

Strengths and Needs Assessment Report

from the State of Idaho

**Idaho Equal Access
Collaborative**

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Section 1 Overview of IEAC Collaboration and Project

Collaboration

In October 2006 the State Independent Living Council received a three-year cooperative agreement, entitled the *Educational and Technical Assistance Grant to End Violence Against Women with Disabilities*, from the Department of Justice, Office on Violence Against Women, to examine and propose changes to the systems responding to women with disabilities who experience sexual and domestic violence.

The State Independent Living Council (SILC), which is Idaho's only gubernatorial advocacy organization run by and for people with disabilities, then formed a project team. The project team was comprised of the Idaho Coalition Against Sexual and Domestic Violence—the State's largest umbrella organization of domestic violence/sexual assault (dv/sa) service providers and, Boise State University Gender Studies Program—Idaho's largest university, nationally recognized for its work in public policy, research, and service. Together, these three organizations formed the Idaho Equal Access Collaborative (IEAC) and began the Planning Phase of the grant project.

The mission of the Idaho Equal Access Collaborative (IEAC) is to promote attitudinal and systemic change to achieve equal access to services for all women with disabilities who are seeking safety and protection from sexual assault and/or domestic violence through the collaborative efforts of Domestic Violence, Sexual Assault, and Disability organizations.

It is the vision of the Idaho Equal Access Collaborative (IEAC) that any victim, regardless of ability, has equal access to the comprehensive services the individual chooses, no matter where the individual accesses the integrated network of service.

Overview of Project Planning Phase

During the first six months of the planning phase, the IEAC worked collaboratively to develop the scope and goals of the project. As part of this process, the IEAC selected three Idaho pilot sites, six pilot site partners, and developed two guiding documents: the Collaboration Charter and the Strengths and Needs Assessment Plan.

Selection of the Pilot Sites: As established by the cooperative agreement between the IEAC partners and the Office on Violence Against Women, this cooperative agreement funding must be used to create attitudinal and systemic change within the collaborating IEAC partners, as well as in the three selected Idaho pilot site communities. To meet these objectives, the IEAC commenced selection of its Idaho pilot sites, which would work closely with the IEAC to achieve the goal of enhancing the services available to women with disabilities who have experienced domestic or sexual violence. The IEAC identified criteria for selecting pilot sites. Based on those criteria, three sites in Idaho—Coeur d'Alene, Rexburg, and Nampa—best met the selected criteria (*Selection of the pilot site communities is described in Section 2.*)

Selection of Pilot Site Partners: At each of the three pilot sites, the IEAC selected one disability and one domestic violence/sexual assault service provider to collaboratively work together to

create attitudinal and systemic change within and between their own organizations. The selection was based on pre-existing relationships, previous collaborative work, willingness to build on pre-existing relationships, and community demographics. The IEAC assisted by providing technical assistance, support and information as needed to the pilot site communities. (*Selection of the pilot site communities and an overview of those communities are described in Section 2.*)

Collaboration Charter: The IEAC worked extensively to develop a collaboration charter. The collaboration charter describes the IEAC's mission, vision, guiding principles, roles and responsibilities of each collaborative partner, decision making and dispute resolution protocols, policies pertaining to internal and external communications, and a media plan. The IEAC Collaboration Charter also contains definitions of terms that have been used throughout the project.

Strengths and Needs Assessment Plan (SNAP): Upon completion of the Collaboration Charter and the first six months of the Planning Phase, the IEAC commenced developing the SNAP. The objective of the SNAP was to identify initiatives that will ensure commitment and participation between the IEAC and the pilot sites in order to increase access to services, capacity and community building and to create attitudinal and systemic change.

The IEAC's SNAP outlined the process for conducting focus groups and interviews at each pilot site to identify their needs and strengths. The SNAP also included the roles and responsibilities of the IEAC partners and an extensive recruitment plan that promoted and provided for the safety, comfort, respect, accessibility and confidentiality of all participants.

The SNAP was submitted to and approved by OVW on July 28, 2008, and the IEAC commenced implementation of the SNAP in each of the pilot site communities, by conducting targeted focus groups and interviews. After completion of the focus groups and interviews in each pilot site, the IEAC analyzed the information that was gathered and compiled the information into this Needs Assessment Report (NAR), which documented the findings of the strengths and needs assessment.

Needs Assessment Report and Development of the Strategic Planning Phase

Upon receiving approval of the NAR, the IEAC will select from the reported strengths and needs of each pilot site and create a broad "menu of initiatives" for each site. This will be the first step toward narrowing the focus of the final pilot site project. Upon completion of the "menu of initiatives," the IEAC will again narrow the focus by selecting only those initiatives for each pilot site which appear to be obtainable, sustainable and allowable under OVW programmatic conditions. The IEAC will then schedule a series of visits to each pilot site to discuss the selected initiatives with the pilot site partners and further narrow the focus to just those initiatives that each pilot site perceives to be most useful in their community. These proposed initiatives will then be submitted to OVW for approval.

Upon approval of the NAR, the IEAC and its pilot site partners will work collaboratively to develop and implement a strategic plan that will ensure the success of each selected initiative. The IEAC will also utilize ongoing technical assistance from the Vera Institute of Justice to ensure development of a strategic plan that incorporates the findings identified in the needs assessment report.

The strategic plan will utilize the strengths that are currently present in the pilot site communities as well as addressing the barriers and gaps in services that have been identified in the report. The strategic plan will also assist in creating new collaborative opportunities between the organizations and advocacy groups as well as strategies addressing future sustainability of the project beyond the current grant.

Section 2

Pilot Site Selection

The IEAC identified the following criteria for selecting pilot sites:

1. Demographics- Most areas of Idaho are populated by mid-sized, predominantly rural cities and towns. To increase the chances of replication of IEAC efforts at other sites at a future time, such mid-size, partly rural towns and cities from different regions of the state were the most desirable.
2. Pre-existing relationships – Of importance in selecting pilot sites was identification of sites with pre-existing relationships between local domestic violence/sexual assault service providers and disability service providers.
3. Previous collaborative work - Also, of high importance in selecting pilot sites was identification of sites which had previously demonstrated their willingness to work collaboratively with local domestic violence/sexual assault service providers and disability service providers.
4. Willingness to build on pre-existing relationships - Additionally, selection of the pilot sites was based on a demonstrated willingness to build on their pre-existing collaborative relationships with local domestic violence/sexual assault service providers and disability service providers. This willingness was ascertained through telephone conversations with the Executive Directors of the pilot site domestic violence and or sexual assault service providers and the pilot site Independent Living Centers.

After evaluating each potential pilot site against the criteria, the IEAC concluded that it would not be possible to find three sites that perfectly met all four criteria, especially the criteria of pre-existing relationships. For those sites without pre-existing relationships, an evaluation of their willingness to collaborate was made. The IEAC determined that three sites in Idaho—Coeur d’Alene, Rexburg/Idaho Falls, and Nampa/Caldwell—best met the criteria. In each of these communities the IEAC identified one domestic violence program and one independent living center that had a history of pre-existing relationships, previous collaborative work, or a willingness to collaborate.

Coeur d’Alene, Idaho: Coeur d’Alene is a medium size community located in the northern “panhandle” of the state. In Coeur d’Alene, the community pilot site partners are the Women’s Center and Disability Action Center Northwest (DAC-NW). This pilot project site meets IEAC criteria because of its mid-size, partly rural population, its diverse population, and its geographic location in the northern part of the state. The Disability Action Center Northwest and Women’s Center are in close geographic proximity to one another. Although they have not previously

worked together, the leaders of both organizations have expressed willingness to collaborate with one another and the IEAC to engage in this work.

Rexburg/Idaho Falls, Idaho: Rexburg and Idaho Falls are located in the south-eastern Idaho area. The community pilot site partners are the Family Crisis Center in Rexburg, Idaho and Living Independently for Everyone, Inc. (LIFE), which is located 30 miles away in Idaho Falls, Idaho. The Rexburg/Idaho Falls area is a mid-size, predominantly rural valley. LIFE and the Family Crisis Center have a good pre-existing relationship and both organizations have expressed willingness to work with the IEAC and one another to address issues of domestic violence and sexual assault against women with disabilities in their community.

Nampa/Caldwell, Idaho: Nampa and Caldwell are located in the south-western Idaho area. The community pilot site partners are the Valley Crisis Center, in Nampa and Living Independence Network Corporation (LINC), approximately ten miles away in Caldwell. The Nampa/Caldwell area is a mid-sized community bordered on the north, east, and south by many rural communities that have no domestic violence/sexual assault service providers, but do have a high number of domestic violence/sexual assault crimes. Although they have not previously worked together, both the Valley Crisis Center and LINC have expressed willingness to work with the IEAC and one another to address issues of domestic violence and sexual assault against women with disabilities in their community.

Section 3

Strengths and Needs Assessment Plan

To accurately assess the current state of services for survivors with disabilities and those who are Deaf in the three pilot site communities, the IEAC planned and conducted a strengths and needs assessment. The results of a strengths and needs assessment can provide important information about violence against women with disabilities in their pilot site community's service area, the services available for survivors with disabilities and the resources of the organizations responsible for providing those services in the pilot site communities. By comparing this current snapshot of each pilot site community with the IEAC's vision statement, describing how things should be, the IEAC will be able to identify unmet needs and be one step closer to developing a plan to address those needs and, ultimately, improving services. Ultimately, the results of the strengths and needs assessment will be used to guide the IEAC's decisions about how to improve services for each community and how to build the capacity of the organizations providing these services.

Global Questions central to the SNAP

The IEAC based the strengths and needs assessment activities on the following global questions, which formed the basis for the specific questions that were used for each pilot sites' focus groups and individual interviews.

1. What resources and services do disability and domestic violence/sexual assault service providers currently have available for women with disabilities who have experienced violence?
2. To what extent do organizational policies, procedures and protocols at the service organizations hinder or promote meeting the particular needs of women with disabilities who are victims or survivors of domestic violence or sexual assault?

3. What barriers exist for service providers which hinder them from providing services and which we could plan strategically to minimize or overcome?
4. What barriers and facilitators to utilizing services exist for women with disabilities, which we could plan strategically to minimize or overcome?
5. What relationships currently exist among service providers and how could the IEAC foster new relationships and collaborations in the pilot site areas? What is the history of these relationships?
6. What do women with disabilities in pilot site areas know about the services currently available to them?

Target Audiences

The IEAC conducted the strengths and needs assessment plan (SNAP) focus groups and interviews during August, September and October of 2008. The “target audiences” of the strength and needs assessment were: (1) the pilot site domestic violence/sexual assault service providers; (2) the pilot site disability service providers; and (3) individuals with disabilities in the pilot site communities.

The IEAC conducted one focus group with each of these target audiences in each pilot site community. Specifically, the IEAC conducted:

- one focus group with disability service providers;
- one focus group with domestic violence/sexual assault service providers; and
- one focus group with individuals with disabilities in each of the pilot site communities.

In each of the pilot site communities, the IEAC also conducted:

- one interview with the disability service providers’ executive director; and
- one interview with the domestic violence/sexual assault service providers’ executive director.

The results of the strengths and needs assessment interviews and focus groups will guide the IEAC in developing a strategic plan that will be specific to each pilot site’s assessment.

Interview Participant Recruitment

The following chart documents the number of focus group and interview participants.

Pilot Site	Disability Service Providers	DV/SA Service Providers	Disability Executive Directors	DV/SA Executive Directors	Individuals with Disabilities
Pilot Site #1	3	4	1	1	11
Pilot Site #2	3	7	1	1	7
Pilot Site #3	2	7	1	1	4
Total Individuals at Focus Groups & Interviews	8	18	3	3	22

- Independent Living Center Executive Directors - The IEAC Co-directors contacted the independent living center executive directors in each pilot site and arranged for an individual interview at the independent living center office. Our goal was to interview all three independent living center executive directors. We were successful in reaching this goal. Each interview was conducted by the co-directors, with one co-director asking questions and the other taking notes. An audio recording of the interview was made to ensure that the information gathered was accurate.
- Independent Living Center Staff - The IEAC Co-directors contacted the executive director of the independent living center in each pilot site and asked them to select up to eleven staff, board members, and volunteers to participate in a focus group to be held at their office at a mutually agreeable date and time. Our goal was to interview between twelve and fourteen individuals who serve on the board, work or volunteer at independent living centers. We were successful in interviewing eight. Each independent living center office was staffed by a total of three people. At two of the three offices, all three staff people participated. At one office, two staff of three were available to participate. No independent living center board members elected to participate. Volunteers elected to participate in the women with disabilities focus group instead. A typed transcription and audio recording of the focus group was made to ensure that the information gathered was accurate.
- Domestic Violence Program Executive Directors - The IEAC Co-directors contacted the executive directors in each pilot site and arranged for an individual interview at the domestic violence program office. Our goal was to interview all three domestic violence program executive directors. We were successful in reaching this goal. Each interview was conducted by the co-directors, with one co-director asking questions and the other taking notes. An audio recording of the interview was made to ensure accuracy.
- Domestic Violence Program Staff -The IEAC Co-directors contacted the executive director of the domestic violence program in each pilot site and asked them to select up to eleven staff, board members, and volunteers to participate in a focus group to be held at the domestic violence program office at a mutually agreeable date and time. Our goal was to interview seventeen individuals who serve on the board, work or volunteer at domestic violence programs. We were successful in reaching eighteen individuals. A typed transcription and audio recording of the focus group was made to ensure accuracy.
- Individuals with Disabilities - To recruit individuals with disabilities for the focus groups and/or interviews in each pilot site the IEAC talked to advocates at the appropriate organizations* about recruiting women with disabilities from their community to participate in focus groups and interviews. The criteria for participation was that the individuals must live in the community, identify as having a disability, and be willing to express their insights pertaining to their experiences as a person with a disability. The advocates were advised that they should not target particular individuals to participate, especially those individuals with a known history of violence. The advocates at the independent living centers took requests for accommodations, private interviews, transportation and daycare. The advocates assisted the IEAC with arrangements for all

* The name of the appropriate organizations shall not be disclosed to protect the confidentiality of participants.

requests. The goal set out in the SNAP was to reach thirty-three individuals with disabilities. The IEAC was successful in interviewing twenty-two individuals, and they provided extensive, substantive, information, which easily met our needs without conducting additional interviews.

Each individual who participated in the focus groups for individuals with disabilities was greeted upon their arrival by IEAC Co-directors. Each participant was provided with a confidentiality waiver prior to participation, an explanation of that waiver, and a \$25.00 cash gift card. This personal contact offered an opportunity for the IEAC to welcome participants, ensure that their accommodation requests were appropriately met, and thank them for their time and input.

Methodology

Memorandum of Understanding: The IEAC and each pilot site partner signed a memorandum of understanding that outlined their mutual commitment to this grant project.

Strengths and Needs Assessment Administrators: The strengths and needs assessment was administered at each of the three pilot sites by the IEAC Project Co-directors. Boise State University's Director of the Gender Studies Program assisted with SNAP administration at each focus group for individuals with disabilities. In each interview, the IEAC Co-directors made an audio recording to ensure the accuracy of their notes. In each focus group the IEAC Co-directors made an audio recording and a transcriptionist, hired by the IEAC, was present to type verbatim answers. All participants were informed that the discussion would be recorded verbatim without any identifying information attached to the individual. Each participant also received a written waiver advising them that they were being recorded and that the information they provided would be used in a report, but would not identify them specifically.

The IEAC also developed the privacy policy, outlined in the SNAP that requires all recordings and transcriptions be kept by the IEAC in a locked cabinet, for a minimum of 120 days, accessible only by authorized staff, and not made available to the general public. All original and copied focus group and interview recordings and transcriptions will be erased or shredded no later than twelve months after being recorded or transcribed.

Section 4 Strengths and Needs Assessment Findings

The information gathered from focus groups and interviews conducted at all three pilot sites has been compiled into a composite set of findings, which are as follows:

- **Individuals with disabilities have inconsistent knowledge about resources available within their communities and no known or easily usable centralized resource from which to obtain that knowledge.**
- **In every pilot site community, there is a need for greater knowledge about, and discussion of, disability, the dynamics of domestic violence/sexual assault, and the intersections between them. The need for this education and dialogue exists**

among individuals with disabilities, disability and dv/sa service providers in the community at large.

- **Accessibility of services includes physical accessibility of service providers' facilities but also entails broader issues of attitudes, atmosphere, and ability to be referred to, and participate in, the variety of available programs and services appropriate to the individual's needs.**
- **Accessibility of services includes physical accessibility of service providers' facilities but also entails broader issues of attitudes, atmosphere, and ability to be referred to, and participate in, the variety of available programs and services appropriate to the individual's needs.**
- **Policies, procedures, protocols, and dedicated budgetary expenditures aimed at addressing the particular needs of women with disabilities who are victims or survivors of domestic violence or sexual assault currently do not exist at service provider organizations. Executive directors and staff at these organizations are, however, interested in assistance in creating and implementing such policies, procedures, and protocols and have provided information on how their boards determine budget priorities.**
- **Lack of transportation options and long geographical distances between service providers limits the ability of individuals with disabilities to utilize services.**
- **Both the disability and dv/sa service providers are well networked into a variety of outside services available within their communities. Their respective networks do not always overlap but might be made to do so in the future to better serve women with disabilities who are victims/survivors of domestic violence.**
- **Domestic violence/sexual assault, disability service providers, and individuals with disabilities share common values and an enthusiasm for improving accessibility around which collaboration can begin.**

The goal of generalizing these findings is to assist in long term strategic planning at each of the current pilot sites, but also to aid in the creation of effective models that would be replicable in subsequent pilot sites in Idaho. These findings should be viewed as working together to create a snapshot of the pilot site communities as a whole. With this goal in mind, the findings have not been prioritized. Each finding is as important as the next to understanding the strengths and needs of pilot site communities. The findings are organized by headings and subheadings. At the end of the discussion of composite findings, a brief section of considerations specific to each pilot site is included.

The IEAC recognizes that advocates, victims/survivors, and abusers can be male, female or transgender. When there is occasion to identify such individuals by personal pronoun in this discussion of findings, however, the IEAC has chosen to use female pronouns to refer to advocates and victims/survivors since most of the respondents were female. In references to abusers, the IEAC has elected to use male pronouns, since national studies indicate the majority of abusers are male and since information collected from focus group participants statewide was consistent with nationwide trends.

Barriers, Needs, and Gaps in Accessing Services

Finding_– Individuals with disabilities have inconsistent knowledge about resources available within their communities and no known or easily usable centralized resource from which to obtain that knowledge.

What we learned from individuals with disabilities

The IEAC found that the domestic violence/sexual assault (dv/sa) and disability service providers regularly referred clients to a variety of community resources. Individuals with disabilities at all three pilot sites, however, reported challenges finding out about services in their community. They expressed frustration at the piecemeal fashion in which they gradually learned what services were available and at a perceived minimal level of overlap, coordination, and interagency knowledge among service providers about services for individuals with disabilities who were victims/survivors of domestic violence.

Inconsistent knowledge about available disability and dv/sa services is a significant barrier to usage of services. You cannot access services you do not know about. The level of knowledge about local services available for women with disabilities who are victims or survivors of domestic violence or sexual assault varied from site to site and from individual to individual. Although every woman with a disability participating in the focus group knew of some local disability and dv/sa services, one or two individuals would know of a particular local service while the remainder of participants did not. Focus group participants often educated one another about what services were available in their communities during the course of the focus groups.

“Why was it so hard? You have to make so many calls and phone calls and stuff. . .It was confusing and tiring. . .So many people and so many different opinions.”

Individual with a disability

Many focus group participants discussed how they discovered an organization or service by “luck” or “chance.” Individuals with disabilities frequently expressed their desire for “wrap around services,” “one stop” services, a simplified web of services, and an easily usable central information resource for services where it is clear how services overlap and interconnect. What individuals with disabilities reported often exists now are lists containing names of agencies, addresses and phone numbers. Instead, individuals indicated that what would be more useful for them would be:

- Roster of service providers including agency names, specific person to contact, services offered, hours of operation, phone numbers, and addresses;
- Roster could be indexed by agency and also by services offered;
- Roster should include physicians and psychiatrists;
- Should be made available in large print format;
- Might be made available in booklet or community bulletin board format or both.

Such resources, individuals with disabilities indicated, should be available in ways that are accessible to individuals with disabilities and also in locations that people with disabilities

frequent. Suggestions for how individuals with disabilities would like to receive such information included:

- Television and radio public service announcements
- Local TV station “tip lines”
- Ads in local newspapers
- Fliers from local agencies such as welfare office, food stamps office, Medicaid, sheriff’s office, police departments, behavioral health, unemployment office, hospital emergency rooms
- Victims Advocate services
- Libraries
- 2-1-1 Careline
- Disabilities service organizations
- Doctors’ offices
- Psychiatrists’ offices
- Psycho-social rehabilitation (PSR) workers
- Attorneys’ offices
- Grocery stores
- Churches
- Posters in women’s restrooms, including bar restrooms

Individuals with disabilities tended not to want information via the internet—at least not exclusively—since many individuals with disabilities do not have access to a computer on a regular basis. **While this grant does not support activities that would meet this need, the information may be useful to the pilot sites when developing other projects.**

Finding – In every pilot site community, there is a need for greater knowledge about, and discussion of, disability, the dynamics of domestic violence/sexual assault, and the intersections between them. The need for this education and dialogue exists among individuals with disabilities, disability and dv/sa service providers in the community at large.

Knowledge about the intersections of dv/sa and disability was minimal at all pilot site service providers. Individuals with disabilities and staff at every service provider at every pilot site advocated for a larger inter-organizational and community-wide effort to cross-train themselves and educate others about these issues as a first step to addressing the needs of individuals with disabilities who are victims/survivors of domestic violence. Such an effort would provide three perceived benefits.

- First, it would train dv/sa and disability advocates in how to best meet the needs of individuals with disabilities who seek services for domestic violence.
- Second, it would educate individuals with disabilities in how to identify what is happening to them as abuse, including disability-specific abuse.
- Finally, it would make disability more visible and normative and lessen the popular stigmas surrounding domestic violence, thus making it easier for individuals with disabilities to break through attitudinal barriers which limit their ability and willingness to seek services they want.

In sum, an increased community dialogue concerning these issues and the services available to individuals with disabilities who become victims/survivors of dv/sa could help foster the type of interagency networking, communication and referral that would facilitate the IEAC’s vision of

women enjoying equal access to the comprehensive services of her choice, no matter where she accesses the integrated network of services. Service providers discussed this training and education as a necessary beginning step toward meeting these goals, but recognized that training and education alone are insufficient to improve access to services for individuals with disabilities who are victims/survivors of domestic violence, and must be supplemented by a variety of other interactions and initiatives discussed in greater detail below.

Staff openly discussed their need for more training. Among staff who had some education upon these issues, individuals opined that although they may receive some initial training about issues of domestic violence and sexual assault experienced by individuals with disabilities when they join an agency, most of their knowledge about these issues—and how to best serve such individuals who walk through their doors or phone their office—comes from their experiences serving such clients which they gain over time, as discussed above. Currently, there is no cross-training among dv/sa and disability service providers and no community-wide education efforts regarding the intersections of disability and dv/sa.

What we learned from dv/sa service providers

Staff requested more knowledge, particularly about mental health-related disabilities and issues such as disability specific abuse, ethics, how to be more proactive to better serve individuals with disabilities, and the Americans with Disabilities Act (ADA). Staff members also expressed interest in learning about some of these issues from individuals with disabilities themselves as well as disability service providers. A majority of staff members acknowledged that their training on these issues was minimal. Many staff hesitantly suggested that information on disability specific abuse was probably in their initial training, but admitted they cannot remember clearly.

Dv/sa service provider personnel also suggested increased community awareness of domestic violence, sexual assault, disability, and violence committed against individuals with disabilities and the services available to them was an important factor in being able to meet the needs of all victims/survivors, including those of individuals with disabilities. One staff member commented on her community's unwillingness to admit publicly that violence exists or that disability exists. Community silence on such issues contributes to few individuals knowing about their dv/sa program and services. A staff member at another pilot site observed a similar situation and noted an additional consequence: that some men and women with disabilities do not recognize what's happening to them as abuse.

What we learned from disability service providers

Disability advocates at all three pilot sites want more knowledge about the dynamics of dv/sa and its intersections with disability. Overall, staff members report that they have not been trained to recognize abuse or how to appropriately serve the needs of clients who disclose abuse. One or two staff members among those interviewed appear to have informal knowledge about cycles of violence, which they incorporate into their attempts to serve clients, but such knowledge was rarely evident in the focus groups. They suggested their dv/sa service provider pilot site partner could help.

Impacts of this need for further education are that clients who are victims/survivors are not receiving optimal access to available assistance, community service providers are not collaborating as well as they might to meet client needs, and community service providers current interactions may be negatively impacting the relationship between the systems. Staff reported that they tried to help clients as best they could but that sometimes their attempts

“backfired,” and advocates place guilt and blame upon themselves. At other times, a disability service provider who received a referral from a local dv/sa agency did not agree with the dv/sa agency’s assessment that abuse was occurring. The consequences to the client of this disagreement are not clear.

There were also often misunderstandings about what services shelters and dv/sa service organizations provided and how such services were provided. Central to this misunderstanding may be lack of knowledge about each other’s philosophical underpinnings, which distorts their perceptions of each other’s work. Information about each other’s philosophical underpinnings is needed. One disability service provider, for example, regretted that shelters were not more proactive, although this is not a shelter’s role. Another feared that if a woman with a disability was referred to a shelter, that they would simply put her in a nursing home because they simply have no money to provide accommodations such a woman might require. Yet another was frustrated that she never received follow up information on clients after referring them to dv/sa service providers, not realizing that dv/sa service providers cannot provide such information on clients who utilize their services. Finally, another staff member expressed perturbation that dv/sa service providers were not “coming up with accommodations” for clients with disabilities. Does disability staff understand that a client must request accommodations first and that dv/sa staff are limited in what they can ask clients relating to disability?

Moreover, two pilot sites reported that they rely upon Personal Care Attendants to report suspected abuse. One site trains its Personal Care Attendants to look for abuse and asks them to report it in the comment section of weekly report forms. Under state law, all centers for independent living must screen their Personal Care Attendants. However, no recognition of the possibility of abuse by the Personal Care Attendants as a form of abuse specific to individuals with disabilities was ever mentioned by staff, nor were additional methods to uncover abuse, described. Education and technical assistance on caregiver abuse and methods of discovery and reporting may be helpful.

“We don’t know what we don’t know.”

Staff member, disability service provider

Regarding community education on disability and domestic violence, disability service providers were generally confident that individuals with disabilities in their communities knew about their organization, however they were less assured that individuals with disabilities considered them a conduit for resources related to dv/sa. Community members and public discourse do not generally include discussions about the intersection between disability and domestic violence.

“Because we’re information referral, people know to call us about some things (i.e. utilities) and we can then refer them to resources for domestic violence. But we don’t specifically advertise that we help women with disabilities who are victims or survivors, so unless they disclose. . .”

Staff member, disability service provider

Disability service providers generally indicated that they had no plans to increase awareness of dv/sa in their communities, however staff at some pilot site organizations recognized the need to educate individuals with disabilities about what abuse and healthy relationships look like.

What we learned from individuals with disabilities

This issue was of critical importance to individuals with disabilities at every pilot site. Based on their past experiences with a variety of service providers, individuals with disabilities intuited that

service providers were untrained in these areas. This created a barrier to seeking services, as was discussed above. Moreover, because such information is absent from their lives and communities as a whole, many individuals indicated that it took a long time for them to identify what was happening to them as abuse because no one in their community would talk openly about these matters. Individuals wanted education on issues such as dv/sa and what healthy relationships look like, beginning in secondary schools and in churches for both young women and men. Some suggested building upon programs that already exist in their community, such as the “Healthy Hands are Not for Hitting” program. Such education should then continue in the broader population. Some suggested public service campaigns. Others proposed a central community training center. Overall, they desired frank, open, public discussion about disability and violence to help garner community support for services and victims/survivors. Individuals with disabilities should play a significant role in this dialogue, encouraging peers to assist peers.

“The only way things are going to change is if each and every one of us who has lived through this kind of situation does something to contribute to the change of the way things are now.”

Individual with a disability who is a survivor of domestic violence

Finding – Accessibility of services includes physical accessibility of service providers’ facilities but also entails broader issues of attitudes, atmosphere, and ability to be referred to, and participate in, the variety of available programs and services appropriate to the individual’s needs.

Full access to services for individuals with disabilities who are victims/survivors of domestic violence involves more than physically getting the individual through the front door. While this initial physical access is certainly an important aspect of access which needs to be addressed at two out of the three pilot sites (#s 1 & 3), it is only the beginning.

Virtually all service providers explained that they try to serve everyone who walks through their doors and will get clients whatever they need while at the same time reporting that few women with disabilities who are victims or survivors of domestic violence or sexual assault seek services or accommodations from their organizations. Individuals with disabilities, on the other hand, had no reticence discussing the many factors which had discouraged them from asking for needed accommodations or even seeking or following through with referrals and services from such service providers.

There is an obvious disconnect between service provider perceptions and individuals’ with disabilities opinions, which must be overcome. To best serve individuals with disabilities who are victims or survivors of domestic violence or sexual assault, both dv/sa and disability service providers should:

- broaden their definitions of accessibility;
- understand the state and federal legal requirements for providing accessible services; and
- explore, recognize and confront attitudes and assumptions about domestic violence and/or disability and their provision of services, which unintentionally limit access to services.

What we learned from domestic violence and sexual assault service providers

While dv/sa service providers were typically skilled at discussing many sensitive issues surrounding violence and abuse with their clients, they were often under-informed about

disability and accessibility issues and uncomfortable or inexperienced in assisting clients with disabilities.

Service provider knowledge about what constitutes accessibility needs to be broadened. Typically, when asked about past successes in addressing accessibility issues, dv/sa service provider Executive Directors and staff discussed wheelchair accessibility, ramps, bathroom accessibility, availability of American Sign Language (ASL) interpreters, ability to accommodate personal care attendants, availability of rooms equipped for Deaf individuals, and the ability to accommodate special diets in shelter facilities.

“...there are so many things we have done, i.e. security, alarms and lights, for those that are hearing and visually impaired. We also had a lady who was terminally ill stay with us a couple of times. We accessed community services outside the agency for a provider to come in 4-5 times a day for medication, transportation, etc.”

Executive Director, dv/sa service provider

All of these are important aspects of accessibility, and service provider efforts to provide such accommodations and become educated on the legal requirements of accessibility mandated by federal laws, should be facilitated further. Service providers often expressed that they were “as accessible as [they] can be” due to financial limitations and/or structural constraints of their buildings and thus did not have an action plan aimed at increasing accessibility.

Individuals with disabilities at all three pilot site areas did not consider their community dv/sa service provider facilities and programs to be accessible. Beyond these accessibility issues, discussed by dv/sa service provider staff and executive directors, individuals with disabilities have unique service needs related to intake, later interactions with staff, and access to programs, such as counseling, education, communal life in the shelter, and support groups. If these needs are not addressed, individuals report that they feel unwelcome, are confused about their options, are unable or unwilling to ask for accommodations they need, and are unable or unwilling to fully utilize facilities and programs offered through the service provider. In the end, the client probably will not receive the services she wants or needs and may not attempt to access services in the future. It is not surprising, then, that service providers discussed few cases when they had actually had the opportunity to serve a client with a disability, although most staff assumed it is because there is little need in their area.

A handful of staff members, however, introspectively questioned whether their organizations were doing enough to reach out to individuals with disabilities who were victims/survivors and were beginning to question where opportunities to do so might be found.

“Few people with physical disabilities come to the dv/sa program and shelter. Are we alienating this population? What’s a way to draw them in? Maybe we don’t have a large population with physical disabilities in need here. But maybe not.”

Staff member, dv/sa service provider

This statement raises several key issues. Studies have been conducted in many states that confirm the high occurrence of physical, emotional, sexual, and disability-specific domestic violence against women with disabilities. There is no reason to believe this would not hold true for Idahoans. In fact, there is substantial anecdotal evidence that the rate of domestic violence against women with disabilities in Idaho is as high as in other states. A need exists for dv/sa services for these women. Yet, if individuals with disabilities perceive that the dv/sa facilities and programs are not accessible, why would they seek services? This staff member has begun

asking the pertinent questions. Despite the best of intentions, are dv/sa service providers unintentionally alienating victims and survivors who have disabilities? And if so, what changes could be made to reach out to this segment of the service population, increase accessibility, and boost utilization of services?

Dv/sa service provider Executive Directors and staff at each pilot site recounted both successes and challenges in serving women with disabilities.

“We had a woman in a wheelchair . . . She had no mobility. She was a victim of domestic violence. I think the reason I see her as a success was because we were able to make phone calls. We had the call center take over to kind of get the ball rolling. . . . It took about two months to get everything done, but that was only because we just would not let up Eventually it all worked out.”

Executive Director, dv/sa service provider

Assumptions about individuals with mental health disabilities were also prevalent at another pilot site, with fear and misunderstanding of such individuals expressed through the use of words such as “crazy,” “psycho,” and “these types of people.” At this site, staff without training disclosed incidents wherein they attempted to informally diagnose clients (in contrast to the client’s diagnosis by a qualified physician) and then provided clients with what they thought would best meet the client’s needs (or choose not to provide services) based on that informal diagnosis.

“You have to treat individuals with disabilities differently and make sure they are medicated properly.”

Staff member, dv/sa service provider

The Executive Director and staff at this site indicated it is sometimes unsafe to help women with mental health-related disabilities in a shelter. They call law enforcement when they feel this is the case. Staff members related that they sometimes panic when a woman with a mental health-related disability requests services and they would like more training and information rather than simply trying to deduce what to do on their own. Others would like to know how to determine if a client has a “mental problem” or if it is “just a bad day.”

What we learned from disability service providers

While disability service providers were typically skilled at discussing many referral and accommodation issues with their clients, they admitted a lack of knowledge about identifying and discussing abuse with their clients, making referrals to dv/sa programs, and in how to assist such clients appropriately. “We are not trained in trauma response, said one staff member. Other staff members seemed discouraged by previous experiences with clients suffering abuse that they had tried to assist but who went back to the abuser.

Regarding access, disability service provider staff reported both successes and challenges on issues similar to the ones reported by dv/sa service providers, such as the need for greater wheelchair access, accommodations for Personal Care Attendants (PCAs) and accommodations for service animals. They also, however, discussed the need for greater programmatic access. Individuals with disabilities often needed accommodations to fully participate in dv/sa programming. For example, staff members encountered the need for a disability staff member to attend education or support groups with individuals with disabilities at

the dv/sa service provider to assist with the reading and understanding of written materials. This corroborates the need to take a broader view of programmatic accessibility, as discussed above, to ensure an individual is able to take full advantage of the programs and services which she is offered.

What we learned from individuals with disabilities

Many individuals with disabilities were able to describe positive experiences with dv/sa and disability service providers that empowered and supported them in their choices. Many individuals with disabilities, however, also described previous experiences with service providers in which they felt unwelcome, judged, and misunderstood and which thus deterred them from seeking further services. Victims and survivors with disabilities explained that, in order to seek and follow through with services, they must enter what they perceive to be a safe, welcoming environment in which they do not feel stigmatized or judged either for their disability or for being victimized by an abuser. They were able to identify many specific characteristics that would facilitate their use of services.

Being placed with service provider staff who understand the particular situation and needs of women who identify as both individuals with disabilities and as victims/survivors of violence is critical, according to these women. Individuals with disabilities in pilot site communities perceived that service providers at both dv/sa and disability service providers often were not trained in how to recognize signs of abuse in women with disabilities. They requested that service provider staff be trained to recognize these signs and, moreover, be trained in how to assist such women in a manner appropriate to their situations. For example, one focus group participant suggested that dv/sa service providers, emergency personnel and law enforcement need to learn how to determine what clients with mental disabilities need immediately to “de-escalate” them, before trying to provide their regular menu of services. Another participant proposed that service providers not place conditions on receiving aid. Utilizing a referral for dv/sa services is not the same as utilizing a referral for assistive devices. If an individual is not ready to make a change, i.e. leave an abusive situation immediately, service providers should respect that choice and still provide all information anyway, understanding that these situations sometimes take time to resolve.

Moreover, individuals with disabilities in or near the pilot site communities reported how perceived service provider attitudes had deterred them from seeking services in the past. Within the focus groups, individuals with a variety of disabilities—but particularly individuals who self-identified as having a mental health-related disability—explained how they felt judged or stigmatized by some service providers. When seeking disability services, they felt judged for being a victim/survivor.

“I think some of it is not so much the service provider as the attitude that’s behind it. I don’t think there’s an awareness of how to deal with victims, survivors, overcomers [with disabilities] . . . So then they come at you with questions and sometimes . . . there’s this judgment that’s behind it . . . that’s one thing that’s really difficult.”

Individual with a disability

When they sought domestic violence services, they felt stigmatized for having a disability. Individuals either did not want to disclose their disability and request needed accommodations from dv/sa service providers or they did not want to disclose abuse to disability advocates. Offered services, therefore, could be insufficient to meet a client’s needs.

“The judgment makes you so you don’t want to go in and talk about it, because you know people aren’t going to be compassionate.”

Individual with a disability

Individuals with disabilities identified several factors that led to their feeling welcome and to an increased ability to speak up and voice their need for accommodations and services. These factors included:

- Atmosphere: Attractiveness and informality of facilities made a big impression on focus group participants, contributing to a “normalizing of atmosphere”. When entering a service provider’s facility for the first time, some individuals with disabilities found placement of desks in reception areas off-putting because of the resemblance to a doctor’s office. They preferred a casual, “laid back” environment to an overly professional, clinical atmosphere.
- Explanations of intake process and why certain questions, particularly those related to sexual experiences, need to be asked.
- Attitude and appearance of staff. Individuals with disabilities lauded those service providers whose compassion, sensitivity, and nonjudgmental attitudes helped them feel accepted and hopeful in an unfamiliar environment. They encouraged service providers to “be real.” Staff language and dress could be intimidating for some focus group participants. Such individuals expressed discomfort about being served by staff that were too formally dressed, preferring casual attire more in tune with what clients themselves might be wearing.
- Perception of being safe while receiving services.
- Consistency of experience: Rather than being handed off to different staff members, individuals with disabilities said they would prefer to stay with one person.
- Staff experienced in helping women with disabilities who are victims/survivors or, at a minimum, staff willingness to admit their inexperience assisting this particular population and to move forward from there. Ideally, individuals with disabilities would like peer-to-peer interactions at service providers.
- Trust: Individuals with disabilities repeatedly requested that staff wait until trust develops between the individual and the service provider before asking questions about sensitive issues such as abuse or sex.
- Confidentiality being kept.

In addition to requesting these qualities of service, several individuals emphasized the broader implications and importance of offering accessible services, which were validation of a victim’s experience and service providers’ work to end domestic violence.

“...this isn’t just about services, this isn’t just about a house, this isn’t just about providing someone with some information. This is about ending domestic violence. This is about ending abuse. And when you’re out there and you’re able to give to us, then what you’re doing is giving hope. . .Every one of us lives that life. Every one of us knows it. When...there’s a place you can

go that says. 'Hey, we have this for you. This is a place for you to live. This is a place where you can have transportation, this is a place where you can get a group,' what you're doing is offering hope."

Individual with a disability

Finding – Policies, procedures, protocols, and dedicated budgetary expenditures aimed at addressing the particular needs of women with disabilities who are victims or survivors of domestic violence or sexual assault currently do not exist at service provider organizations. Executive directors and staff at these organizations are, however, interested in assistance in creating and implementing such policies, procedures, and protocols and have provided information on how their boards determine budget priorities.

Generally, any policies, procedures, and protocols currently in existence at any pilot site organization are reported to be informal and unwritten. All dv/sa and disability service providers expressed interest in the future creation of formalized written policies, procedures, and protocols aimed at addressing the particular needs of women with disabilities who are victims or survivors of domestic violence or sexual assault. Executive Directors at disability service providers at all pilot sites reported that they did not have line items within their budgets specifically dedicated to handling issues of domestic violence among their clients. Executive Directors at dv/sa service providers at all pilot sites indicated that they did not have line items within their budgets specifically designated for accommodating the needs of clients with disabilities.

Executive Directors described the process of helping women with disabilities who are victims or survivors of domestic violence or sexual assault as a reactive process, rather than a proactive one. Executive Directors at all service providers, whether disability or dv/sa, discussed how budgetary priorities are developed by examining the needs of the populations who accessed their services in the recent past. As one Executive Director commented, "Allocation of funding depends on who walks through the door." However, since all Executive Directors believed that few individuals with disabilities had attempted to obtain services for domestic violence issues, this resulted in no specific budgetary commitments to assist this particular population's needs.

What we learned from dv/sa service providers

Staff and Executive Directors at dv/sa service providers generally reported that no formal policies, procedures and protocols aimed at addressing the particular needs of women with disabilities who are victims or survivors of domestic violence or sexual assault exist at their agencies, except, perhaps, on intake forms. There was some confusion among staff, however, about what types of questions were allowed to be asked on these forms and what questions could be asked subsequently. Some staff members, for example, indicated they asked clients about medications while others would not. Most staff expressed frustration that they could not simply ask clients about disability issues and some suggested ways to get such information "under the table," i.e. from law enforcement.

In general, staff members reported that the awareness that a client has a disability and may need an accommodation comes from talking with clients, filling out intake forms, and then observing and using their "intuition," "common sense," and informal consultations with other staff members. This usually results in each staff member doing what each thinks is best to meet the clients' needs. As one staff member commented, "We get creative."

Most staff members did, however, express their strong desire to assist individuals with disabilities whenever possible to provide the victim/survivor with what they needed. The policy at one site, as one Executive Director responded, is not to turn anyone away and that encompasses women with disabilities as well as all women. Then once a client with a disability is in the shelter, the staff assists in determining her needs and how to meet them.

"We take care of her needs so she doesn't have a reason to go back."

Executive Director, dv/sa service provider

What would build upon these service providers' admirable vision and strengthen their ability to take care of the needs of women with disabilities who are victims or survivors of domestic violence or sexual assault is the creation of written policies, procedures, and protocols which simultaneously formally recognize the unique needs of such women and incorporate those needs and considerations into organizational training and protocols. Without this type of official systemic change, service provider intentions may be laudable but actual service delivery may be confusing for staff and inconsistent for clients. Intake processes may be inappropriate, accommodations may not be requested or offered, and services may not be appropriately tailored to the client's individualized needs.

What we learned from disability service providers

Executive Directors and staff at disability service providers report that organizational policies, procedures and protocols regarding violence perpetrated against individuals with disabilities tend to be informal and unwritten. Staff at disability service providers generally do not ask a client about abuse directly but do look for it informally, each in their own way. Many staff members reported "reading between the lines" or using "gut instinct" and "intuition."

". . . you just start drawing out more information and then you realize the bells and whistles go off in your head that the person is abused."

Staff member, disability service provider

If a client discloses abuse, staff inquires about the abuse in more depth, often consult with other staff members or the Executive Director, and then typically refer the client to community dv/sa service providers. Personal Care Attendants (PCAs) were considered important to identifying and reporting abuse at two of the three pilot sites. A formalized procedure to report suspected abuse existed at one of these sites, but not at the other. There was no discussion of possible abuse by Personal Care Attendants (PCAs).

Executive Directors and staff appeared willing and, indeed, enthusiastic about creating such policies, procedures and protocols. They requested assistance to do so, often with the stipulation that such policies allow flexibility when assisting clients because, in their experience, *"every scenario is different. . .you can't say 'step one, step two, step three, step four,' because, you know, you're not buying a car. . .Not every policy or procedure would work with every individual."*

Overall, Executive Directors and staff at both disability and dv/sa organizations recognize the benefits of establishing and formalizing protocols to assist individuals with disabilities who are victims/survivors and have requested advice on how to do so. If specific line items in budgets are to be dedicated to providing services to individuals with disabilities who are victims/survivors, however, Executive Directors were clear that they must demonstrate need to their boards. In the past, need has been established by perceived numbers of clients walking

through the service providers' doors requesting particular types of accommodations or services. Executive Directors and board members must be convinced to define need differently and proactively if systemic change is to occur. To effect change in the way funding is allocated, board members and Executive Directors will need to formally recognize the unique needs of individuals with disabilities who are victims or survivors. Board members and Executive Directors will also need to consider the possibility that individuals with disabilities who have experienced violence may not be seeking their services, because they do not see the service providers as accessible or as a safe place to disclose abuse. A proactive approach to creating an accessible and welcoming environment may be necessary before people will seek their services.

Finding – Lack of transportation options and long geographical distances between service providers limits the ability of individuals with disabilities to utilize services.

Idaho is a large, frontier, state, and each pilot site's service area includes large rural populations. DV/sa and disability service providers are often located a substantial geographic distance from one another. In two pilot site areas, the dv/sa and disability service providers are located in two different towns, because there are so few service providers in these areas. A lack of transportation hinders women with disabilities who are victims or survivors of domestic violence or sexual assault from seeking services. The lack of transportation may take many forms, such as insufficient public transportation options to service provider locations, no wheelchair accessible van, no money for a taxi to service provider location, and no friend or service agency staff member available to provide a ride. Even when public transportation options to service providers are available, it is often unsafe for women with disabilities who are victims or survivors of domestic violence or sexual assault to utilize public transport. Provision of reliable, safe, transportation options is extremely important so that individuals with disabilities can take advantage of offered dv/sa and disability services.

What we learned from DV/SA service providers and Disability service providers

Executive Directors and staff from both types of service providers recognize that a lack of transportation often limits the ability of women with disabilities who are victims or survivors of domestic violence or sexual assault to seek services. Many staff members drive women around when they can, but recognize that this informal and uncoordinated effort is frequently insufficient to meet clients' full needs. They are doing the best they can with the resources they have available. Many service providers expressed a wish for a wheelchair accessible van.

What we learned from individuals with disabilities

Lack of transportation to service providers was frequently mentioned by individuals with disabilities as a significant and prohibitive barrier to seeking services, particularly in the two pilot sites where disability and dv/sa service providers operate in two separate towns.

"Many people with disabilities may be landlocked. They may not have the ability or resources to drive, to get there, transportation, to connect, to talk to someone, especially if they are being totally controlled."

Individual with a disability

Moreover, women with disabilities who are victims or survivors of domestic violence or sexual assault report that their safety while waiting for public transportation when it is available is a concern. As one woman related, ". . .my abuser is here and all his friends are here. So I have to

wait out on the street corner. . .So even having the public transportation is really difficult for me because you can run into anybody that knows him. . .”

To offset the geographical distance between service providers that operate in different towns, individuals with disabilities suggested bringing services of the two towns together. And, ideally, individuals with disabilities would like a shuttle service which would pick them up at their homes rather than on public street corners or other locations where they would have to wait in visible locations alone.

Section 5

Strengths and Opportunities

Finding – Both the disability and dv/sa service providers are well networked into a variety of outside services available within their communities. Their respective networks do not always overlap but might be made to do so in the future to better serve women with disabilities who are victims/survivors of domestic violence.

Both disability and dv/sa pilot site partners participate in large, informal networks incorporating a diversity of services and service providers throughout the pilot site communities to serve women in their communities. They do not, however, participate in the same networks. An individual with a disability who was a victim/survivor of domestic violence and who attempted to access services would be offered a different set of uncoordinated options depending on which service provider she consulted. Service providers know about each other’s agencies; however no firm, formal relationship of trainings, collaboration or referrals has been established. While forging a collaboration between dv/sa and disability service providers, it should be feasible to merge elements of the disability and dv/sa networks to enhance options for women with disabilities who are victims/survivors of domestic violence.

“We are quite a ways from the ideal, but it could be good!”

Staff member, disability service provider

What we learned from DV/SA service providers

Staff and Executive Directors at dv/sa service providers typically revealed an impressive knowledge of local resources available to help victims and survivors of domestic violence and sexual assault. Executive Directors were confident in staff knowledge. Staff provided the names of numerous local agencies with which they enjoyed regular interactions, reciprocal referrals and interdependent relationships to meet clients’ needs. Very few of organizations discussed, however, were disability service providers. In two out of the three pilot sites, dv/sa advocates specifically mentioned that they did not enjoy connections to the disability service providers with which they would be partnered on this initiative. When dv/sa staff was aware of the existence of disability service providers, this awareness was often limited to the name of an organization, an address and a phone number listed on a sheet of paper. There was little meaningful interaction, reciprocal referral, or combined advocacy occurring. One dv/sa staff member at an organization that is proud of how well networked they are into community resources for dv/sa, reported that she made home visits to one client with a disability because she did not know where she could refer her. Advocates were aware that this situation was not necessarily the most effective and efficient way to provide services to clients, and could create confusion for both service providers and clients.

Let's come up with one comprehensive, consistent, non-contradictory plan to help a client rather than "all these different tentacles coming off an octopus."

Staff member, dv/sa service provider

Domestic violence/sexual assault advocates generally expressed interest in, and recognized the advantages of, creating a greater degree of interagency collaboration. They requested more integration between their services and networks of resources and referrals with those of disability service providers. They suggested various measures to effect such an integration, which are enumerated below.

What we learned from disability service providers

Executive Directors at disability service providers praised their staff for their knowledge of community resources available to assist individuals with disabilities. Phrases such as, "My staff know about every service in town," were frequently repeated. This can partly be explained by the mission of the disability service providers. Staff described themselves as "generalists" whose primary responsibility is often referring clients out to appropriate community services. Staff exhibit positive "can do" attitudes. "I'll call anyone," one staff member commented. When staff were asked to describe their relationships with other local service providers and the history of these relationships, the discussions were lengthy, encompassing a wide variety of local service providers offering a plethora of services. "We invite agencies to come and meet us, or we go out and meet them." Disability staff members frequently attend local interagency meetings of service providers to individuals with disabilities. Some serve on boards of other service provider organizations. Others frequently exhibit at information fairs, senior fairs and housing summits. *"Collaborating works for us,"* one staff member opined.

"Connections to other organizations are our strength."

Executive Director, disability service provider

Although dv/sa services were among those described and although disability service providers at all three pilot sites described having referred clients for dv/sa services, these were not the service providers with which they enjoyed frequent, regular, and collaborative relationships. For example, at one pilot site, the disability service provider enjoys a strong networked relationship with a variety of community agencies providing services for individuals with disabilities. Staff reported that they have visited many local agencies to "share what we do and find out about what they do, but not with the dv/sa service provider." Even the staff members at the disability service provider at another pilot site, which exhibited the best knowledge of local dv/sa resources and the most developed relationships with dv/sa service providers among all the pilot sites, expressed misunderstandings and uncertainty about what exactly the dv/sa service providers could provide and what a relationship between their organizations would look like. Instead, disability advocates reported they sometimes were not sure about all the services their local dv/sa service providers offered and wished they had more communication and understanding of what such dv/sa service providers provided for clients and how they functioned. There is little cross-training among dv/sa and disability service providers currently in the pilot site locations. One staff member at a disability service provider well networked into local resources for individuals with disabilities acknowledged that she sent clients to dv/sa service providers when she did not know what to do for them. Another staff member at a different organization admitted she did not know where to send clients when abuse was

disclosed. Despite the current gap in communication between the dv/sa and disability service providers, their experience working with other community service providers give them experiences from which to draw when they eventually work with each other.

Like dv/sa advocates, disability advocates generally expressed interest in, and recognized the advantages of, creating a greater degree of interagency collaboration and integration between their services and networks of resources and referrals with those of dv/sa service providers. They suggested similar measures to integrate assistance to women with disabilities who become victims/survivors of domestic violence, which will now be enumerated.

Finding – Domestic violence/sexual assault, disability service providers, and individuals with disabilities share common values and an enthusiasm for improving accessibility around which collaboration can begin.

What we learned from individuals with disabilities

Focus group participants asked service providers to devise a simpler system that works equally for everyone. Individuals with disabilities, as discussed above, repeatedly requested a more centralized, simplified, and rationalized resource for service provision “with people who know how resources overlap and interconnect.” Both disability services and dv/sa services “need to be connected immediately” in “wrap-around service for that client.” The proposed collaborations between disability and dv/sa service providers and the integration of their networks of service providers may offer one way to meet this request.

Although the language used may differ, disability advocates, dv/sa advocates and individuals with disabilities want the same thing: to support and empower individuals by offering them choices to better their circumstances, while respecting an individual’s dignity and right to choose. dv/sa advocates described their roles in listening closely to their clients and in providing a safe, welcoming, supportive environment in which victims/survivors can explore options for their futures. “We listen, and let people know they are loved,” one staff member said. An Executive Director, stating her philosophy of advocacy, described her “number one priority” as providing the resources to meet clients’ needs so that the client does not feel she has to return to an abuser.

“If I can eliminate this and say, ‘No, no. I can help you with that. I can take care of that. Then she doesn’t have a reason to go back. But, if you want to go back because you want to go back, that’s fine. That’s your choice. But I don’t want a woman to leave here saying she has to go back because we can’t give her something she needs.” Advocates empower women while respecting their right to choose.”

Executive Director, dv/sa service provider

Domestic violence/sexual assault advocates empower women while respecting their right to choose. This sounds strikingly similar to disability advocates’ explanation of their role with clients. Advocates explain that their job is not to fix what may be wrong in a client’s life. Instead, it is to lay out options, resources, and choices from which a client can choose. In the end, it is the client’s choice and responsibility to follow through on those choices. Disability advocates, like dv/sa advocates, cultivate close listening skills and provide “hugs and Kleenexes” in their effort to provide a safe, supportive environment in which clients can feel comfortable making those choices. The importance of dignity, respect, choice, and self-empowerment were also powerful messages emerging from the focus groups with individuals with disabilities.

Participants asked for services to be provided without judgment, with respect for the individual choice and with input from individuals with disabilities.

Overall, individuals in the pilot site communities evinced willingness, and indeed an enthusiasm, to collaborate and build bridges between organizations, with individuals, and with communities to work on these issues. These shared values should form a powerful foundation from which to begin such work.

OBSERVATIONS ON INDIVIDUAL PILOT SITES

While the pilot sites exhibited many similar characteristics as described above, and while the creation of broad strategies and replicable models is critical to effective statewide systemic change, each current pilot site exhibited particular challenges and strengths that should also become part of the strategic planning process. As the last question of each focus group and interview, the IEAC asked participants for any additional information the IEAC would need to know to work effectively within that community that had not already been discussed. The resulting body of information must be incorporated with the generalized findings during the strategic planning process to suggest menus of initiatives that are simultaneously general enough to be replicated at future pilot sites but specific enough to work within the particularized environment of a specific pilot site community.

Pilot sites were assigned a number randomly to allow the IEAC to discuss individual sites while protecting the confidentiality of the executive directors, staff, and individuals at those sites.

Pilot Site #1

Pilot Site #1 appears to have many resources to assist women with disabilities who become victims/survivors of domestic violence, and individuals with disabilities as a group seemed better informed about this wide array of services than at the other pilot sites. The potential of these services to be utilized most effectively, however, is not being fully tapped. Services could be coordinated with greater consistency and publicized to a greater degree to better reach out to and serve these individuals.

Among pilot sites 1, 2 and 3, the disability and dv/sa Executive Directors and staff at pilot site 1 revealed the greatest enthusiasm about working with one another. There is a great degree of leadership and buy-in from both Executive Directors. A practical reality of both agencies' operations that will need to be taken into account with strategic planning is that this leadership is not available on site on a consistent basis. The dv/sa service provider's Executive Director is often out of the office on professional travel. The disability service provider's Executive Director is not resident in the pilot site community and is typically connected to staff by telephone, as he coordinates four offices over a broad, rural and semirural geographic area in the region. Also, staff at both organizations, while enthusiastic, also indicated they are very much overcommitted to pre-existing projects. When beginning specific strategic planning for this pilot site, planners should address ways to convey to staff how certain initiatives can actually save them time by increasing systemic efficiency.

Finally, more so than at any other pilot site disability service provider, staff repeatedly discussed the need for all that they do to adhere to Independent Living (IL) Philosophy. The heart of this philosophy centers around asking clients about what they want to achieve and helping them meet these goals. Advocates at the disability service provider seemed unsure as whether the proposed initiatives to aid victims/survivors of abuse would be consistent with the Independent

Living Philosophy and the type of work they performed with clients. The Executive Director, however, stated that if there is any suspicion of abuse occurring or that a client is in imminent danger, “*We overstep pure Independent Living Philosophy.*” Strategic planning will need to accommodate these views, ensuring that any menu of options is presented in an Independent Living Framework for our services.

Pilot Site #2

Strengths of this partnership include that the leadership of both pilot site partners is strong and that the service providers are located near to one another geographically, which should increase opportunities for face to face communications and for individuals with disabilities to make use of the services of both organizations. The dv/sa service provider is the most physically accessible of all the pilot sites, and the disability service provider refers more of its clients to local dv/sa service providers than any other disability service provider interviewed. The approaches of the two organizations revealed the most commonalities, with the disability service provider staff being cognizant of protecting client safety and training Personal Care Attendants (PCAs) to look for abuse and the dv/sa service provider having resources to make many needed accommodations. There was little apprehension voiced about assuming the extra responsibility of this collaborative work, even with limited monetary resources available.

Although the dv/sa service provider has the most comprehensive services and resources of any pilot site dv/sa service provider, strategic planning should take into account the facility’s desire to meet as many of its clients’ needs in-house as possible. The dv/sa service provider philosophy is that if they meet a client’s needs, she will have no need to return to an abusive situation. The dv/sa service provider philosophy is laudable. The staff and Executive Director reported, however, that they can’t get clients the services they need unless the clients are in the shelter. The problem, report the Executive Director and staff, is with “outside,” i.e. any services they don’t provide in house. As the Executive Director stated, “*If others aren’t willing to do as much as I’m doing. . .*” She says she is trying to provide a full service agency but recognizes she’s not able to. There may be an attitudinal barrier that could impact their ability to work effectively and reciprocally with other community service providers that the IEAC could plan to work around.

The dv/sa service provider at this pilot site seemed the most aware and knowledgeable about the unique service needs for women with disabilities who are victims or survivors of domestic violence or sexual assault. The staff and Executive Director were aware that their organization served women with disabilities, but opined that they generally cannot get clients with disabilities the services they need unless they are in the shelter. The problem, as they see it, is “*outside,*” with other service providers. They do not see any problems with their organization meeting the needs of women with disabilities but “*it is just harder*”.

Lastly, the disability service provider works primarily with multiple shelters in the immediate area. They described one shelter as being more effective than the others. Another less effective shelter, however, is closer to the disability service provider. It has sometimes been easier for the disability service provider to find shelter space for clients at this nearer shelter. Strategic planning should recognize the sensitive nature, in a community this size, of these relationships and work to minimize any problems that might occur with other shelters due to the expanded relationship between the disability service provider and the dv/sa service provider.

Pilot Site #3

The LDS Church, including the LDS Church's Brigham Young University (BYU), is a strong influence in this pilot site community. The pilot site partners will need to work within that influence. Fortunately, the Church provides many social support services and resources that are unavailable elsewhere in the community. At the same time as the LDS Church engages in such valuable work, it tends to work in isolation. Partners will need to focus on creating openings into the Church's work and on creating collaborative opportunities.

A critical starting point would be to establish a representative from the disability service provider in the pilot site community who would work with the dv/sa service provider, the LDS Church, its members, and non-LDS individuals, building bridges between these groups. The disability service provider Executive Director pledged money to fund this position when such a person is found.

A positive relationship should also be forged between the disability service provider and BYU, which supports many of the dv/sa programs services by providing social work interns. A way to link the disability service provider into this pre-existing relationship should be discussed. Overall, the influence and resources of the LDS Church and BYU in this pilot site community must be worked into the strategic planning for the collaboration between the disability service provider and the dv/sa service provider.

Domestic violence/sexual assault staff believed that there are resources in the community for dv/sa if the victim/survivor has money.

Overall, the need in this pilot site was greater than in any other pilot site. For example, services for individuals with disabilities who are victims/survivors were the least coordinated of all the pilot sites. The disability service provider, as described above, has tried to work with individuals with disabilities and dv/sa service providers but has not enjoyed a great deal of success, which they attribute, in part, to religious and cultural issues. Moreover, the Executive Director at the dv/sa service provider stated she was not coordinated with other local agencies to provide services to women with disabilities who needed accommodations. The dv/sa staff describes their shelter as having no accommodations for clients who are deaf or blind. The shelter is also not wheelchair accessible. There were no efforts at broader programmatic accessibility discussed by the dv/sa staff or the Executive Director. Staff members were unfamiliar with identifying assistive technology resources in the area.

Both disability service providers and dv/sa service providers seemed the most misinformed about the intersections of domestic violence and disability, harboring many misconceptions and biases that are a barrier to effectively providing services to women with disabilities who become victims/survivors of domestic violence, as was discussed in detail above. Some first steps the IEAC could assist each organization in taking would be in creation of a Domestic Violence Workplace Policy for the disability service provider and increased training for their Personal Care Attendants. The dv/sa service provider requested assistance with policies and procedures on medications, confidentiality, and the legal and ethical ways to ask clients about disability issues and needed accommodations.

Individuals with disabilities were also very misinformed about their local services to assist victims of domestic violence and sexual assault and exhibited a great deal of anger as a result of this misperception. Their criticisms were leveled primarily at a dv/sa service provider that is NOT the community pilot site partner. Focus group participants perceived that women with

disabilities and human trafficking victims had a particularly difficult time accessing services. Although individuals' anger was not directed at the pilot site dv/sa service provider partner in particular, significant effort will need to be made to re-establish trust between service providers and the individuals they attempt to serve.

Section 6

Implications of Strengths and Needs Assessment Findings

The information gathered from focus groups and interviews conducted at all three pilot sites was compiled into the above composite set of findings, which shall assist in long term strategic planning at each of the pilot sites. The implications of these findings, shall be used to identify possible initiatives that the IEAC can undertake in general, as well as in each particular pilot site location.

Implications:

- WWD would like “wrap around services,” available at one easily usable central information resource for services, where it is clear how services overlap and interconnect. They specified that they would like:
 - A roster of service providers including agency names, specific person to contact, services offered, hours of operation, phone numbers, and addresses;
 - The roster could be indexed by agency and also by services offered,
 - The roster would include physicians and psychiatrists;
 - The roster would be available in alternative formats and in ways and locations that are accessible to people with disabilities; and
 - It might be made available in a booklet or community bulletin board format or both.

Suggestions for how individuals with disabilities would like to receive such information included:

- Television and radio public service announcements
- Local TV station “tip lines”
- Ads in local newspapers
- Fliers from local agencies such as welfare office, food stamps office, Medicaid, sheriff's office, police departments, behavioral health, unemployment office, hospital emergency rooms
- Victims Advocate services
- Libraries
- 2-1-1 Careline
- Disabilities service organizations
- Doctors' offices
- Psychiatrists' offices
- Psycho-social rehabilitation (PSR) workers
- Attorneys' offices
- Grocery stores
- Churches
- Posters in women's restrooms, including bar restrooms

Individuals with disabilities tended not to want information via the internet—at least not exclusively—since many individuals with disabilities do not have access to a computer on a regular basis. **While this grant does not support activities that would meet this need, the information may be useful to the pilot sites when developing other projects.**

- At each pilot site there is a need for education and dialogue among individuals with disabilities, disability service providers and dv/sa service providers. The IEAC must foster this type of interagency networking, communication and referral to facilitate the IEAC's vision of women enjoying equal access to the comprehensive services of her choice, no matter where she accesses the integrated network of services.
- Currently, pilot site disability service providers and dv/sa service providers hold inconsistent views as to what constitutes abuse. Occasionally, when referrals have been made to one another, the receiving agency has disagreed that abuse was occurring. Education to bring both service providers to the same understanding of what constitutes abuse is needed to prevent damage to their working relationships.
- Currently, dv/sa and disability service providers hold misconceptions about the services each provides. Cross-training to educate each other about what services they offer is needed to alleviate these misunderstandings and resulting frustration over what service providers think the other should be doing. As well, cross-training on each other's philosophical underpinnings is required so that they understand why each organization offers the services they do, and the spirit in which those services are offered.
- Currently, pilot sites rely on Personal Care Attendants to report suspected abuse, despite the fact that PCAs may be the abusers. The pilot sites would benefit from education on this topic. Technical assistance in developing alternative avenues and methods of identifying and reporting abuse is also needed.
- Service providers currently have a narrow view of what constitutes accessibility. Education, technical assistance and cross-training to provide a broader view of what constitutes accessibility would be helpful to make their programs welcoming to individuals with disabilities. For example, education and technical assistance regarding: the Americans with Disabilities Act (ADA) intake procedures, interactions between survivors with disabilities and staff, program accessibility, counseling, support groups, education, communal shelter life, and survivor education, would be helpful. Also, reviewing all website, documents and materials to make sure they are integrating disability and creating a welcoming environment for survivors with disabilities would be helpful.
- Service providers may benefit from education about individuals with disabilities and dv/sa victims to increase appropriateness, understanding, and comfort when working with these populations.
- Collaboration among community service providers is integral to meeting the many unique service needs of survivors with disabilities. Service providers should receive technical assistance to facilitate this collaboration and create avenues for making referrals or combining advocacy.

- Service providers should be provided with technical assistance in creating and implementing formal, accessible, policies, procedures, and protocols within their agency, including formalized, but flexible, procedures for reporting suspected abuse of individuals with disabilities.
- Currently, Boards of Directors do not perceive enhancing service for survivors with disabilities as a priority. They cite to the low number of individuals contacting their programs for assistance. Unfortunately, survivors with disabilities report that they do not contact these service providers because the programs do not appear to be welcoming or accessible. Boards of Directors should be educated about this dynamic and encouraged to proactively allocate funding to enhance their program's services such that they are more welcoming and accessible to survivors with disabilities.
- Service providers should be provided with technical assistance to develop a web of coordinated and collaborative working relationships and resulting referral systems that is simple and works equally well for everyone.
- Service providers should receive cross-training about each others' philosophies and services so they find common ground from which to enhance their working relationships.
- Ensure that development and implementation of outreach materials and public awareness campaigns send a message of a welcoming environment.
- Increase their confidence in each other such that they can work together and make referrals to one another.

How DV/SA and Disability Advocates Envision Future Collaborations

- Increased coordination and regular communication between local dv/sa advocates and disability advocates and their organizations, possibly through interagency meetings where each agency has a spokesperson who then takes information back to share with the entire staff at the home agency.
 - Each agency should know specific contact persons within other agencies, as well as the specific services each agency provides or refers out to. Desired formats were written, CD, and website formats.
 - Face to face contact was considered critically important. Agency representatives should visit one another's facilities and meet staff and Executive Directors. This, it was felt, would increase trust among the organizations and individuals.
 - Communication between organizations should be frequent and transparent.
 - Such communication should involve a frank discussion of what resources each agency provides, what each hopes for from other organizations, and what each agency understands as its ethical and legal obligations regarding service provision, confidentiality, and mandatory reporting, among other issues.
- Joint trainings and conferences with local dv/sa advocates and disability advocates, ideally with Continuing Education Units (CEUs) offered. Attendees and presenters should attend with a "we need to learn from you" attitude rather than a "come in and fix you" attitude.
- Exchange of board members.

- Creation of multidisciplinary teams composed of representatives from different agencies to aid clients to “reintegrate [the client] into the community as a healthy, employed, successful woman.”
- Avoid duplication of efforts and services.

The desired outcomes of such collaborative efforts are that individuals with disabilities who are victims/survivors of domestic violence could be offered a consistent set of choices to meet their needs. For example, the dv/sa staff at one pilot site reported that they have never referred to the disability service provider in that community and have no access to assistive technology for a client who might need such an accommodation. By effectively integrating the disability service provider’s network and the dv/sa service provider’s network, an individual could have access to the same assistive technology (AT) resources, whether she sought services at the disability or the dv/sa service provider. Certainly there are not unlimited resources in each community, but the integration desired by both dv/sa and disability service providers could increase opportunities for individuals with disabilities who identify as victims or survivors to access the services they need and want.

Appendix A
Demographic and Statistical Information

Demographics of Pilot Sites and Pilot Site Selection Process:

- Coeur d’Alene, Idaho: Women’s Center and Disability Action Center Northwest (DAC-NW)

Located in the upper panhandle of Idaho in Kootenai County, Coeur d’Alene is the third fastest growing county in Idaho. The IEAC chose this pilot project site because of its diverse population, geographical location and the location of the Disability Action Center Northwest DAC-NW, independent living center. It is the least populated of the IEAC’s pilot project sites with a population of approximately 40,000. Coeur d’Alene is the county seat and the largest city of Kootenai County. The city has grown significantly in recent years due to a substantial increase in tourism; however the median household income is \$33,000. There are several smaller cities located within 50 miles that do not have any domestic violence/sexual assault services so the Women’s Center is the only dv/sa resource for these communities other than the services provided by Washington State. The same holds true for the disability community. The DAC-NW is the only independent living center serving individuals with disabilities in the community.

It was the intent of the IEAC in the initial discussions during the selection of this site to work with the Coeur d’Alene Indian Tribe, however, after the VERA retreat in June 2007 we were informed that the tribe was in the process of forming their own domestic violence/sexual assault coalition and was not interested in participating at this time.

- Rexburg/Idaho Falls, Idaho: Family Crisis Center and Living Independently for Everyone, LIFE, Inc.

Located in east central Idaho in Bonneville County, Idaho Falls is the largest city with a population of approximately 53,000 city and an area population of 110,220. The median household income in the city is \$40,512. Idaho Falls has many faith based organizations that serve families in need but the only domestic violence/sexual assault service provider, the Family Crisis Center, is located in Rexburg, Idaho which is approximately 20 miles from Idaho Falls. The IEAC chose this pilot project site for that reason and because LIFE, Inc. had already established a relationship with the Family Crisis Center.

- Nampa, Idaho: Valley Crisis Center and Living Independence Network Corporation, LINC.

Located in the western part of Idaho, Nampa is the second largest city in Idaho and the largest city in Canyon County with a population of approximately 78,000. Nampa is 20 miles from Boise with many rural communities that have no domestic violence/sexual assault service providers. In some cases victims of domestic violence/sexual assault have sought services in Ontario, Oregon which is approximately 45 minutes away. Nampa has a large Hispanic population due to the agricultural industry in the out lying areas. The median household income is \$34, 758. The IEAC chose this site due to the number of domestic violence/sexual assault crime statistics, lack of public transportation, and it’s close proximity to the city of Boise.

- State:

Idaho is a large (84,000 sq. miles), geographically diverse state with a widely dispersed population of 1.4 million, approximately half of which is female. Approximately 12% of Idahoans live at or below the poverty level. Idaho is considered a frontier state, 17 of its 44 counties have 6 or fewer people per square mile. Domestic violence is prevalent in all communities, but rural communities are unique in that they increase isolation and create special considerations for victims. According to a statewide statistically valid assessment conducted in 2005 by Boise State University for the State Independent Living Council, 44% of Idaho households have at least one member with some form of disability. At least 60%, or 92,400, of Idahoans with disabilities are female.

Idaho's social climate is unique. Idahoans possess a strong "pull your self up by the bootstraps" attitude which can be detrimental to the initiation and sufficient funding of desperately needed social services. Support from agencies outside of Idaho provide Idaho with much needed funding to develop important social service systems allowing us to positively affect change and to help those most in need.

Idaho's disability related service organizations, domestic violence and sexual assault programs, and supporting groups including faith-based, law enforcement, legal assistance, healthcare, counselors, caregivers, and families, all report both a high occurrence rate of abuse and difficulties serving women with mental, physical, and/or emotional disabilities. Service providers at all levels complain of difficulty serving women with disabilities because of a widespread lack of cross-disciplinary collaboration, training, and services.