

Transitional Housing for Survivors of Domestic and Sexual Violence: A 2014-15 Snapshot

The following is the narrative for the webinar presentation: [Overview Webinar #2 \(Chapters 5-8\)](#)

Slide #1.

(No narration. This is the title slide.)

Slide #2.

Welcome to the webinar series describing the report entitled, "Transitional Housing for Survivors of Domestic and Sexual Violence: A 2014-15 Snapshot."

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This project would not have been possible without the valuable contributions of the dedicated provider staff who took the time to candidly share their experience and insights to inform the text, nor would it have been possible without all of the research, advocacy, and creative energy of all of the practitioners whose publications and online resources we learned from and cited.

Special thanks also go to the following people and organizations for their help:

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- Dr. Cris Sullivan (Michigan State University) and Anna Melbin (Full Frame Initiative) for their very helpful reviews and comments on initial drafts of the report chapters.

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The project webpage at www.air.org/THforSurvivors contains links to the 12 chapters of the Report. Each chapter of the report contains background information and reference material on the topics covered, and extensive collections of provider comments from our interviews. Each chapter includes an executive summary; lists of questions that the interviews raised for us, and that we invite interested readers to consider; a reference list; and an appendix describing the project methodology and approach.

The project webpage also contains links to:

- A brief webinar describing the project methodology and approach, and four Overview webinars describing the content of the various chapters of the report;
- Four brief podcast interviews highlighting the approaches of a few of the providers we interviewed; and
- "Broadsides" highlighting a couple of the topic areas this report addresses.

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The project report is divided into 12 chapters. The first overview webinar describes chapters 1-4.

Slide #5.

The webinar you are currently viewing is Overview Webinar 2, which describes chapters 5-8.

Slide #6.

The third overview webinar describes chapters 9 and 10, and the fourth and final overview webinar describes chapters 11 and 12.

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Before starting to explore the individual chapters of the report, we should state the obvious: that many of the topics are interrelated. For example, how a funder measures success may, for better or worse, impact how the providers that depend on that funding shape their participant selection process, the kind of housing their programs support, their programs' policies on participant lengths of stay and the types of assistance staff are asked to provide. Source of funding may well impact all of those aspects of programs, and more. The type of program housing may impact policies on length of stay, participant selection, the definition of success, and staffing decisions. Participant selection policies may impact program decisions about the type of housing to support, length of stay policies, and staffing priorities.

That is, policies, procedures, and decisions affecting one aspect of providing transitional housing for survivors may impact and be impacted by policies, procedures, and decisions affecting other aspects.

One more thing before getting started with the individual chapters. Our report has followed the example of numerous publications -- for example, by the National Center on Domestic Violence, Trauma & Mental Health and the Missouri Coalition of Domestic and Sexual Violence -- and uses feminine pronouns to refer to adult victims/survivors of domestic and sexual violence, and masculine pronouns to refer to the perpetrators of that violence.

Citing data compiled by the Bureau of Justice Statistics, the Missouri Coalition, in the 2012 edition of *Understanding the Nature and Dynamics of Domestic Violence*, explains that decision as follows:

"According to the most comprehensive national study by the U.S. Department of Justice on family violence, the majority of domestic violence victims are women. Females are 84 percent of spouse abuse victims and 86 percent of victims at the hands of a boyfriend or girlfriend. The study also found that men are responsible for the vast majority of these attacks—about 75 percent. And, women experience more chronic and injurious physical assaults by intimate partners than do men."

This use of pronouns is not meant to suggest that the only victims are women, or that men are the only perpetrators. Indeed, the victims and perpetrators of domestic and sexual violence can be male or female or transgender, as can the staff that support their recovery, and our shortcut is only used to keep a long document from becoming a little wordier and less readable.

Lastly, although the OVW funds transitional housing programs to address the needs of not only domestic violence survivors, but also survivors of sexual assault, stalking, and/or dating violence, the preponderance of program services are targeted to DV survivors, the large majority of TH program clients are survivors of domestic violence, and much of the literature and most of the provider quotes address domestic violence. Consequently, most of the narrative is framed in terms of addressing "domestic violence" or "domestic and sexual violence," rather than naming all the OVW constituencies.

Just a reminder for viewers interested in the project methodology and approach, that from the project webpage, you can download a brief webinar on the "Project Methodology and Approach." Alternatively, you can read about the project methodology and approach in an appendix at the end of each report chapter.

Slide #8. NEW

Chapter 5 explores some of the staffing-related challenges and approaches in operating a transitional housing program for survivors. Topics covered include staffing patterns, including the pros and cons of staffing continuity from shelter to transitional housing, hiring strategies, pros and cons of hiring survivors, pros and cons of having a clinician on staff, pros and cons of having child-focused staff, addressing staff diversity, staff training, staff supervision and support, and the use of volunteers.

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The narrative begins with a brief review of the many factors that might influence staffing decisions, including program capacity and funding; housing configuration (i.e., congregate, clustered, scattered site); housing ownership (i.e., provider-owned, provider-leased, privately owned); the geography of the service area and where participant housing is located; the demographics of the community or region served; the size of the parent agency and its ability to contribute the time and expertise of staff from the other programs it operates.

That narrative is followed by provider comments that illustrate the variety of shapes and sizes of TH programs and their staffing patterns.

On average, according to semi-annual reports from the period 7/1/12 through 6/30/14, providers used OVW grant funding to pay for .8 FTEs of a case manager/advocate-type position, .11 FTEs of specialized staff (e.g., counselor, child advocate, child care worker, legal advocate, etc.), and .07 FTEs of administrator time. Generally speaking, provider comments indicated staff-to-participant ratios of between 1:8 and 1:12. For a variety of reasons, described in the report, it is not possible to calculate actual caseload sizes from semi-annual report data.

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The Chapter 5 narrative and provider comments discuss the criteria that programs use in making hiring decisions -- how providers balance consideration of candidates' experience, education, personal attributes, attitudes, and knowledge and beliefs; what they look for, and what they attempt to avoid.

On the matter of hiring survivors, some providers are enthusiastic, and harken back to the roots of the movement, while other others are wary. Other providers are in the middle of that continuum. While acknowledging the credibility and perspective a survivor's life experience affords and their commitment to the work, some of the providers who expressed reluctance described their concern about the difficulty survivors may have in maintaining professional boundaries, and about their vulnerability to secondary traumatic stress - - particularly if their own experiences of domestic or sexual violence are "too recent."

On the matter of including a clinician on staff, our interviews likewise found diverse opinions: On the one hand, given the trauma that survivors carry, and the not infrequent co-occurrence of mental health or substance use issues, a clinician's knowledge and perspective can be useful. Also, clinical supervision can add an important dimension to the support and guidance that advocates/case managers receive, and a clinical supervisor is well-positioned to recognize early signs and symptoms of secondary traumatic stress in direct service staff. On the other hand, some advocates are wary of how a clinical focus can pathologize survivors, and of how clinicians have misdiagnosed symptoms of trauma and instead labeled survivors with mental illness diagnoses.

Perhaps because of increasing awareness about the physiological and neurological impacts of trauma (and traumatic brain injury), the providers interviewed for this project seemed to broadly -- but by no means unanimously -- agree about the beneficial role that clinicians can play, and the advantage of having clinicians on hand who understand the impacts of domestic and sexual violence, as opposed to depending on external clinicians who may lack that perspective, and whose approach may, therefore, be less trauma-informed. Of course, clinical staff are not something that small providers with very limited budgets for staffing can afford.

There were mixed opinions about whether child-focused services should be a priority of a TH program. Some providers embrace their agency's role in working with children, citing the profound impacts on children of exposure to violence and the importance of primary relationships, like the mother-child bond, in promoting resiliency. They noted that often, work with children that begins when a family is in shelter can continue, even as families move on to transitional housing. Since OVW guidelines prohibit providers from using the TH grant to pay for children's services, other than childcare or ancillary services, any child-focused staff would have to be funded with other sources.

Other providers felt that survivors' children were not part of their primary clientele; asserted that a child's needs were best addressed by working with the mother, or with mother and child, but not separately with the child; stated that school personnel could address any child-related needs; and, given the voluntary services model, questioned whether there was a proper role for a child-focused staff person in a program, unless the gatekeeper parent had identified an unmet need that school-based personnel could not address.

On the topic of staff diversity, providers generally agreed that having someone on staff from the same ethnic, cultural, religious, and/or linguistic community strengthens the ability of a TH program to serve survivors from that demographic -- provided that such staff are otherwise qualified for the role they will fill. In particular, there seemed to be strong appreciation of the importance of having the capacity to communicate with survivors in the language they prefer. Interestingly, the issue of racial diversity of staff arose less frequently in our interviews, and the only providers that spoke about staff diversity in terms of gender identity and/or sexual orientation were the providers interviewed specifically for their expertise and experience in serving LGBTQ survivors.

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The Chapter 5 narrative and comments on staff training and support cover a lot of ground.

With respect to training... All providers interviewed for this project indicated that their programs require new staff to participate in an intensive training, typically 20-40 hours long, offered by their agency or their state coalition. Different providers have different training requirements, and use different curricula and training materials. At present there is no national standard, although one paper cited in the section proposed such a standard, and outlined a suggested curriculum.

Some agencies have annual training requirements; others don't. Even where providers did not mention annual training requirements, they did say that throughout their employment, staff are encouraged to attend on-line and in-person trainings and conferences, including trainings sponsored or conducted by their state or national coalitions, subject to availability of funding, if there is a cost attached. (OVW requires grantees to include funds for travel and attendance at its mandatory trainings.)

The narrative contains links to online training materials and curricula developed by state coalition and other sources of expertise. State coalition websites are also good places to look for training manuals addressing specific topics, and the narrative contains links to over a dozen such sites.

National advocacy and technical assistance providers have produced toolkits, resources, and webinar training covering a multitude of relevant topics, and the narrative contains links to resources on the websites of the National Network to End Domestic Violence (NNEDV), the National Resource Center on Domestic Violence (NRCDV), the National Center on Domestic and Sexual Violence (NCDSV), the National Center on Domestic Violence, Trauma and Mental Health (NCDVTMH), and the Battered Women's Justice Project.

The narrative and provider comments in Chapter 5 also address the approaches providers take, or might take, to supervise and support program staff, and to prevent, and if need be, address staff burnout and secondary traumatic stress (STS). The case managers/advocates who walk alongside and support survivors are the backbone of TH programs, and staff turnover is costly, in terms of time and expense of hiring and training replacement staff, and, even more important, in terms of the adverse impact on survivors who lose a trusted partner in their journey to heal and rebuild their lives.

The providers we interviewed address the risk of secondary traumatic stress and burnout by offering paid time off, so staff can step away and decompress from the work, and wellness packages, including gym memberships and free counseling; by allowing staff to work a flexible schedule; by teaching and encouraging self-care; by providing regular supervision; by acknowledging work successes and personal milestones, like staff birthdays; by organizing fun activities; by setting aside time at regular meetings or periodic retreats for staff to provide and receive peer support in dealing with difficult situations, challenging emotions, and other issues; and by teaching and supporting staff in setting appropriate boundaries. Links to published and online resources and provider comments provide additional insights about specific approaches for creating a healthy and sustainable work environment.

The narrative provides information and links to reference materials on three types of supervision.

- In her recorded training on "[Advancing Trauma-Informed Services through Reflective Supervision](#)" Dr. Terri Pease of the NCDVTMH describes **reflective supervision**, a non-prescriptive, non-hierarchical, non-judgmental approach that provides a safe space for staff to discuss work experiences that they would like to process and learn from. The goals of this approach are improving service quality, and enhancing staff skills and job satisfaction. Dr. Pease describes the supervisor's role as facilitative, helping the staff member reflect on what they were trying to achieve, what they did, how it worked -- the consequences and how the survivor reacted, how they feel about what they did, what they could have done differently or additionally, what they can learn from the experience, and how that will influence their future efforts.
- The National Association of Social Work's guidance manual on **Social Work Supervision** offers a different perspective on the elements and roles of a supervisory relationship. As framed by the NASW, supervision addresses three primary domains: administrative (doing your job), educational (personal growth and professional development), and supportive (addressing unsustainable stress and potential burnout).
- [SAMHSA's \(2014\)](#) manual on Trauma Informed Care in Behavioral Health Services provides guidance on clinical supervision, explaining the three roles the supervisor takes, depending on the needs of the staffperson: (a) the teacher, providing guidance in the use of specific counseling strategies with program participants; (b) the counselor, helping the staff member reflect on her work and her personal reactions to participants; (c) and the consultant, providing the staff member with advice on specific issues. Although supervision for case managers/advocates in a TH program is not necessarily clinical or provided by a clinically trained person, the framework suggested by the SAMHSA manual, and in particular, the guidance on supervision in the context of a trauma-informed program, may nonetheless be helpful.

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Chapter 5 concludes with a discussion and provider comments about the use of volunteers. Although shelters, hotlines, and other center-based programs often utilize volunteers, many of the providers interviewed -- especially providers operating scattered site programs -- indicated that their TH program does not.

Providers most likely to utilize volunteers were full-service domestic violence and sexual assault providers that also operate non-residential service programs that serve TH program participants, and agencies that operate congregate or clustered housing programs, or programs in which scattered site participants are close enough to regularly access services or attend activities at a central meeting place.

Of the TH programs that reported utilizing volunteers, some leverage pro bono services by local professionals (e.g., attorneys, therapist/counselors), who provide the kind of services that the agency cannot afford to fund out of its budget, and cannot leverage from other providers. Other programs utilize MSW student interns to offer routine assistance to TH program participants. Some programs engage corporate or community volunteers in periodic "days of service" to maintain program facilities or in more one-on-one type activities, like assisting with mock interviewing or resume development. Some programs have community volunteers that fill administrative roles; provide haircuts, manicures or pedicures, or massages; teach yoga for participants (or staff); contribute food or baked goods for meetings or presents for the holidays; or help with childcare during adult group meetings.

Several providers spoke about the importance of integrating volunteers from segments of the community that are not adequately represented on the paid workforce in order to increase the overall diversity and cultural and linguistic competence of the program. In some cases, these volunteers may serve as interpreters, if they speak a language spoken by one or more participants, but not by staff. Advocates for cultural and linguistic competence might argue that lack of proper compensation devalues their importance to the program, and might prevent the program from accessing professional caliber interpreters who would do a better job.

Some providers recalling the "early days" when domestic violence programs were all staffed by volunteers, believe that with the right training (comparable to starting staff) and strong supervision, volunteers can provide essential participant services. Other providers, expressed concerns about the consequences of volunteer turnover or lapses in confidentiality, and were reluctant to commit resources to the necessary training or to put volunteers in direct care positions. Still other providers believe that even with training, volunteers are not qualified to work with survivors, and that it would shortchange participants if volunteers delivered services instead of fully qualified and trained staff.

Even if they do not provide direct services, utilizing volunteers was seen as a way of engaging the community in supporting and publicizing the work of the agency, and building the base of funding and political goodwill.

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Chapter 6 addresses "length of stay," a term used to describe the duration of assistance in a transitional housing (TH) program, and one of the most controversial aspects of jointly OVW/HUD-funded projects.

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On paper, HUD and OVW have more or less the same approach to length of stay. The OVW authorizing statute defines the minimum term of transitional housing as six months, and the maximum length of stay as 24 months, but allows a survivor to request a waiver enabling an extension by up to six months, if she has made a good faith effort to obtain permanent housing, but has been unsuccessful. The OVW's annual solicitation directs grant recipients to be prepared to offer at least three months of follow-up support.

HUD's regulations do not define a minimum length of stay in a TH program, but set the maximum stay at the same 24 months, and allow for an additional six months of post housing placement case management for follow-up support (§578.53(b)(3) of the [CoC Interim Rule](#)). §578.79 of the CoC Interim Rule also allows homeless participants to *"remain in transitional housing for a period longer than 24 months, if permanent housing for the individual or family has not been located or if the individual or family requires additional time to prepare for independent living."* The regulation warns that HUD may discontinue funding for a TH project *"if more than half of the homeless individuals or families remain in that project longer than 24 months."*

However, the era of such extended stays in transitional housing is long since gone.

HUD's regulatory framework for rapid rehousing likewise imposes a 24 month limit on rental assistance. RRH grants can either be funded through the Continuum of Care (CoC) program or the Emergency Solutions Grant (ESG) program. In the interest of targeting assistance to the neediest individuals and families, ESG-funded grants require that rental assistance be terminated, if at the 12-month anniversary, the program participant's income exceeds 30% of the Area Median Income; there is no such one-year mandatory cutoff for rental assistance funded through a CoC RRH grant.

However, both the ESG and CoC regulations direct the entity administering the grant (a Continuum of Care for CoC grants, and a state/county/jurisdiction for ESG grants) to develop and implement written standards governing the amount, duration, and scope of rapid rehousing assistance, and, as noted in its [Rapid Rehousing Brief](#), HUD expects the duration of assistance to be far less than the two year limit -- the document suggests a six month timeframe -- thereby allowing the grant to serve more homeless households:

Specifically, the [Rapid Rehousing Brief](#) cites as an "operating principle ... that households should receive just 'enough' assistance to successfully exit homelessness and avoid returning to the streets [or] emergency

shelter;" (p.1) and explains that RRH grant funds are intended to support "crisis-related, lighter-touch (typically six months or less)" (p.5) housing assistance and staff services, while relying on linkages to other community-based services (which may or may not be adequate, available, or accessible) to address survivors' other needs:

"Rapid re-housing is not designed to comprehensively address all of a recipient's service needs or their poverty. Instead, rapid re-housing solves the immediate crisis of homelessness, while connecting families or individuals with appropriate community resources to address other service needs." (p.2)

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The narrative describes how OVW grant-funded programs take different approaches to framing the duration of assistance for participants. Some programs simply treat the **maximum length of stay** as the **expected length of stay**, while other programs define a **targeted length of stay** or a baseline period of assistance and then allow for extensions -- which may be routinely approved, or conditionally granted -- up to the maximum 24 months. Some programs routinely provide only six months or a year of assistance; others routinely offer the full two years allowed by law.

While there is nothing inherently problematic with setting targeted lengths of stay or dividing the total stay into a baseline period and periodic extensions for the purpose of focusing on progress made and progress yet to be made, the narrative observes that programs that make such extensions of assistance contingent on "demonstrated effort" or "participation in services" or "progress" may be at odds with the VAWA voluntary services requirement, or at risk of violating the OVW's admonition (in its annual [solicitation of TH proposals](#)) against "requiring survivors to meet restrictive conditions in order to receive services."

To the extent that such policies have a disparate impact on the ability of persons with disabilities (or other protected classes) to receive program assistance, they may also violate anti-discrimination laws, and, if the provider owns or leases the housing to which access is conditioned, fair housing laws.

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42% of the TH providers we interviewed (all but two of which were OVW grantees) receive HUD TH or RRH grant funding. Quite a few of those providers cited pressure from HUD (or from the Continuum of Care or state/county/jurisdiction administering their HUD grant) to reduce participant lengths of stay to levels the providers felt were inadequate to support survivors in their recovery from the violence and abuse they fled and their preparation for next-step housing or other options.

On the one hand, shorter lengths of stay allow programs to serve more survivors within their existing budgets, and provide what some providers see as "external motivation" for program participants to focus on the tasks they need to complete in order to successfully transition to permanent housing or other option they prefer.

On the other hand, a shorter length of stay may limit a program's ability to adequately support survivors in recovering from the trauma and the other adverse impacts of abuse; in overcoming serious obstacles to gainful employment and/or sustainable housing (if those are the survivor's goals); and/or in addressing any of the survivor's non-housing-but-high-priority needs/concerns (e.g., pertaining to their or their family's health or safety; legal issues, like child custody; children's developmental setbacks; etc.)

Scattered site participant-leased apartments now constitute almost two-thirds of all OVW-assisted TH units, and constitute 90% of the new units added over a recent two-year period. Scattered site, participant-leased housing constitutes an even larger portion of the inventory if we count units funded by HUD grants in programs whose serves are funded by OVW. Since all HUD-funded RRH units, and an increasing percentage of OVW-funded units must be leased by the survivor, the **ability to obtain a lease in her name has increasingly become a prerequisite for survivor participation in an OVW TH program.**

Shortening the program timeframe makes it less feasible for survivors with serious housing barriers to access transition-in-place programs, and may discourage such providers from even trying to serve them --

unless the housing search process is on a "different clock" than the portion of the program that takes place once the survivor is in their transition-in-place housing; so that time the survivor spent in shelter, while they received assistance finding housing and resolving their housing barriers doesn't get deducted from the time they are allowed to receive rental assistance and accompanying case management/advocacy support.

A shortened program timeframe may also jeopardize the ability of survivors with significant housing barriers to be served in traditional TH programs (i.e., program that temporarily house participants in provider-owned or provider-leased housing). The duration of the housing search process is often a determining factor in the length of stay in such TH programs, and it is not uncommon for survivors who are otherwise ready to move on to remain in a program because they can't find decent housing they can afford -- or a landlord who will rent to them. The last thing TH providers want to do is prematurely discharge a survivor who is ready to move on, and force them to choose between shelter, couch surfing, or returning to the abusive relationship they fled, simply because there wasn't enough time to complete a housing search.

Unfortunately, there is no way to track the number of survivors with serious housing barriers who have been unable to enroll in a transition-in-place program, due to inability to lease an apartment, and/or unable to enroll in a traditional TH program, because their housing search was likely to require more time than the program could allocate given pressures to shorten stays. Given the sharp decrease in the numbers of traditional TH programs, a survivor would be lucky if both options were still available in their service area.

Slide #17.

The OVW is committed in its Transitional Housing Assistance Grant program to ensuring that grant-funded housing and services are available to survivors from the full diversity of subpopulations, and are offered in a culturally and linguistically competent manner. Chapter 7 examines the implications of that commitment, that is, the nature of the different subpopulations who need that assistance, what it means to provide such assistance in a culturally and linguistically competent manner, and how providers fulfill that obligation.

Slide #18.

Domestic violence and sexual assault affects people from all walks of life. Thus, in its annual grant solicitation the OVW encourages applicants to "explore ways in which they will meaningfully increase access to OVW programming for specific underserved populations (based on race, ethnicity, sexual orientation, gender identity, disability, [and] age" and warns against discriminatory "procedures or policies that might exclude victims from receiving ... assistance based on actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition, physical health condition, criminal record, work in the sex industry, or the age and/or gender of their children."

Rather than presuming to identify and catalog the relevant attributes and needs of all these subpopulations, the chapter 7 narrative provides extensive listings of subpopulation-specific resources which will hopefully provide the reader with useful background information and specific insights into how members of the various communities may experience domestic and sexual violence, and how they may be appropriately supported.

It is all too easy -- and misleading -- to generalize about people from different racial, ethnic, religious, or linguistic communities, as if they were homogeneous. While common stereotypes of African Americans, Latinas/Hispanics, Asians and Pacific Islanders, and Native Americans/Alaska Natives, for example, may have some basis in reality, they may also have a basis in racism, misunderstandings, and outdated generalizations and assumptions. Treating people from a common racial or ethnic background as if they were all cut from the same cloth ignores the many factors that shape individual beliefs, values, and experiences: the country, region, or tribe a person (or their forebears) may have come from; how long they (or their parents) have been in the U.S, if they have immigrant roots; the extent to which they and their family have integrated into the "mainstream" or maintained traditional ways; their age and generation, and the age at which they came to the U.S. (and whether/where they attended school), if they are immigrants; the extent to which they are affiliated with traditional religious or cultural institutions; the extent to which they speak English, if that was

not their native language or the native language of their parents; their socioeconomic status and the socioeconomic status of their parents/extended family; where in the United States they live and grew up; etc.

In the same way that racial, cultural, and linguistic communities are not homogeneous, so, the LGBTQ community includes different subpopulations. For example, although there may be commonalities in their struggles against discrimination, lesbian women, gay men, bisexual men and women, and transgender men and women are likely to have had different experiences with self-acceptance, coming out, and with acceptance or rejection by their family of origin, their peers, and the larger community. There are parts of the country where lesbians and gay men can be open about their sexuality, and there are parts of the country where they may be wary of coming out. According to the specialized LGBTQ providers we interviewed, bisexual and transgender individuals are often less-well received, even in communities that have nominally welcomed gay and lesbian men and women. Survivors with other, less mainstream gender identities may face greater challenges. In addition to relationship-related trauma, some LGBTQ survivors may carry trauma from their personal struggles to overcome their own or the larger society's negative attitudes about who they are.

Likewise, survivors with disabling conditions could come from any number of demographics. They may have a physical or cognitive or sensory limitation in common with other persons with disabilities, but could otherwise be very distinct from one another, in terms of race, ethnicity, language, gender identity, sexual orientation, or life experience. Likewise members of the Deaf community may have a language and communication style in common, but they are all individuals, with distinct needs, preferences, and life experiences.

Slide #19.

The CLAS Standards for Cultural and Linguistically Appropriate Services, developed and promulgated by the Office of Minority Health of the U.S. Department of Health and Human Services, and published in December 2000 provide a good jumping off point for the discussion about cultural and linguistic competence.

Although the standards reference racial, ethnic, and linguistic subpopulations, they are equally applicable to other subpopulations -- persons with disabilities, with diverse gender identities or sexual orientations, or from particular faith communities, etc. -- that have experienced discrimination, oppression, marginalization and/or other barriers to accessing appropriate services ... but which, at the same time, have traditions, resources, and communities of support that can be leveraged to create or enhance safety and wellbeing.

Likewise, although the CLAS standards are "primarily directed at health care organizations," they are equally applicable to programs addressing the needs of survivors of domestic and sexual violence.

In the same way that delivering trauma-informed care involves every facet of a provider organization's interaction with clients/consumers, and not just the direct services provided by an advocate or clinician, so, "culturally and linguistically appropriate services should be integrated throughout an organization."

The 14 CLAS standards address culturally competent care (Standards 1-3), language access services (Standards 4-7, which correspond to mandates for federally funded entities under Title VI of the Civil Rights Act of 1964), and "organizational supports for cultural competence" (Standards 8-14).

Following the discussion of the CLAS standards, the chapter includes an extensive set of provider comments presenting their thoughts about what it means to be culturally competent.

Slide #20.

As noted earlier, much of Chapter 7 is devoted to annotated resource listings and provider comments on the constituencies they serve:

- Immigrant and diverse populations, in general
- African Americans
- Latina / Hispanic Survivors
- Asian American / Pacific island Survivors

- Native American and Alaska Native Survivors
- LGBTQ Survivors

The section on LGBTQ survivors includes statistics from the aforementioned National Intimate Partner and Sexual Violence Surveys of 2010 reporting on victimization by sexual orientation, as well as statistics reported by member organizations of the National Coalition of Anti-Violence Programs, which tracks all kinds of violence against LGBTQ persons.

Because the OVW semi-annual report does not collect data on gender identity and sexual orientation, there is no published information about the numbers or percentages of LGBTQ survivors in the TH program caseload. Although OVW-funded programs may have served LGBTQ survivors before, the 2013 reauthorization of the Violence Against Women Act, marked the first time that "a federal funding statute ... explicitly bar[red] discrimination based on actual or perceived gender identity or sexual orientation," sending an historic message that LGBTQ survivors were welcomed by those programs.

Different providers have made different levels of progress in developing cultural competency, with respect to serving LGBTQ survivors: For example, one provider we interviewed described their belief that it was intrusive to ask about sexual orientation. Another provider mentioned work with NNEDV technical assistance staff on strategies for asking about gender identity or sexual orientation.

When our interviewers asked providers about their challenges and approaches in serving LGBTQ survivors, a number of providers indicated that, "it wasn't a problem." In some cases, that meant that because their program used a scattered site housing model, they didn't have to worry about how LGBTQ survivors and their "more traditional" cisgender heterosexual participants would coexist in a shared living arrangement. In some cases, "not a problem" probably meant that the program had not served any LGBTQ survivors that it knew of.

(As noted in Chapter 2, to the extent that DV shelters are the primary referral source for a TH program, the TH program is less likely to see survivors who feel that "the shelter is not for people like me," for example, older adult survivors, male survivors, LGBTQ survivors, survivors from an immigrant population that doesn't typically seek shelter, or that speaks a language that isn't spoken in the shelter, etc.)

In hindsight, it would have probably been helpful to ask (a) whether the program had knowingly served any LGBTQ survivors; (b) how the topic of survivor gender identity and sexual orientation is raised; (c) whether and how the program has ascertained and addressed any special needs; and (d) how services for LGBTQ participant are different, if at all, from the program's "usual" services.

Slide #21.

Chapter 7 continues with narrative and annotated resource listings addressing the special needs of and approaches for serving

- Young adult survivors
- Older adult survivors
- Male survivors and survivor families with older male children
- Ex-offender survivors (who, in addition to experiencing domestic and/or sexual violence prior to incarceration, lived through the traumatic and often violent experience of their incarceration).
- Deaf survivors
- Survivors with disabling conditions

The chapter also includes provider comments addressing most of these subpopulations.

Among the key resources pertaining to serving ex-offender survivors are materials disseminated by the OVW-funded National Clearinghouse for the Defense of Battered Women.

Among the key resources pertaining to serving older adult survivors are materials developed by the OVW grant-funded National Clearinghouse on Abuse in Later Life.

The source for much of the information about serving Deaf survivors is the National Resource Center on Domestic Violence (NRCDV)'s [Special Collection on Violence in the Lives of the Deaf or Hard of Hearing](#). As described in the [introduction to Deaf Culture](#), accessible from that webpage,

The Chapter 7 narrative devotes considerable attention to issues surrounding the provision of transitional housing and services to survivors with disabilities. According to an extensive review of the literature by [Powers, et al. \(2009\)](#), compared to women without disabilities, women with disabilities are more likely to experience physical and sexual violence, and more likely to experience increased severity of violence, multiple forms of violence, and longer duration of violence. In addition to physical, emotional, and sexual violence, women with disabilities experience violence intended to undermine their independence and ability to care for themselves, including "destruction of medical equipment and communication devices, withholding, stealing or overdosing of medications, physical neglect, and financial abuse," perpetrated by "partners who may dually function as unpaid or paid personal assistants; ... parents or other family members, friends, and health care and other service providers."

The authors explain how the impact of the violence is exacerbated by "dependence on a perpetrator for essential personal care and/or specialized services for communication or mobility (such as an interpreter or mobility guide), [which] add[s] an additional layer of difficulty to seeking safety." As with other domestic and sexual violence, the risk increases with a perpetrator's alcohol or drug abuse.

In addition to addressing violence perpetrated against survivors with pre-existing disabilities, the chapter also addresses the disabling conditions **caused or exacerbated** by domestic and sexual violence: the PTSD, complex trauma, depression, anxiety, traumatic brain injury, physical injuries and scarring, coercive substance abuse, and/or the dependence on alcohol or drugs that develops or worsens as survivors look for ways to numb the pain.

As charted by [Hopper, Bassuk, & Olivet, 2010](#)) and elaborated upon in a publication by the Wisconsin Violence Against Women with Disabilities and Deaf Women Project, severe trauma-related conditions can impact the ability of a survivor to effectively participate in a shelter or transitional housing program; in turn, their reduced level of participation and/or "problematic" interactions with staff or other survivors may be **misinterpreted** as the result of lack of motivation or commitment, a bad or uncooperative attitude, laziness, a "difficult" personality, and/or other personal attributes that result in their being deemed a poor candidate for further assistance, particularly in a program with a short timeframe. As discussed in other materials in the section of the chapter on traumatic brain injury, survivors who have suffered TBI or damage caused by strangulation may exhibit some of these same "problematic" behaviors, which may result in the same kind of mistaken attributions about their attitudes and motivation, similarly limiting their access to assistance.

Slide #22.

The narrative continues with a survey of federal laws -- including Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, and the Fair Housing Act -- which define providers' obligations to serve survivors with disabilities, and to offer reasonable accommodations and/or to modify policies and procedures which might have a **disparate impact on persons with disabilities**, so as to make the housing and services offered through their programs more accessible. The narrative includes an annotated list of relevant online resources intended to support such compliance by housing and service providers.

Although providers may be familiar with their obligations with respect to persons with physical or sensory disabilities, they may not be as aware of their obligations with respect to survivors with the kind of psychiatric, emotional, and/or cognitive disabilities that can result from, or be exacerbated by, chronic exposure to violence and abuse and/or head injury. They may also not realize that their obligation to offer reasonable accommodation applies to survivors who suffer from alcoholism or from the effects of drug abuse -- as long as the use of illegal substances is not current.

As noted in the narrative, the underlying spirit and purpose of reasonable accommodation requirements have much in common with the "survivor-centered approach" that victim services providers embrace: both seek to

"meet participants where they are" and to remove barriers to successful program participation -- which, at least in part, is also what rules reduction efforts have been about.

Thus, for example, the need for such accommodation can be sensitively, but proactively explored with a survivor, without requiring that survivor to document or even acknowledge their disabling condition, for example by simply asking, "Would it be helpful if we do X?"

Accommodation of a disabling condition is not required, if would *alter the fundamental nature* of a program, or if the participant's condition poses a *direct threat* to staff or other participants.

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The remaining portion of the Chapter 7 narrative specifically addresses the challenges serving survivors whose disabling conditions adversely affect their mental, emotional, or cognitive health, and which therefore also impact the level or quality of their participation in program services and activities. Providers told us that these survivors, who often have co-occurring substance dependencies, are some of the hardest to serve.

The narrative and accompanying resource listings specifically address alcohol and/or drug dependence, mental illness, trauma (including PTSD, complex trauma, and concomitant conditions, which can be mistaken for mental illness), traumatic brain injury (TBI), and strangulation, and explain how these conditions can result in a wide range of symptoms, including low energy levels; hopelessness, irritability; reduced ability to concentrate on, understand, and remember information; anxiety or hypervigilance; reduced ability to think ahead; and/or inability to effectively deal with the unexpected. Participants coping with PTSD, TBI, and other behavior-affecting conditions may be vulnerable to re-traumatization by "triggers" like meeting new people, being asked personal questions, hearing about or being told that they have not met program deadlines or expectations, feeling "overloaded" with information, hearing raised voices or witnessing conflict, participating in a sensitive medical exam, etc. As previously noted, without a trauma-informed lens, providers might simply conclude that these survivors were poorly suited for their program.

The narrative identifies and provides links to online resources which may be helpful in working with survivors facing these often co-occurring challenges.

The narrative also describes and provides links to resources describing OVW-funded collaborations between victim services providers that sought to strengthen their ability to serve survivors with disabilities and disability-focused organizations that sought to strengthen their ability to serve consumers who were experiencing or had survived domestic or sexual violence.

The details of these complex, but ultimately successful, collaborations -- and the extensive provider comments that close out the chapter -- provide context for understanding the challenges that grantees face in serving survivors with co-occurring behavioral health conditions (and the poverty that not infrequently complicates the situation); and illustrate the importance of adequate resources, including partnerships with trauma-informed providers who understand the implications and impacts of domestic and sexual violence, and who have the expertise and cultural competence to address the clinical issues.

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The OVW Transitional Housing (TH) Assistance Grant program is statutorily authorized to fund programs providing transitional housing and related assistance to survivors of domestic violence, sexual assault, dating violence, and stalking. Although the various chapters of this report touch on services to address sexual assault and stalking, they are mostly written with a focus on survivors of domestic violence, reflecting the focus of the preponderance of funded programs.

Chapter 8 is the exception; it focuses on the challenges and approaches to serving other OVW TH program constituencies, and in particular, survivors of non-DV-related sexual assault. A part of this chapter also addresses the challenges and approaches in serving survivors of human sexual trafficking.

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OVW TH grantees are not required to serve all four constituencies; they specify on their application which constituencies they plan to serve. In our interviews with funded (and a few formerly funded) providers, we asked which of the constituencies they serve; most providers said that they serve survivors from all four OVW constituencies, but that they primarily serve survivors of intimate partner violence (IPV), which includes domestic violence, dating violence, and stalking by an intimate partner.

Several of the providers who described their focus as IPV noted that DV survivors are also often survivors of stalking or sexual assault, which may or may not have been connected to the domestic violence; however, a majority of these survivors are in their TH program because they are fleeing domestic violence. A small number of providers stated that they exclusively serve DV survivors.

Even the full service domestic violence and sexual assault providers that we interviewed, who described their preparedness to offer in-house access to sexual assault-specific counseling, support groups, and other related services, reported that in most cases, the TH participants that have utilized those services were DV survivors who had also experienced sexual assault, rather than women whose primary reason for enrolling in the program had been sexual assault.

The four program-wide semi-annual reports covering the period 7/1/2012 - 6/30/2014 confirm that the large majority -- upwards of 85% -- of persons served by OVW-funded TH programs were DV survivors. Consistently fewer than 10% of TH program participants counted in these reports were cited as having been victimized by someone other than an intimate partner or dating partner. However, quite a few providers indicated that the domestic violence their participants fled included sexual assault, or that the DV survivors in their program had experienced sexual assault at some other point(s) in their lives. Likewise, providers elaborating on their services to victims of stalking, indicated that the perpetrator of that stalking had typically been the intimate partner that the survivor had fled.

Although intimate partner violence accounts for the huge majority of cases served by OVW TH programs, according to the [National Intimate Partner and Sexual Violence Survey of 2011 \(Table 3\)](#), the perpetrator of rape and other sexual assault was more often than not an acquaintance, but not an intimate partner.

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A number of providers explained that the reason their programs primarily serve DV survivors, and not survivors of non-IPV sexual assault, is that survivors of non-DV-related sexual assault are not regularly referred for specialized transitional housing by the DV shelters from which most of their participants come.

As discussed in greater detail in Chapter 2 ("Survivor Access and Participant Selection"), the FVPSA grants that help fund most DV shelters target assistance to survivors of Intimate Partner Violence (IPV) and violence perpetrated by a family member, but not, for example, victims of sexual assault by a supervisor, co-worker, teacher, fellow platoon member, or stranger.

That is, the only *eligible* survivors that *FVPSA-funded DV shelters would be in a position to refer are survivors whose homelessness was related to either (a) domestic violence or (b) sexual assault by a family member.*

Another reason why TH programs may serve more DV survivors than survivors of non-IPV sexual violence is that whereas fleeing domestic violence typically means leaving the home she shares with the perpetrator, a victim of sexual assault may not have to leave her home in order to be safe; whether she feels a need to relocate may depend on where and by whom she was assaulted. And unlike a domestic violence victim, who may not have been allowed access to her or the household's assets by her abusive partner, the victim of non-IPV sexual assault may well be able to access her assets, depending on the perpetrator's relationship to her (e.g., parents or other caregivers may control such assets, whereas a co-worker or acquaintance would not).

Thus, whereas fleeing domestic violence all too frequently precipitates homelessness, rape or sexual assault may or may not be *the precipitating factor* in a woman's homelessness; instead, rape, sexual assault, and the

trauma that result may be **contributing factors** to subsequent homelessness; and then, once a woman becomes homeless, a source of recurring victimization and trauma, given the lack of a secure place to stay.

As discussed subsequently in this chapter, a disproportionately high percentage of homeless women in mainstream shelters -- or unsheltered situations -- are survivors of sexual assault (as children or adults), often with co-occurring trauma, mental health problems, and/or substance use issues. In turn, their lack of a stable living situation and co-occurring mental health, substance abuse, and/or trauma-related conditions leave them vulnerable to further victimization and predation; and their involvement in the mainstream shelter system, where their homelessness and co-occurring behavioral health needs typically overshadow their history of sexual abuse -- which may not even have been documented, due to the stigma, shame, victim-blaming, and/or guilt attached to disclosing/reporting victimization as a child or as an adult -- make it highly unlikely that they will be referred into an OVW-funded TH program.

A small handful of providers offered comments reflecting their apparent belief that their OVW and/or HUD funding only allowed them to target DV survivors, and not survivors of sexual assault by a perpetrator other than an intimate partner. As noted elsewhere, the OVW's annual TH grant solicitation allows, but does not require, funded providers to serve **all four constituencies**. As mentioned in Chapter 2 ("Survivor Access and Participant Selection"), [HUD's "Category 4" definition of homelessness](#) includes all four OVW constituencies. Although locally adopted "written standards" may narrow eligibility or prioritize certain segments of the population for assistance, for example, based on income, those standards and priorities do not typically distinguish between Category 4 constituencies.

Slide #27.

Most of the providers we interviewed about their different approaches to serving survivors of domestic violence vs. sexual assault did not describe significant differences. Instead, they talked about an across-the-board effort to meet survivors where they are, so that, for example, individual counseling is always tailored to client needs. However, they suggested that other type of services (e.g. budgeting/money management, employment assistance, housing search) are the same for all survivors.

There were, however, a few providers who did distinguish between the needs of DV survivors and survivors of sexual assault. For example, they suggested, survivors of sexual assault might have a lower level of trust about leaving their children in the care of others, or might be uncomfortable being in public areas on their own, and might benefit from staff accompaniment to offsite appointments.

Given each victim's uniquely personal experience of domestic violence and/or sexual assault, and given that some survivors may have reasons to fear further violence from the perpetrator, while others may not, the narrative largely avoids further generalizations about the similarities and differences in the traumatization and recovery process of victims of domestic violence vs. victims of non-IPV sexual assault.

Safety planning is the exception to that rule. The Victim Rights Law Center (VRLC), which specializes in matters related to sexual assault, has developed safety planning resources for providers working with survivors of non-IPV sexual violence, and in particular, with women who are homeless -- either in mainstream shelters or on the street. The VRLC emphasizes the importance of safety planning that specifically addresses the realities and risks attendant to homelessness -- in shelter, if the survivor has a bed there; on the street when the shelter shuts down during daytime hours, and where some survivors sleep, especially if they don't feel safe in shelter; at a drop-in center or meal program or where the survivor receives services; where she uses drugs or drinks (or accesses methadone or other treatment), if she has a dependency; etc.

Given the high percentage of homeless women who have experienced rape and sexual abuse; given that the experience of living on the street or staying in shelters exacerbates the risk of additional victimization; given that a substantial portion of homeless have mental illness and substance dependencies, and given how mental illness and substance use heighten the risk of future victimization; and given that most homeless victims of sexual abuse do not have the option to stay in a trauma-informed DV shelter (unless their victimization was by an intimate partner or family member), or the benefit of a well-defined path from a DV

shelter to an OVW-funded TH program ... the narrative asks, "what would improve access by homeless sexual assault survivors to trauma-informed transitional housing?"

While specialized TH programs need to be as prepared as they can be to provide housing and services that can support such survivors in healing, stabilizing their living situation, and hopefully, avoiding future victimization, the majority of homeless survivors of sexual assault will continue to be served by mainstream homeless programs. It seems critical, therefore, that those programs develop the capacity to better serve survivors of sexual assault, perhaps by partnering with local rape crisis centers and/or full service victim service providers: (a) to increase awareness of and access to sexual assault services and counseling; (b) to strengthen staff understanding of and sensitivity to the trauma that survivors of sexual assault carry; (c) to support safety planning that is appropriate to the needs of homeless survivors; and (d) to enhance providers' capacity to provide trauma-informed services.

At the same time, perhaps some of the specialized TH programs that now focus on domestic violence survivors might, in the future, broaden that focus to also address the needs of survivors of non-IPV sexual assault. Our interview with the VRLC's National Director of Training and Technical Assistance explored some of the pros and cons of evolving programs with a dual focus vs. carving out a portion of existing funding to support programs that specifically target assistance to survivors of non-IPV sexual assault.

While adding entirely new capacity would be the ideal solution, that may not be possible in a resource-constrained environment. On the one hand, eliminating any of the already-too-limited system capacity to serve DV survivors would leave more DV survivors without options when their shelter stays end; on the other hand leaving survivors of non-IPV sexual violence with only their current extremely limited access to specialized, trauma-informed programming deprives them of their best hope for a path out of homelessness. A third option -- broadening the role of existing programs to address both domestic violence and non-IPV sexual assault -- without adding resources to bolster staff capacity could dilute the impact of programs, and diminish their ability to adequately support either constituency. There are no easy answers.

However, there are resources that might better prepare providers to serve survivors of non-IPV sexual violence, and the chapter includes an annotated list of resources that providers will hopefully find helpful.

Following those listings, the narrative presents information about Military Sexual Trauma (MST), including a description of MST and data about its prevalence; an extensive annotated listing of U.S. Department of Veteran Affairs (VA) resource materials describing the problem, the VA's multi-pronged approach, and VA programs to help affected service members and veterans; and an annotated listing of non-VA resources.

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The final portion of Chapter 8 addresses human sexual trafficking. The narrative begins with a discussion about the prevalence and demographics of sex trafficking, which is a global problem, as well as a widespread, pernicious, difficult-to-stop, and dangerous-to-escape-from problem in the U.S. Trafficking increasingly serves as a lucrative and relatively low-risk business opportunity for gangs and organized criminal enterprises; it also sometimes manifests as a family-run business.

Trafficking victims include: (a) foreign born women and girls who have been smuggled into the U.S., who are isolated by their language, who have no family here, and so, have few, if any, places to turn for help; (b) American-born women and teenage boys and girls from big cities and small towns -- including runaway and homeless youth -- who after leaving behind dangerous, exploitive, and/or dysfunctional home situations, have been lured into the sex industry, where they are controlled with a combination of manipulation, violence, and drugs; (c) a disproportionate number of Native American women and children (and women and children from indigenous communities in Canada).

Although survivors of prostitution and sex trafficking are increasingly understood to be victims, they are still subject to shame and stigma, and in some states, criminal punishment. The changes in our nation's understanding and attitude are gradual, and incomplete: a federally funded study of options for serving survivors of trafficking reported that providers they interviewed cited examples of trafficking victims who had

been placed in DV shelters facing humiliation and isolation due to the perception that they were prostitutes or willing participants, rather than victims of abuse and crime.

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The needs of survivors of sex trafficking are not unlike the needs of survivors of chronic domestic or sexual violence. As with survivors of these other types of violence, victims' needs vary based on their trauma history and life circumstances, and based on the intensity, and duration of the violence and abuse. As described in one of a series of reports funded by the U.S. Department of Health and Human Services, survivors' needs begin with safety -- because they are valuable assets to their traffickers, who will try to get them back. Other needs include food, clothing, shelter and then longer-term housing, translation and interpretation for international victims, legal assistance, and advocacy support for navigating the gamut of government and social service systems.

The authors of one of the federal reports add that "*most victims also need health screening (tuberculosis, sexually transmitted diseases, pregnancy), vaccinations/immunizations, medical treatment for physical injuries, and dental care,*" that, "*service providers report that all victims of trafficking have some type of mental health need,*" and that, "*domestic victims often present with serious substance abuse issues,*" because drugs serve as both an enticement and a mechanism for controlling the victims. Although international victims may also have drug problems, the report suggests that they may not be acknowledged, "*out of shame, fear of stigma, or ... for fear [that] treatment records will be subpoenaed and used against the victim in a legal case (criminal, civil, or immigration).*"

As part of the help they receive with integrating into the mainstream community and economy, trafficking victims may need the same kinds of services as other survivors, depending on their life experience; for example, they many need child care, education, job training, life skills training, etc.

Another report from the series of federally funded studies questions whether survivors can be served in an integrated program that also serves survivors of other domestic or sexual violence. The report author asserts:

"Programs for domestically sex-trafficked girls must be run by individuals who live and breathe trafficking in contrast to administrators lacking that expertise and specialization. . . . As described by providers, it is of primary importance that staff truly understand minor victims of domestic sex trafficking and the impact of their life experience."

The authors further observed that,

"This need to hire staff with an authentic understanding of The Life and a natural ability to connect with domestically sex-trafficked girls has led some providers ... like [SAGE \[Standing Against Global Exploitation, SF\]](#) and [GEMS \[Girls Education and mentoring Services, NY\]](#) [to] prioritize hiring women who were sexually exploited, including minor victims of domestic sex trafficking [that] have successfully exited The Life. SAGE explains the rationale for using a peer support model as follows: Clinicians spend 75% of their time establishing trust, while peers can start from a place of trust. One provider remarked that someone who has exited can convey hope in a way those of us who haven't been there cannot...."

The Chapter 8 narrative concludes with an annotated listing of print and online materials that address the needs of the women and teenage girls and boys who have been trafficked; information about the organizations and efforts to assist victims in escaping and recovering from the trauma of trafficking and sexual slavery; information about paths to legal immigration status for victims whose lack of status has contributed to their vulnerability; and training and support resources for providers.

This last narrative is followed by comments from the small handful of providers that have specifically opened their programs to serving survivors of trafficking, including one TH program which exclusively targets sex trafficking survivors.

Slide #30.

Thank you for taking the time to attend this presentation. We encourage you to return to the project website where all of the webinars, the 12 chapters of the report, the podcasts, and the broadsides can be found.