-type: none"> • Call Blair Spikes and he can work with the police to get an accessible bus. • There are only 3-4 accessible cabs in Austin.
Legal Advocacy – gaps and needs	<ul style="list-style-type: none"> • “Staff in group homes has been touching people with disabilities and that’s wrong.”
Accessibility barriers	<ul style="list-style-type: none"> • People with disabilities don’t always have access to a telephone to call for help. • Lack of roll-in showers • Wider doors (36” and 42”) • Need help emptying leg bags • SafePlace staff needs training on disability etiquette and general disability information. • Staff attitudes toward people with disabilities are important. • “Attention to physical barriers like boxes.” • “Patience with speech differences.” • “Not presume what needs are: I use a wheelchair but can use a bathtub but staff needs to ask and not presume.” • “Respect: make sure that staff don’t talk down to people with disabilities.” • “Not look at the disability as the cause – mirror back to person that you know that the disability is not the reason for the abuse.”
Gaps in and needs for education and training	<ul style="list-style-type: none"> • Teach people with disabilities they can be independent. • Teach people with disabilities that it’s ok to ask for help. • Care providers need to know what abuse is, the forms it can take. • Victim services staff needs to know how to support people who talk with supportive devices. • Disability service providers need to do a better job of screening their new employees. • Train disability service staff on boundaries. • Staff should know the long term effects of rape. • Allow the time needed to process the emotion and not just communicate [staff need training on responding to disclosure]. • Disability service providers [e.g., case managers, counselors, etc.] should screen for abuse by separating the individual from other people. • SafePlace staff should have some general knowledge of disability. • The importance of education [for people for disabilities] should be stressed: it’s important to know 1) what abuse is 2) that it can happen to you and 3) how to ask for help. • “I’d like to come back again and be with other people with disabilities about this [talking about abuse].”
Gaps in and needs for education and	

People with Disabilities: Focus Groups	
training (continued...)	<ul style="list-style-type: none"> • “If we could have a small group of disabled people get together about abuse that would be great.” • “I’d like to do anything that would help SafePlace, like this group.” • “Could we have a weekly ongoing group about this? For people with disabilities.” • “If there’s anything you do after this, could I be a part of it? Is there anything I could do?” • “[Knowledge of trauma] If you’ve been raped, that that type of stuff carries throughout your whole life and this might lead to a mental illness.” • “If disabled from birth – they may not know they’ve been sexually abused.” • [Service providers should have] sensitivity to the possibility that there could be abuse and to recognize the signs that abuse is happening. The person might not identify certain things as abuse – especially if that’s what they have grown up with.” • “I wouldn’t want them to call [APS] without letting me know.” • [teach people with disabilities] “You don’t deserve any abuse. It’s not your fault.” • “Give people language. If this is a group about empowerment – I’m gonna give you some ways to take action. You are something special and you can deal with this.” • “It’s awful and embarrassing. I didn’t know what to say as a friend and a person.” • “Probably what brought them here is probably a lot of other stuff like abuse in the past and more than that – the person probably already felt like they were victimized from past experiences.”
Targeted outreach to disability community	<ul style="list-style-type: none"> • SafePlace could have a booth at disability service provider events and go to job fairs. • Tell the community specifically about the Disability Services program. • Get the word out that rape, sexual abuse really does happen. • Have survivors speak out about sexual assault in the disability community. • Educate the public about people with disabilities, abuse. <p>Medical and disability service providers:</p> <ul style="list-style-type: none"> • Get information about services to Home Health Agencies, visiting nurse agencies and other attendant care providers. • Work with DME providers and have SafePlace hotline listed on the emergency number sticker on the equipment. • Doctors and therapists need to know that SafePlace works with people with disabilities. • Get the information out to stores – the general community. • Service provider staff needs to be reassured that SafePlace will be a welcoming place. • “People in public need to be educated. They have made comments about how we (should) be in institutions.”

People with Disabilities: Focus Groups	
Targeted outreach to disability community (continued...)	<p>Media and materials:</p> <ul style="list-style-type: none"> • Have TV stations donate air time to get the word out. • SafePlace could use a linkd-in account. • Have people with disabilities in ads. • SafePlace could advertise in newsletters / New Mobility, etc. • Make a commercial – sexual assault in the disability community. • Include the international sign of disability on your website. • Have a little wallet card with SafePlace’s information on it. <p>Email lists</p> <ul style="list-style-type: none"> • SafePlace could send emails out through community email lists. • ADAPT e-mail list • Outreach groups: • Different cultural groups (different groups identify abuse differently) <p>12 step groups</p> <ul style="list-style-type: none"> • Churches • Elderly people with disabilities • Gay and lesbian community • Students with disabilities offices at ACC, UT and St. Edwards • Consumer groups
Coordination of services	<ul style="list-style-type: none"> • Have one contact person at SafePlace for referrals from other agencies. • Have a weekly, ongoing support group for survivors with disabilities. • Service providers should have a place where the client can identify preferences for attendants and types of care. • SafePlace staff should communicate with disability service providers when clients with disabilities are not “appropriate” for group – to ensure they are still engaged in services. • Work with Travis Medical, they are responsive. • Have a resource person with one of the attendant care agencies. • SafePlace should provide a helper in shelter, and in community. • “Wait to get at what the person is saying. It’s hard to disclose.” • [attendant abuse] “I’ve experienced more abuse for attendants than anyone else.” • [attendant abuse] “When you have someone else take care of you all kinds of things happen. It’s scary you don’t know who is going to come into your house.” • “I want to hear about what other people have been through.”

SafePlace Direct Services Staff	
Gaps, Barriers or Needs	According to Participant Group
Possible social, emotional and safety consequences for reaching out for help when abused	<ul style="list-style-type: none"> • Stigma in society – “The stigma and myths associated with people in group homes keep people from being able to pursue the services.” • No access to financial resources, payee • Isolation
Transportation	<ul style="list-style-type: none"> • Transportation is a barrier. • “A number of people who need the counseling at Austin State School but they can’t get them here, or they won’t.”
Legal advocacy – gaps and needs	<ul style="list-style-type: none"> • A lot of the burden to pursue services lies with the survivor. • “Can AI attorneys help with people who apply for SSDI? To change payee?” • [Can AI help with] housing discrimination against individuals with disabilities? • [Can AI help with] custody – Child Protective Services involvement with parents who have disabilities? • [Can AI help with] CPS mandated plans requiring survivor with mental health disability to take medication? • Sexual Assault as a form of family violence in group homes is a nexus for Advocacy, Inc. • AI could help with parents who have cognitive disabilities who are completing a mandated CPS plan. • AI attorneys need extensive training on survivor issues. • [Can AI help with] “Getting fired, losing SSDI?” • Need one page document that talks about what AI does/doesn’t do. • Need help for people who have severe disabilities. • “Agreement that Advocacy, Inc. would be called if someone showed up at the hospital.” • [Can AI help with] “Texas Rural Legal Aid (TRLA): Family law cases of people who have bipolar disorder or who have schizophrenia because they are too intense, beyond the worker’s ability to cope.”
Accessibility barriers	<ul style="list-style-type: none"> • “The walk-in group orientations have not gone well for people with disabilities (specifically people with cognitive disabilities).” • Walk-in group orientations stigmatize survivors with cognitive disabilities. • Paperwork (intake) is not accessible to individuals with disabilities. • “My client who uses a wheelchair got caught in the glass door in reception area.”

SafePlace Direct Services Staff	
Accessibility barriers (continued...)	<ul style="list-style-type: none"> • Bathroom door is inaccessible for person attempting to open the door (reception area bathroom). • Parenting classes are not accessible for people with disabilities. • SafePlace support groups are not accessible for people who use communication devices. • Counseling offices are upstairs at the shelter. • The walk-in gate [to shelter] doesn't have a ramp. • The walk-in gate system is difficult to use / understand. • Not having enough personnel is a barrier. • Group home residents can be put onto the waiting list but may not be able to call back. • "Clients with hidden disabilities come in and staff thinks they [clients] are resistant, interpret it as defiance, not disability." • "[Staff need to] support people with disabilities in expressing themselves sometimes in alternative ways (through stories, playing games, having a less typical way of expressing themselves)." • "[There used to be] a policy of doing long term work and extending deadlines for people with disabilities."
Gaps in and needs for education and training	<ul style="list-style-type: none"> • Staff feel overwhelmed or intimidated by working with people with disabilities. • Client with PTSD was intimidating. • Disability service systems have changed and staff need updated information about what resources are available (DARS, DADS, etc.). • SafePlace staff is not sensitive to hidden disabilities. • Information on what Disability Services program at SafePlace can offer • Information on Family Medical Leave Act (FMLA) • Need to know resources available in the community for survivors with disabilities. • Applying the ADA to SafePlace's work with clients • Staff need training on working with individuals who have mental health disabilities including what is it, what does it look like and how does it affect the person. • How to prioritize one client's needs over another when one has mental illness. • Our staff needs to know the ways that disability manifests itself in interactions with staff. • Group home staff needs information on basic dynamics of violence and indicators of abuse. • Our staff needs general familiarity, comfort and sensitivity in working with individuals who have disabilities. • Mental illness and substance abuse issues come up all the time. • "We need guidance on identifying levels of disability we don't serve here."

SafePlace Direct Services Staff	
Gaps in and needs for education and training (continued...)	<ul style="list-style-type: none"> • “We need information on where to get support if client is draining staff.” • “We don’t know how much information to give other residents about someone else’s disability.” • “Training on where to funnel a client whose needs are too great for our services” • Better training for Mental Health Officers at domestic violence scene • Training for SafePlace staff on working with children with disabilities • Overview of accessibility issues for SafePlace staff for visually impaired, Deaf etc. • SafePlace staff would like training on how Austin Police Department makes decisions about the outcomes (jail, state hospital, etc.) of a domestic violence call when the survivor has a disability (especially mental illness). • Train Sexual Assault advocates on responding to survivors with mental illness. • Have internal classes for people with disabilities on empowerment and healthy relationships. • Incorporate Disability Services trainings into agency wide advocate meetings (last Friday of every month). • “There is a lot more sensitivity training as an entire shelter staff that we could do.”
Targeted outreach to disability community	<ul style="list-style-type: none"> • People who live in group homes are assaulted and underserved by SafePlace. • People with profound disabilities requesting services are low. <p>Places for outreach:</p> <ul style="list-style-type: none"> ○ Advocacy, Inc. ○ AIDS Services of Austin ○ Any Baby Can ○ APS (Adult Protective Services) ○ ARCIL (Austin Resource Center for Independent Living) ○ David Powell Clinic ○ Easter Seals ○ Family Eldercare ○ OSAR (Outreach, Screening, Assessment and Referral) – Bluebonnet Trails MHMR ○ PES (Psychiatric Emergency Services) ○ Social Security Offices
Coordination of services	<ul style="list-style-type: none"> • “Have someone on staff that you could go to and say <i>I have a client with these issues, can you give me suggestions and/or background on this disability, etc.</i> When we need info, need someone NOW who can help us.” • [St. David’s hospital should be held accountable for calling a social worker as support for a

SafePlace Direct Services Staff	
Coordination of services (continued...)	<p>sexual assault survivor with mental health needs, rather than expecting the sexual assault accompaniment staff or volunteer to provide mental health services.]</p> <ul style="list-style-type: none"> • Interfacing with other agencies (e.g. Austin State School) is difficult. • CPS does not make accessibility accommodations / modifications for clients with communication devices [don't know if this is an isolated case or practice]. • Have a SafePlace specific MHMR liaison. • There isn't a question on the project options registration form re disability. • Need to know how to access emergency and routine mental health services for clients • Difficult to find therapists for survivors who accept Medicaid, Medicare. • External referrals to other agencies have long waiting lists. • SafePlace needs an on-site or on-staff psychiatrist. • More opportunities for face-to-face contact, introductions with other service providers • Need contact person at other agencies to streamline referrals to those agencies. • We need an actual person for technical assistance at Advocacy, Inc. • Internal services (within SafePlace) are not known by staff who works with survivors with disabilities. • Need Mental Health Officers to come to SafePlace and provide training about their protocol and criteria for making an emergency in-patient commitment for psychiatric services. • Need a cheat sheet on SafePlace's server with disability service providers, their mission and services, and how to refer. • Partner with Austin Police Department to have "critical conversations" with detectives. • Have a resource guide on the (internal) server. • "Shelter isn't referring clients with disabilities for transitional housing who are needing more support and could be successful at SHP [Supportive Housing Program]."

Advocacy, Inc. Staff	
Gaps, Needs and Barriers	According to Participant Group
Possible social, emotional and safety consequences for reaching out for help when abused	<ul style="list-style-type: none"> • Lose financial stability • There are limited services available and then less will be provided if someone speaks out about abuse – “In MHMR system, bringing up issues of abuse would mean that the consumer would be jeopardizing the other services/counseling that they need.” • Relocation may be necessary • Restraint used • There may be media accounts of the experience • Investigation • May need protective order • Institutionalization • “If [the person] is in facility or institution for a long time... no hope and increased danger.” • Violence escalates when there’s an investigation.
Transportation	<ul style="list-style-type: none"> • Partnering with Medicaid (and Greyhound bus system program) may provide relationship needed to increase access to accessible transportation.
Legal advocacy – gaps and needs	<ul style="list-style-type: none"> • Only assisted with one protective order since priority area was changed to include domestic violence cases.
Accessibility barriers	<ul style="list-style-type: none"> • AI and SafePlace could partner to develop policies/procedures for programs to support people in institutions who may not have access to email/phone and yet need to pursue services. • SafePlace and AI could address the needs of people to have caregiver services in shelter. • SafePlace needs to be accessible to men with disabilities. • “SafePlace response needs to be good if someone with a disability calls and requests services.” • “Lack of returned calls from SafePlace to Advocacy, Inc. clients and AI staff. I never heard back from anyone I tried to call (at SafePlace). She got lost in the system.”
Gaps in and needs for education and training Gaps in and needs for education and training (continued...)	<ul style="list-style-type: none"> • Physical violence is more readily identified compared to sexual assault – “More DV than sexual abuse. SA still happens, just more barriers to disclosure and also because physical and other forms of violence are more evident.” • Staff with allegations made against them (in institutions) are put on paid leave during

Advocacy, Inc. Staff	
	<p>investigation.</p> <ul style="list-style-type: none"> • Sometimes consensual sexual activity between clients is seen as abuse. • Sometimes people with developmental disabilities are prosecuted as offenders when it's their responses to sexual abuse that causes the acting out behaviors. • AI staff should focus on validating the individual whether APS determines [a case is] founded or not. • AI staff needs to know what resources are available if the case is unfounded. • Need to know how to give emotional validation to survivors. • Need to know how to refer clients with domestic / sexual violence issues to healing resources such as local Domestic Violence program • Need to know what SafePlace can do, has done. • Information on what the important parts of assessments are (not so AI can do them but so they can ensure clients get what they need) • Previous training offered to AI staff by SafePlace staff was helpful. • Intake and managers need more information on domestic violence and sexual assault. • First responders need to be educated on domestic violence. • Intake workers need information about how and when to ask about abuse. • "AI staff needs to know what to do if a person makes an allegation against them (AI staff). How should staff respond to the person? How can staff deal with the personal impact of having an allegation made? These allegations happen because someone has been abused in the past by care providers but not by AI staff but it gets carried over." • AI needs to make the SafePlace fact sheets available on the AI intranet. • "SafePlace could educate AI staff on what to do if people call for help." • "In an institutional setting, people who make allegations that result in unfounded [cases] are punished with restricted access to the telephone because the person is seen as threatening or as a problem to staff." • "MHMR staff not adequately trained to identify or document or adequately treat people who have been hospitalized and have a trauma history."
<p>Targeted outreach to disability community</p> <p>Targeted outreach to the disability community (continued...)</p>	<ul style="list-style-type: none"> • Expand use of posters. • AI caseworkers could have a card and distribute in the field. • Make education about abuse part of the (30-45 day) transition plan when clients leave institutions. • AI could follow-up after transition, screen for abuse [and refer]. • Intake workers could screen for abuse. • SafePlace and AI could work with the Centers for Independent Living to get the word out

Advocacy, Inc. Staff	
	<p>about abuse.</p> <ul style="list-style-type: none"> • Outreach through local Social Security and Medicaid offices.
Coordination of services	<ul style="list-style-type: none"> • “We only have contact once and you don’t have much time to establish rapport.” • There is no formal policy in place (other than mandatory reporting and reporting to managers) to report and respond to abuse. • In state school system, AI staff might need to provide direct intervention. • “Restraint often acts as a cloak for caregivers to abuse a consumer.” • Sometimes AI develops a safety plan but not a lot of outside resources will help. • Reach out to institutional treatment teams and ensure trauma-informed care is provided. • Need help to institute a seclusion and restraint policy. • AI staff doesn’t have a lot of feedback about referrals of clients to DV programs. • SafePlace needs to work with AI to do assessments of people with disabilities including their trauma history. • AI and SafePlace could partner on the Developmental Disabilities Council initiative on healthy relationships. • AI and SafePlace could begin to institute education about healthy relationships during deinstitutionalization. • Advocacy, Inc. and SafePlace could develop a data system to review trends and patterns of allegations of abuse (DV/SA). • SafePlace and AI can promote independence training by talking with disability services staff about how to identify abuse, how to report. • SafePlace, AI and Adult Protective Services can work with APS investigators so that stronger cases are made when abuse is perpetrated against individuals with cognitive disabilities. • Advocacy, Inc. and SafePlace could have an agreement for a supervised referral process after intake workers screen callers – with one contact person (in order to streamline the referral process). Could include: <ul style="list-style-type: none"> ○ “3-way call” ○ “Releases to share information” ○ “Screening question for abuse [to use] with callers” ○ “Provide information back and forth about services. (For instance, AI staff needs to know about attendant care, length of shelter stay, etc.)” • ICF/MR allegations are processed differently than other allegations.. • Referring cases to APS has not been helpful. • No support in place for AI staff to explore the legal/ethical obligations of reporting abuse
Coordination of services (continued...)	

Advocacy, Inc. Staff	
	<ul style="list-style-type: none">• Need to work with SafePlace to intervene when the treatment milieu has been jeopardized• Need to work with SafePlace to more effectively work with MHMR• AI staff could have more detailed conversations to support and increase the work that is done.• Develop a formalized safety plan to be used during transition planning when working with an individuals moving out of an institution.• Advocacy, Inc. and SafePlace could partner with APS to provide training on how to interview individuals with disabilities.• Train AI staff on the education and housing needs that SafePlace can provide.• Have a community integration project available for SafePlace [rather than traditional intake process].• “[AI] is well known for the rights issues, but people don’t come to us for abuse; don’t see us as someone who could be helpful in that way.”

Disability Service Providers	
Gaps, Barriers or Needs	According to Participant Group
Possible social, emotional and safety consequences for reaching out for help when abused	<ul style="list-style-type: none"> • Lose services • Not be believed – “If you have paranoia, used to not being believed because of your history of delusions.” • Guilt • Low self-esteem • Bad experience attempting to call SafePlace for help • Disruption in level of care if abuser is caregiver • Reprisal • Lose one of few relationships • Won’t have the same voracity • Shame • Stigmatization • May not know who they can transition to • Lack of control over their lives • Abuser may control medication, access to food, access to toileting and personal hygiene • Retaliation • No network to get emergency support • Person can’t verbally disclose the abuse • May not consider SafePlace a resource • The power differential [stronger level of dependency] may prevent disclosure • No confirmation from society about the person’s value • Even if it’s abuse – there’s a level of comfort • May not believe that they deserve a healthy relationship • May have limited mobility • Person may not see that they have a right to ask for help • “If you’re living with the abuser and you report, you’ll be on the street.” • “If I fire my attendant, who will help me get to bed?” [according to a service provider with a disability] • “To report that would jeopardize what little social interaction you do have.” • “Social isolation and lack of human contact is pervasive.”
Transportation	<ul style="list-style-type: none"> • None detailed

Disability Service Providers	
Legal advocacy – gaps and needs	<ul style="list-style-type: none"> • None detailed
Accessibility barriers	<ul style="list-style-type: none"> • SafePlace workers [hotline] could use a script when denying services so the same answer is given in a way that allows a person to understand what is happening. “One client’s reaction was, <i>See, I told you they can’t help me.</i>” • Some people with disabilities don’t have access to phones to call for help. • The shelter is often full. • People with disabilities need to know how to get to SafePlace and how to physically enter the premises. • The latch on the walk-in gate (in front of resource) is too high for someone who uses a wheelchair. • The secrecy of SafePlace is a barrier. • Clients should be able to bring their case managers with them to SafePlace. • “Communication disabilities can be exacerbated with stress.”
Gaps in and needs for education and training	<ul style="list-style-type: none"> • Hotline workers at SafePlace need information on working with people with cognitive disabilities. • Hotline workers are sometimes terse with callers. • First responders need education on violence against individuals with disabilities.. • Home health agencies need training on when to report abuse. • Austin Travis County Mental Health Mental Retardation (ATCHMHMR) and BlueBonnet Trails require training and SafePlace could be integrated into those trainings. • Adult Protective Services workers on the facility side need to know more about rape, molestation and the rape exam protocol. • Training on the link between employment, domestic and caregiver violence along with PTSD symptoms needs to be provided to the community service providers. • Home and Community-based Services (HCS) programs need information on signs and indicators of abuse. • Disability service providers need information on how to keep themselves safe if they enter someone’s home. • Service providers need information on what to do if there’s an allegation made against them. • Build opportunities for social interaction and build self-esteem. • Train Austin Police Department during their 2 year recertification or 40 hour Crisis Intervention Team trainings. • Train MHMR staff during the yearly training day.

Disability Service Providers	
Gaps in and needs for education and training (continued...)	<ul style="list-style-type: none"> • Incorporate education into existing programs. • Train MHMR unit managers on SafePlace services and present on domestic/sexual/caregiver abuse at MHMR new workers training. • Train APS workers on how to tailor their services to people with specific disabilities. • Provide concrete examples and opportunity to practice if someone discloses. • “Train people with disabilities to train their peers.” • Agencies need education on abuse against individuals with disabilities: <ul style="list-style-type: none"> ○ Adult Protective Services ○ The Arc of the Capital Area ○ ATCMHMR (Austin Travis County Mental Health Mental Retardation) ○ Austin State Hospital ○ Austin State School ○ Capital Metro Transit ○ Department of Assistive and Rehabilitative Services (DARS) ○ Easter Seals ○ Educare ○ Empowerment Options ○ Family Eldercare ○ HCS Group Homes ○ Kenmar Residential ○ Marbridge ○ Mary Lee Foundation ○ MacBeth Recreation Center ○ Medical Providers ○ ResCare ○ Volunteers of America
Targeted outreach to disability community	<ul style="list-style-type: none"> • Increase knowledge of SafePlace services in the community. • People need to know that SafePlace serves people with disabilities. • Relationships with at-risk communities (East 2nd clinic) need to be built. • SafePlace representation in places other than day programs • Cap Metro drivers need information regarding abuse. • Have SafePlace business cards available on the buses (including Para transit). • Get free or discounted placards for the buses. • Day program participants need education on violence. • Adult Protective Services workers need to know how to access SafePlace services.

Disability Service Providers	
Targeted outreach to disability community (continued...)	<ul style="list-style-type: none"> • Information on 211 needs to be updated. • Send out information on email lists in Austin. • Don't ask people to come to SafePlace for programs, go to agencies. • Materials need to be available in simple language and Spanish. • Use Public Access TV. • Larger classes can increase comfort. • Educate local service providers on the services that SafePlace can offer people with disabilities. • Need to be high profile in news, commercials, TV and radio. • There is an attendant network on the internet. • Awareness of the issue of abuse, when to report, who to report, how to report needs to be increased and can be addressed by Goodwill and SafePlace together. • Marbridge participates in the Community Action Network (see below). • Use the logo as an icon in case people can't read. • Have a presence at health and disability fairs. • Business cards for MHMR caseworkers could help get the word out. • Present at consumer groups (Cap Metro has a list). • Provide a 20 minute in-service every 6 weeks at MHMR brown bag meetings. • Contact private Medicaid waiver programs and use payers to mandate trainings. • Get the word out about SafePlace services through respite care providers. • Go to agencies and do in-service presentations on SafePlace services. • SafePlace could use devoted time mandated by [Federal Communications Commission] FCC for [Public Service Announcement] PSA. • Engage people with disabilities into SafePlace events such as the SafePlace walk. • Tailor the classes to the audiences you are providing them to. • Have your programs build self-esteem. • Have an outreach person refer to more resources. • Coordinate with Cap Metro to do outreach to the community. • Target people through the Austin Mayor's Committee for people with disabilities. • Outreach through the upcoming ADA celebration. • MHMR could institute a screen saver that SP works with sexual assault survivors.
Coordination of services	<ul style="list-style-type: none"> • Peer support could help with emotional, social and safety consequences of speaking out. • In partnering, need to focus on prevention because intervention is not effective. • Disability services direct care workers who have allegations/proven abuse are free to go to

Disability Service Providers	
Coordination of services (continued....)	<p>other providers and work.</p> <ul style="list-style-type: none"> • MHMR has a consumer abuse and neglect reporting system separate from criminal system. • The Developmental Disabilities Planning Partnership of the Community Action Network meets 3rd Thursday of every other month. • The reporting process to Adult Protective Services needs to be streamlined. • Need a contact person at SafePlace to streamline the referral process from external agencies. • A team approach to respond supportively to the survivor could help support staff of service providers. • Travis County Health and Human Services has a variety of services. • Allow clients to bring their case managers with them to SafePlace. • Develop a SafePlace community voice mail to receive requests for services and follow-up with people who don't have access to phones. • SafePlace staff can go to East 2nd Clinic and there's opportunity for cross-referral with MHMR and ADAPT. • Build relationships with agencies to increase response to disclosures after educational programs are provided. • Train disability service providers on how to inquire about abuse and respond to disclosures. • "Don't ask people to come to SafePlace because people will think, I'm a victim. Why have I been singled out?" • "A lot of people with disabilities are phone dependent would be more comfortable talking with someone over the phone, they wouldn't feel as threatened."

SafePlace Leadership	
Gaps, Barriers or Needs	According to Participant Group
Possible social, emotional and safety consequences for reaching out for help when abused	<ul style="list-style-type: none"> • None detailed
Transportation	<ul style="list-style-type: none"> • None detailed
Legal advocacy – gaps and needs	<ul style="list-style-type: none"> • “Having to change payee is an issue that comes up.” • Problems with guardianship • Child custody battles linked to disability
Accessibility barriers	<ul style="list-style-type: none"> • “We try to get the information on the hotline but survivors may not disclose their disability.” • When residents arrive to shelter, we may not know what they need re their disability. • “Survivors in shelter have kept “watch” over other resident who was suicidal (this keeps people from working on their own stuff).” • No Braille signage is available for people who are blind. • Sometimes have to move clients around when someone needs one of the accessible rooms. • Don’t have staff to help with physical needs, other residents help. • People with cognitive disabilities don’t always work well in shelter (bored, neglected). • Need a person to be with people with cognitive disabilities to help with cooking etc. • People with brain injury/seizure sometimes get targeted by other residents because they have a difficult time regulating interactions. • Residents need to access wheelchairs 4-5 times / year. • Intake process is cumbersome and overwhelming for people with cognitive disabilities. • Some staff has biases against individuals with mental health disabilities and substance abuse issues. • Police push survivors with substance abuse issues or mental health disabilities. • Police do not respond well to survivors in mental health crisis. • Staff spent more time giving physical help than to clients without disabilities. • Buzzer system isn’t accessible. • Pulling the door out isn’t accessible to people who are blind. • It’s hard for people with disabilities to live in a communal environment. • Sometimes need to write not to Deaf individual and this is “low tech.”

SafePlace Leadership	
Accessibility barriers (continued...)	<ul style="list-style-type: none"> • “Sometimes needs exceed what we can do but philosophy says we go extra mile. Leadership demands we do. There are no excuses find out what you need and do it.” • “Don’t screen out anymore. There’s definitely been a philosophical shift since 2001 when we moved into the new shelter.” • “Been helpful to work with supervisors to move away from the idea that we need to protect people with disabilities.” • “We’ve also moved from a goal for controlling the environment to a model where we are working with prevention and then responding to problems as they come up.” • “[Some staff] just can’t get past their own values.” Some suggestions are: <ul style="list-style-type: none"> ○ Hire folks knowledgeable and willing to think outside the box. ○ Training ○ Leadership ○ Meet needs as they come up. ○ Allow folks time in supervision to talk about what came up. ○ [We are] comfortable going to Disability Services. ○ The informal chatting ○ “It’s most helpful to be able to contact someone from [Disability Services] program to be able to present a scenario and then ask for help. Is there a way to put something more formal in place for this?” ○ “If there was a way to feed information and resources to all of our advocates and case managers. They could keep that information and pull it up when they need it.”
Gaps in and needs for education and training	<ul style="list-style-type: none"> • “Staff are fearful of people who have seizures – [could there be] technology that could alert us when someone needs help regarding a seizure?” • Calls on the hotline when the person has substance abuse issue are difficult for workers. • Staff need information and resources about: <ul style="list-style-type: none"> ○ Disabilities themselves ○ Accessible housing ○ Resources and supports available in the community
Targeted outreach to disability community	<ul style="list-style-type: none"> • None detailed
Coordination of services	<ul style="list-style-type: none"> • There are long wait periods for clients with mental health disabilities who pursue services from Austin Travis County Mental Health Mental Retardation (ATCMHMR). • It takes months to get help from Home and Community-based Services (HCS).

SafePlace Leadership	
Coordination of services (continued...)	<ul style="list-style-type: none">• Staff is willing to go to Disability Services staff for help.• Need a connection in the community for individuals with disabilities who leave shelter but don't return to their families.• APS workers close case because person is in shelter.• APS workers don't help to develop safety plans for the clients.• Staff spends more time finding resources for clients with disabilities.• Had to call Austin State Hospital twice for intervention.