Massachusetts Governor's Council to Address Sexual and Domestic Violence

Systems Change and Integration Committee

Blueprint Report, Domestic Violence

August 2009

I. Introduction

In February 2009, recognizing the lack of integration among government systems and the potential harm this could cause to the Commonwealth's residents, Lieutenant Governor Timothy Murray, Chair of the Housing/Homelessness Taskforce and the Governor's Council to Address Sexual and Domestic Violence (GCASDV), charged the members of the GCASDV Systems Change and Integration Committee ("the Committee"; see Addendum A for roster) to identify and suggest systems-level opportunities to ensure that people contending with multiple issues, (e.g., some combination of sexual and domestic violence, homelessness, addiction, mental and physical health issues), are well–served by government systems.

Massachusetts has been a leader in applying government resources to prevent domestic and sexual violence, and to support those who are hurt by it, both directly and through education and public health measures. Like much progress, there have been places and times where our efforts and successes have created unintended negative consequences that require further action and remediation. As such, the Committee was asked to respond to these key questions:

1. Where do systemic fragmentation, misalignment, and/or inaccessibility significantly impede survivors' progress?
2. Where are the opportunities for government action to significantly mitigate or eliminate these impediments?

Section II describes the process employed to identify which of myriad possible concerns the Committee would examine. It is important to note that while many of the issues we identified and the recommendations in this blueprint impact survivors of both sexual and domestic violence, this blueprint is primarily focused on domestic violence, which includes sexual assault in the context of an overall partner relationship, but does not explicitly address sexual violence by strangers, trafficking, and other associated forms of violence and abuse.[1] A separate review is needed to identify priorities and develop recommendations for meaningful systems change for sexual assault survivors and for the integration of domestic violence and sexual assault systems.[2]

In Section III, we examine three specific problems; identify several existing initiatives that hold promise for addressing each problem; and make specific recommendations for action. The three problems discussed herein are:

- Conflicting requirements for victims involved with multiple systems may trigger new risks and harms.
- Issue-tailored continuums of care for homelessness and domestic violence require survivors to assume a "primary issue" that neglects the interconnections between these issues.

[1] While the Systems Change and Integration Committee is a designated committee of the Governor's Council to Address Sexual and Domestic Violence, membership on this as most committees is voluntary. As such, there is not a guarantee of absolute representation of every interest on every topic. Although the authors of this blueprint (see Addendum A) represent a range of agencies and sectors, the committee feels that its expertise is more weighted towards domestic violence than sexual assault.

[2] The fragmentation of domestic violence and sexual assault within our systems (which is not reflective of how juxtaposed these issues in fact are in the lives of many survivors) must be addressed separately, deliberately and substantively.

- Inconsistent and unclear guidelines for mandated reporting of suspected child abuse and neglect in the context of domestic violence, and for child welfare's response to these reports, create new dangers and harms.

We conclude our report with some summary observations and recommendations in Section IV.

II. Criteria for Determining Issues and Recommended Actions

In conducting its review, the Committee recognized that there are many places within individual systems where insufficient resources or particular eligibility criteria (necessary for government to be consistent and efficient in processing cases, but perhaps not always consistent and efficient in the overall goal of helping survivors move forward) result in victims' not getting the help they need and/or in failing to increase people's safety. Furthermore, victims are often involved with multiple systems simultaneously, and the weak connections and coordination *among* systems produce the same result. Every issue raised within and between systems was incredibly significant, so the Committee adopted the following screening rubric to identify the three issues that are detailed in this report:

- **High importance**: The issue negatively impacts a large number of survivors and/or dramatically impacts a smaller number of survivors in ways that are very difficult to manage or that are extremely harmful.
- **High feasibility**: The issue can be addressed and stands a good chance of succeeding if well addressed. It doesn't depend on significant other changes occurring, or on leveraging political will that is not present.
- **Timely:** A particular window of opportunity for addressing the issue exists. The issue capitalizes on changes that are already occurring and can be addressed simultaneously with other issues/improvements where there is momentum, political will and attention.
- **Low budget impact**: The issue can be addressed without significant outlay of funds. Ideally, it has the potential of realizing cost savings to the Commonwealth in a relatively short time frame.
- **Targeted**: The issue is specific, and progress correlates to measurable benchmarks and outcomes.
- **Highly actionable**: The issue can be addressed in a few short steps that the Lieutenant Governor's leadership could set in motion without requiring legislative approval or vote.
- **Non-duplicative**: The work raises and/or addresses issues and/or frames issues differently from work being undertaken by other working groups (e.g., there are already efforts underway to infuse trauma-informed practices across the EOHHS Secretariat and to integrate trauma services with the new regional homelessness centers).

III. Problem Identification and Recommended Action Steps

Each of the three issues selected through this rubric has special significance for homeless providers and the contracting process because the new state-level investment in anti-homelessness efforts and the move of homelessness services from the Department of Transitional Assistance (DTA) to the Department of Housing and Community Development (DHCD) create opportunities for change (two of the three issues are particular to the intersection of domestic violence and homelessness). Issues are not ranked in order of importance.

Problem A: Conflicting requirements for victims involved with multiple systems may trigger new risks and harms

Survivors who choose or are required to receive help from state systems/agencies often find themselves with multiple service plans which at best are not well-coordinated and at worst sometimes conflict in their requirements. At best, they create unnecessary confusion for a victim already overwhelmed and confused by multiple systems and interventions. When they are at odds, such conflicts necessitate a survivor's prioritizing one plan over another, which may trigger additional state intervention, may result in a survivor's being deemed "non-compliant," and/or may even decrease the survivor's and/or children's safety.

What this means for survivors:

- Systems can work at cross-purposes and decrease safety and/or family stability (e.g., revocation of probation and re-incarceration of a mother, children placed into foster care, loss of housing subsidies).
- The challenges and even harms that can result also require further state or state contractor involvement with a family (e.g., being forced to take an apartment in a different town may trigger a loss of a job, which may lead to a need for public benefits and publicly subsidized health care, as well as legal representation to address the conflict between systems).
    - What this means for the Commonwealth: the state may incur increased expenses as new problems are created that then require additional case management and subsidies.
- Neither blanket confidentiality policies, nor their reverse (generalized information sharing policies) increase safety and may undermine it.

Where we can look for lessons and best practices:

- High Risk Teams – These are teams usually comprised of the appropriate local law enforcement officers, domestic violence program staff, probation officers, and staff from the local district attorney's office (among others) who educate each other on specific, identified high risk cases, monitor offenders and work to keep victims safe. Their goals are to offer victims of domestic violence most at risk for harm multiple options and services; promote information sharing and collaboration amongst key

providers of services including state, municipal and community; address multiple and various issues facing victims and their children; provide continuity throughout a process (prosecution, court involvement or shelter); are victim/participant focused; and contain the critical components of perpetrator assessment and accountability. The High Risk Team approach is driven by the needs of a particular community, building on its strengths. In some cases, it is coordinated by a community-based organization, emphasizing the centrality of community involvement in domestic violence and the need for multiple community agencies to collaborate. In other settings, highly productive teams have been convened by the court system or law enforcement. The approach is differentiated from coordinated case management by the relational component among participating agencies and between programs and victims.

- The CARE Project was a Centers for Disease Control and Prevention (CDC) funded domestic and sexual violence prevention intervention. Efforts in Berkshire County and in Chelsea provided a forum for agencies and systems to develop collaborative responses, in this case to Latina/o communities. The development of a network of providers in each community allowed for the development of practices and policies to remediate gaps and conflicts in care and service, ultimately allowing for the delivery of more comprehensive, culturally relevant services.
- One Family One Plan is an interagency administrative review designed to ensure that each plan of care for the child and her/his family is coordinated and compatible for children and families concurrently or recently involved with more than one of the following agencies: the Department of Children and Families (DCF), the Department of Youth Services (DYS), the Department of Transitional Assistance (DTA), the Office for Refugee and Immigrants (ORI) or MassHealth. One Family One Plan incorporates a youth development approach to service planning that is child-centered, family-focused, and comprehensive and tailored to the strengths and needs of the individual child and family. Where conflicts arise in agencies' policies/plans, team members review the issues, reach consensus, and modify policies/plans in the best interest of the families. Discussions also ensure that the Governor's priorities and the EOHHS goals for families are addressed, including: access to education and employment to promote economic self sufficiency; high quality health care that is safe, effective, patient-centered, timely, efficient and equitable; housing and safety; and availability of relevant community-based care and support services. Systemic barriers that inhibit the creation of a unified service planning are identified and brought to the attention of CYF Agency Heads and the EOHHS Secretary.

Recommendations:

While sharing information across systems is the often cited solution to this problem, confidentiality is an absolute necessity for the safety of survivors and their children. While sharing information and collaboration are necessary elements for addressing this challenge, great care and planning must precede the enactment of any policy concerning information sharing, and this planning must include representatives from involved agencies and victims

services programs, as well as survivors or agencies representing survivors. Confidentiality and information sharing policies and practices cannot be fully automated, but rather should follow guidelines that balance the risks and the benefits, significantly supplementing trained providers' exercise of case-by-case judgment.

1. *The Executive Office should require state agencies, and state agencies should require their contractors to create policies and protocols for survivors involved with multiple systems to ensure that survivors are not penalized for acting on one mandated plan that puts them in violation of another mandated plan.*
2. *The Executive Office should direct state agencies to develop Memoranda of Understanding (MOUs) establishing procedures and practices for resolving inter-agency conflicts around client plans.* These memoranda should include consideration for waiving or amending agency protocols, rules and/or procedures when necessary for the safety of the family and/or the coordination of services.
3. *The Executive Office should expand the One Family One Plan program to include DHCD (homelessness), and to cover families involved in multiple systems where domestic violence is an identified issue.* Case coordination should explicitly include people with expertise in both domestic and sexual violence, and on clients' cultural communities. It should also include legal perspectives including, if applicable, civil (probate, labor, housing, civil rights laws, etc.), criminal, and immigration laws.
4. *The Executive Office should direct state agencies to include demonstration of past performance in and plans for future case coordination and conflict resolution among agencies and providers in scoring responses to Request for Responses (RFR).*
5. In all contracting, *state agencies should require that resources are allocated in the providers' budgets which specifically compensate staff for time spent participating in collaborative efforts around specific cases* as a direct expense, not an administrative one, which often does not include direct contact with a victim.
6. *The Executive Office should create an online resource for anonymous submission of examples of conflicting protocols and convene a working group to analyze these periodically, make targeted recommendations to systems, and report quarterly on reports received, recommendations promulgated, and adoption thereof within agencies.* Such a working group should include, at a minimum, ombudspersons from state agencies, representation from the Executive Office, and a task force of GCASDV.
7. *The Executive Office and state agencies increasingly recognize the need for community-specific, cross organization/agency coordination.* This should continue, and such coordination should be incentivized, whether through public recognition, championing or provision of additional resources. Organizations and agencies should be asked to provide consistent representation at collaboration meetings, fostering relationships between individuals that can be instrumental in ensuring that, in a crisis, a survivor's needs for safety and security are met.

8. *State agencies in coordination with secretariats should encourage community process by convening planning teams to design safe information sharing of service plans.* These teams should include state funders/agencies, community providers and domestic violence program staff, as well as survivors or organizations representing them. Guidelines should be created to support this process; such guidelines must include an admonition that no blanket confidentiality policies or blanket information sharing policies should be implemented as a remedy for cross-systems service planning.
9. *State agencies should explicitly include multiple agencies in trainings and include scenarios of cross-system conflict (rather than assuming conflict is always between survivor and system) in role-plays and other pedagogical tools.*

Problem B: Issue-tailored continuums of care for homelessness and domestic violence require survivors to assume a 'primary issue' that neglects the interconnections between these issues.

In general, services require people to take on a particular "problem" identity or label before the option of assistance is explored. Gaining access to shelter and survival services, whether homelessness or domestic violence, currently requires identifying homelessness or domestic violence as the "primary issue." This initial identification determines not only for what services a survivor will be eligible immediately, but also what services will be available later, as well as the expectations the survivor can have of the system over a period of time. Each system was designed to work with populations that are now actually subpopulations (i.e., homelessness systems were originally designed to work with a population composed largely of veterans and those who had been previously institutionalized; while these issues are still highly present among those who face homelessness, many other challenges and issues are represented). Furthermore, neither the homelessness or domestic violence system was created with full awareness of how closely linked these two issues are.

In fact, 50%-60% of homeless mothers and children are fleeing violent relationships[3]; 83% of homeless and poor women[4] (and up to 92% of homeless mothers[5]) have been victims of severe physical violence and/or sexual abuse, and "40% of these women have experienced major depression and more than one-third have suffered from post-traumatic stress disorder—three times the rate of women in the general population. 28% attempted suicide at least once."[6]

Although irrefutably documented, the interconnection between domestic violence and homelessness has not led to a true integration of these systems, where survivors who are homeless could access either or both continua of services to best meet their needs, and where survivors who do not self-identify (particularly to strangers and systems) as being trauma survivors have access to services that recognize that trauma is a normative experience for those who are homeless.

[3] National Center for Family Homelessness, as cited by Project Safe, April 2009
[4] Browne, A. and Bassuk, E. (1997) "Intimate violence in the lives of homeless and poor housed women: prevalence and patterns in an ethnically diverse sample," *American Journal of Orthopsychiatry* 67(2) 261;
[5] National Center for Family Homelessness, as cited by Project Safe, April 2009
[6] Browne and Bassuk: quote from related press release from Better Homes Fund (April 22, 1997).

We are concerned that this problem will be exacerbated as homelessness and domestic violence are now housed under different Secretariats (i.e. the Executive Office of Health and Human Services, and the Department of Housing and Community Development).

What this means for survivors:

- Survivors may experience a system that does not respond to the wholeness of their situation.
- Survivors encounter systems with two fundamentally different descriptions of the problem: a housing/resource problem (homelessness), or a relational problem (domestic violence), instead of a framing that recognizes the insufficiency of either description in isolation. Each framing leads to dramatically different interventions and responses.
- Survivors often encounter systems that prioritize addressing domestic violence over any other issues, which may not be the survivor's top priority.
- Survivors may not reveal their trauma in a homeless shelter for fear the shelter will not allow them to stay due to safety reasons; survivors may not be explicit about their homelessness prior to domestic violence in a DV program for fear of being seen as 'simply' trying to get shelter.
- Survivors' experience of homelessness as a reinforcing trauma, as clearly documented by researchers, is not validated by either system.
- Those who face not only homelessness and domestic violence, but a range of other challenges, such as medical or mental health concerns, addiction or court involvement may find it almost impossible to find services that can support the complexity of their situations.
- Neither system has fully embraced a mandate to work with those who are victimized on the streets, such as situations involving prostitution or trafficking, or the abuse of one person who is homeless by a partner who is also homeless; as a result, their needs remain largely unmet.
- Survivors may not have access to the same benefits, or experience confusion over what they qualify for, depending on which label they chose or were given early on.
- Neither system is set up to deal with young survivors (16 – 24) of violence who are on the streets and who may engage in survival sex and/or be in abusive relationships.
- Housing systems are not well equipped to support elderly survivors, survivors with disabilities, survivors whose primarily language is not English, and GLBT survivors. Confidentiality policies can increase these survivors' isolation from communities of support and assistance. Although progress has been made, a still pervasive lack of

sensitivity among providers and other residents can re-victimize many of these survivors.

- The unit of service is either the family, or the children, or the adult survivor, often leading to conflicting demands on members (e.g., what is good for an adult female survivor as a "unit" may not be the best thing for her family, or for her as a mother) without recognizing these inherent tensions).

Where we can look for lessons and best practices:

- Project Safe is a partnership among DTA and six community organizations in Chelsea and Boston, MA created to empower homeless women economically, physically and psychologically. Community partnerships allow for a flexible range of supports—from economic literacy and financial development, to self-defense, to trauma education and counseling, to advocacy—in an integrated way. Project Safe demonstrates the power of government-community partnership (beyond contracting) when providers and participants create a shared sense of purpose and community process, while also addressing individual participant needs. Project Safe begins with recognition that trauma is part of the life of participants, but does not require disclosure at any particular point in the program.

- On The Rise, Inc. is a community based program (Cambridge, MA) supported in part by DCF. On The Rise works with women who are facing extended periods of homelessness or cycling through homelessness, and whose needs have not been fully addressed by mainstream systems. On The Rise provides support, accompaniment and advocacy to individual women in any and all systems women seek assistance. On The Rise cultivates relationships with systems and providers that help both providers and survivors navigate conflicting protocols and expectations. On The Rise specifically supports individuals whose homelessness and histories of violence are highly intertwined. On The Rise also explicitly builds community among participants and staff, combating the social isolation often heightened when marginalized people seek to move out of homelessness and/or leave an abuser and/or take other steps forward. There is not a time limit on how long women can participate in this community.

Recommendations:

1. *The Executive Office should direct DHCD (with input from staff at DTA), DCF and DPH to develop joint contracting streams* that allow for organizations with demonstrated expertise in domestic violence, homelessness, and the intersection of the two (as a separate concern) to work in ways that do not require them, or their participants, to assume a "primary label" of either homeless or domestic violence.
2. *The Executive Office should direct DHCD (with input from staff at DTA), DCF and DPH to compare eligibility-for-service and intake requirements* to identify areas where the divide between homeless and domestic violence situations are reinforced, and to alter requirements, forms and process to reduce this divide.

3. *The Executive Office should create a working group including members of GCASDV to identify where access to state and federal benefits and services are markedly different depending on the label one chooses, and develop strategies to lessen these disparities.*

4. *The Executive Office should charge GCASDV to create shared definitions of key terms,* such as safety, risk, harm and stability, which currently have different connotations in homeless services and domestic violence services. Such a process should include representation DHCD, DTA, DPH, DCF and key constituencies from the domestic violence community and the homelessness community. *Intake procedures and outcome measures should be reviewed in each system to ensure alignment with these shared definitions whenever possible. When such alignment is not possible, a full explanation should be submitted to the Executive Office along with a joint plan for mitigating the harm from such conflicting definitions.*

5. *Targeted interventions (i.e., domestic violence providers and homelessness providers) not covered by recommendation 1 should be required by their state funders to demonstrate a process on a community or coalition level to mitigate fragmentation* (similar to recommendation 2). Failure to meaningfully address these issues in a sustained fashion (with recognition that some changes will be difficult to implement without new resources) should be considered in re-contracting.

6. *State agencies should explore, encourage and participate in community-based partnerships* (beyond contracting) *between the state and community-based agencies,* such as in the examples above. The Executive Office should direct DHCD (with input from staff at DTA), DCF and DPH to identify existing examples and to develop a plan for increasing the number or nature of these partnerships over the next 24 months.

7. *In training providers, state agencies should encourage participation by other community organizations who may be working with highly marginalized survivors.* State agencies should partner with these organizations in adapting trainings to equip providers to work with people facing multiple challenges, such as addiction or legal involvement and/or who have identities currently under-considered in program planning (e.g., GLBT, youth, elderly).

8. *The Executive Office should direct state agencies to implement the concept of "trauma informed services" in basic training* for all new staff; ongoing professional development focused on issues of trauma, domestic violence and homelessness; and the development of related protocol and policy.

9. *State agencies should incorporate this "trauma informed perspective" into their contracting* and requirements of contractors, in training, policies, protocols and professional development.

Problem C: Inconsistent and unclear guidelines for mandated reporting of suspected child abuse and neglect in the context of domestic violence, and for child welfare's response to these reports, create new dangers and harms.

Guidelines and best practices for mandated reporting of children alleged to be suffering from serious physical or emotional injury from abuse or neglect (a filing referred to hereafter as "51A") when domestic violence is a factor are neither well-understood nor followed consistently across government agencies and within community-based organizations contracting with the Commonwealth. Indeed, many mandated reporters may be unaware of the existence of such guidelines and best practices. Moreover, the lack of clarity and consistency is particularly pervasive when domestic violence co-occurs with other issues, such as homelessness. The result can be inconsistent filing (whether too soon/often, or not soon/often enough) and inconsistent responses from child welfare advocates and agencies. In addition, those who report suspected abuse and neglect as well as responding child welfare practitioners often fail to recognize that filing a 51A can, in and of itself, increase risk to adult and child victims of domestic violence.

The determination of who is required to report abuse and neglect, and the penalties for not doing so are dictated by Massachusetts law. As such, the filing of child abuse /neglect reports may result from an individual or agency objective to minimize liability. This may lead to excessive filing, and may also contribute to staff trainings being more liability- and legally- focused, rather than being integrated into trainings about domestic violence and assessing the safety needs of families.

What this means for survivors:

Both over-filing and under-filing have potential serious consequences for survivors and their children.

- Under-filing (i.e., not filing, or filing too late) may leave some children in volatile, dangerous situations where the state has a protective duty. Not filing may also leave a non-offending parent/survivor without the necessary protections and supports to keep their children safe from an abusive parent. However, more filing is not the solution.
- Over-filing often stems from an inaccurate generalization that all domestic violence situations are equally lethal, thereby leading those who report and those in the child welfare system who receive the reports to overreact. These filings can lead to unnecessary removal of children from non-offending parental custody. These removals not only traumatize children, but also alienate parents who might otherwise benefit from DCF's support and services, and burden the state foster care system.
- 51As are often filed by individuals working within systems that are designed to provide safety and protection (e.g., courts, police, etc.), but that are limited in their ability to hold the offender accountable. This then creates a situation where the victim is held responsible, with minimal or no systemic support.
- A family (particularly the adult victim and children) may not receive protection and supports that could have been helpful. For many community members, service providers and systems, filing a 51A report has become the primary "intervention,"

instead of a tool to increase safety. This can lead to missed opportunities for the family to receive more immediate intervention from within their community, and to over-filing in situations that might have been better served by an alternative intervention.

- A survivor's and children's safety may be further compromised simply by the filing of a 51A:
    - The offender may gain access to information about the survivor, including where s/he is living, receiving health care, etc, even if the survivor has sought shelter in a confidential location.
    - Adult victims are often named as "abusers" or "the person being filed on," when they are experiencing abuse themselves. This often thwarts the survivor's efforts to stay safe, keep children safe, and can lead to an antagonistic relationship with DCF and to survivors' being labeled "non-compliant" or "uncooperative."
    - 51A reports are often filed without notification or collaboration with the adult survivor, making it challenging for DCF to effectively create a sound safety plan with the family, thus increasing dangerousness and risk.
    - Fear of having a 51A filed if the totality of the situation is revealed keeps many survivors from reaching out for help.
- Although the focus of a 51A is children, the focus of the investigation and intervention is often placed on the adults. Inadequate attention is given to identifying the impact on the children's situations and needs, and on securing the community or professional support that children often need to remain resilient through these situations.

Where we can look for lessons and best practices:

- DCF initiatives to educate mandated reporters about domestic violence and risk assessment: In February 2008, DCF published a brochure *Promising Approaches: Working with Families, Child Welfare and Domestic Violence* (see Addendum B) in a concerted effort to give clarity to mandated reporters on the complicated issue of children, their well-being and domestic violence. The brochure succinctly covers a number of important topics:
    - The impact of domestic violence on children;
    - Higher risk situations that require a filing;
    - How the 51A is filed may have significant ramifications for the safety of the family;
    - How to file safely to maximize the benefit for the family, including actions beyond filing;
    - Clarifying that domestic violence does not automatically warrant a 51A filing ;
    - What a practitioner can do to help a family when a 51A is not filed,

While the brochure is not intended as a stand-alone document or a replacement for training, it serves as a reference point for practitioners.

With this brochure as a guide, the DCF Domestic Violence Unit staff worked collaboratively with Early Education and Care (EEC) to develop curriculum and provide training to all EEC Regional Resource staff on domestic violence and details of considering options and safety when children are present. Beginning in September, 2009, with technical support from the DCF Domestic Violence Unit, Regional Resource staff will provide training for all child care staff across the Commonwealth.

Information from this brochure has also been used to develop trainings for the following:

- Women, Infants and Children (WIC), a DPH funded program, provides nutrition, health education, healthy food and other services free of charge to qualified families.
    - All new WIC staff receives training on domestic violence in general and on filing 51As safely in the context of domestic violence; this training is presented by a member of the Domestic Violence Unit at DCF.
    - Based on a large overlap in the number of WIC participants and families experiencing domestic violence, DPH now recommends that all WIC programs screen pregnant, post-partum and breastfeeding women for domestic violence when screening can be done safely.

Recommendations:

1. *The Executive Office should provide high level, public endorsement of the principles outlined in the DCF Brochure* across secretariats (not simply EOHHS), and steward cross-agency policy development to train agency staff and contracting organizations in appropriate, safe filing and alternatives. Utilize expertise locally and nationally in designing best practices in community and child welfare responses to children exposed to domestic violence.
2. *The Executive Office, in partnership with GCASDV, should support and provide technical assistance to DCF in its development of new policy and procedures that promote differential response options in domestic violence cases.*
    - Enable and support differential response (i.e., providing an alternative pathway to a traditional child protective investigation. In these cases, the state increases resources and efforts to avoid placement and seeks to engage a family's community and natural helping systems to support them.)
    - Assist DCF in convening a multidisciplinary group (DPH, DCF Domestic Violence Unit and office staff, Jane Doe Inc., GCASDV) to provide technical assistance concerning the differential response policy and practice guidelines as they pertain to domestic violence cases.

3. *The Executive Office should capitalize on the new and evolving Regional Homeless Centers as an opportunity to pilot the development of proactive policies focused on responsive and safety-promoting mandated reporting practices.*
    - Include domestic violence experts from state agencies and survivors, or agencies who represent survivors in policy level discussions from early stage.
    - Incorporate 51A training into the new homelessness regional centers' cross-agency, inter-program trainings on trauma-informed services (the current practice of providing 51A training separately and outside a trauma context leads to many of the harms noted above).
4. *DHCD, in partnership with GCASDV, DCF and DTA, s*hould *ensure that relevant DHCD staff and employees of contracted adult and family shelters receive essential information, training and ongoing support on mandated reporting and* domestic violence as part of training in trauma-informed care/services/practice.
    - Incorporate 51A education into trauma-informed trainings to better equip practitioners to recognize and respond appropriately to the intersection of domestic violence and homelessness.
    - Make such training a required element of contracts moving forward.
    - DHCD should encourage and support its homelessness providers in forming relationships with the domestic violence community of practice, including DCF's Domestic Violence Unit, as resources to support homelessness providers' efforts to ensure families' safety.

What is common to each of these recommendations is the recognition that, while domestic violence is highly detrimental to children and families, in some cases, there may be protective factors that can be deployed or alternatives to filing a 51A and/or to removing the children from parental custody that may produce better, safer outcomes. The intersection of issues described in each of the three problems in this blueprint adds a level of complexity to the state's response to potential abuse and neglect that require sophisticated, tailored responses across government and the nonprofit sector.

IV. Conclusion

Throughout the Commonwealth, both in government and in communities, we are surrounded by examples of commitment and creativity in helping survivors leverage their strength to find safety, stability and supportive connections to others. We have come—collectively—to recognize that survivors' needs are complex and fluid and that their strengths are extraordinary. Awareness that survivors are our neighbors and colleagues, and that our neighbors and colleagues seek services, is now a recognition woven into our laws, policies, and public funding. Although there is room for improvement, we have come a long way in recognizing that survivors come into contact with all of our systems every day, not just those labeled as "survivor" services.

There is much to be proud of.

At the same time, we must recognize that there is much that remains to be done, and it is urgent work. As the issues identified in this blueprint illustrate, inattention to outdated systemic arrangements may lead to further harm for victims and their families and imposes an extraordinary, unnecessary cost burden on the state. This is a "lose-lose" proposition. We can and must do better. Here, we have outlined some starting points, which alone will not solve the problems, but are clear, immediate steps that the Executive Office and government agencies can take to support community efforts and survivors. The best approach—whether working with survivors, communities or agencies, is to build upon current strengths and assets. This has been our approach to constructing this blueprint.

Because the Systems Change and Integration Committee was charged by the Lieutenant Governor with identifying areas for systemic intervention, our recommendations are primarily targeted towards government. Nothing in this should be taken as a mandate for systems-centric practice. In fact, each of the recommendations reinforces system-level *survivor-centered* practice.

The changes we suggest are well within reach, and this time in history—when resources are short and the need is growing—is one uniquely suited to change. We further suggest that the implementation and effectiveness of the reforms suggested above will depend on the exercise of clear leadership from the Executive Office, and accountability by all parties. But to ensure that this process does not repeat the stripping of control, choice and voice many survivors and communities seek to escape, those implementing the change must also be held to the following principles of practice and change:

- Participant-driven and community-focused;
- Transparent to participants and communities;
- Accountable to participants and communities.

The Lieutenant Governor, in his active stewardship of multiple interagency and advisory councils, has demonstrated leadership that we hope he, the Executive Office, and all of us can capitalize on to move these recommendations forward.

Addendum A: The Systems Change and Integration Committee

The Systems Committee of the GCSDV is comprised of individuals working to end sexual and domestic violence in various ways. The Committee is representative of systems across the state, including hospitals, community-based organizations, domestic violence and sexual assault advocacy groups, Jane Doe Inc., the Full Frame Initiative, Department of Youth Services (DYS), Department of Public Health (DPH), Department of Children and Families (DCF), Department of Transitional Assistance (DTA), Department of Developmental Services (DDS). The initial charge of the Committee was to identify and suggest systems-level opportunities to improve the state's responsiveness to individuals and families experiencing (or who have in the past experienced) sexual and domestic violence.

Membership on the committee is voluntary and is determined in part by the particular question being addressed. During the period this blueprint was created, members included:

Kate DeCou (Springfield College School of Social Work)
Marie-Elena Edwards, co-chair (DYS)
Valorie Faretra (DTA)
Janet Fender (DTA)
Carol Gomez (Matahari, Eye of the Day)
Sue Hubert (DCF)
Beth Nagy (DPH)
Janice O'Keefe (DDS)
Katya Fels Smyth, co-chair (Full Frame Initiative)
Joan Stiles (DCF)
Joanne Timmons (Boston Medical Center)
Isa Woldeguiorguis, co-chair (Jane Doe, Inc.)

Addendum B