B. Experience and Expertise

For the lead applicant (CBO)

a. The history and mission of the organization, and populations served by the organization.

Safe Horizon respectfully requests $2,122,000 over five years from the Mayor's Fund To Advance New York City's Connections to Care Program (C2C), to expand trauma-informed mental health services within its citywide residential programming for survivors of domestic violence. Safe Horizon's Domestic Violence Shelter Program (DVSP) – the largest system of private domestic violence shelter in the United States (U.S.) – provides safety and support for thousands of adults and children each year in all five boroughs of New York City (NYC). Via a partnership with the Safe Horizon Counseling Center (SHCC) and the agency's Training Department, we will ensure comprehensive mental health care for domestic violence survivors.

Safe Horizon's history began in 1975, when the Vera Institute of Justice launched a pilot program in response to the urgent need to assist witnesses who felt too threatened to testify in NYC's criminal courts. Three years later, that pilot program became the Victim Services Agency (renamed Safe Horizon in 2000), offering a broader array of services to help an increasing number of survivors of various victimizations. By 1981, the Victim Services Agency provided a wide range of programs, including shelter, counseling, and other practical support. Over the next three decades, Safe Horizon developed other innovative programs that have become nationally recognized models for delivering crucial assistance to crime victims and their families during times of crisis. Our mission is "to provide support, prevent violence and promote justice for victims of crime and abuse, their families and communities."

Safe Horizon offers a comprehensive array of programs, touching the lives of more than 250,000 individuals affected by violence each year. Our services are available for all victims regardless of age, race, gender or gender identity, sexual orientation, ethnicity, religion, socioeconomic status, immigration status, language, or place of birth. Our clients are survivors of domestic violence, sexual assault, child abuse, stalking, human trafficking, and other crimes.

Safe Horizon is the largest non-profit organization helping victims of crime and abuse in the U.S. The agency functions as the 'go to' provider of victim assistance throughout the five boroughs of NYC, and is especially renowned for the depth and breadth of its services for survivors of domestic violence, which include the City's 24-hour Domestic Violence Hotline.

b. Details on the current level of the CBO's performance–including the number served, populations served, impact, the programmatic needs of the population(s) proposed to be served, key outcomes, and different services offered.

Safe Horizon's DVSP – the "CBO" for the project that is the subject of the present proposal – provides safe, confidential housing and supportive services to victims of domestic violence and their children. Last year, the program supported 914 adults and 1,285 children.

The DVSP operates six crisis and two transitional shelters. Individuals and families fleeing violence and in need immediate assistance may be eligible for crisis shelter, also called emergency shelter, monitored by the New York State (NYS) Office of Children and Family Services (OCFS). Under NYS guidelines, clients eligible for crisis shelter may reside in emergency shelter for an initial period of 90 days and can be granted extensions up to 90 days. If clients are unable to find stable housing within 180 days and still need additional support, they may be eligible to move to a Tier-II facility, known colloquially as transitional shelter. Safe Horizon's Tier-II shelters are governed by the NYS Office for Temporary Disability Assistance (OTDA), and provide shelter for six months to one year. Services offered at the Tier-II shelters

include all of the previously mentioned services available at crisis shelters with additional supports around employment, education, and permanent housing.

On average, clients remain in the DVSP for six to nine months. The majority of clients are unemployed or underemployed women aged 18-30 who have at least one child, and as many as five children. Most of the children in the DVSP are under the age of four. Our clients are almost all reliant on Public Assistance and other public benefits programs. Their most exigent needs are for food, clothing, childcare, safety, financial support, and assistance with housing. As such, DVSP staff focus on assisting clients in these areas while also supporting their emotional needs.

As shelter eligibility is contingent on the threat of imminent danger, our clients are, as a rule, suffering from the trauma of fleeing for their lives. Often, relocating to a shelter is an action that must occur abruptly; many clients flee their homes in the middle of the night, leaving behind friends and family. Accordingly, clients must deal with the trauma associated with such momentous disturbances to their lives and their children's lives, and many subsequently suffer from posttraumatic stress disorder (PTSD). Thus, a significant and unmet need is for on-site trauma-informed counseling and psychiatric interventions—services that are not covered by existing funding for domestic violence shelter. Without these services, clients remain at risk for outcomes associated with PTSD. For example, adults may have difficulty finding and maintaining employment, trusting social service agencies, and remaining in stable housing.

c. *The CBO's total staff size, as well as the number of direct service staff.*

The DVSP is comprised of a network of eight shelters across NYC's five boroughs. As the program is open 24 hours per day (including during storms and natural disasters), sites require round-the-clock oversight. The DVSP employs 164 staff, including 98 direct service staff.

d. *The target population(s) to be served through C2C, and the contracts/programs of the CBO that currently serve them. List the service levels and outcomes for the past three years.*

Safe Horizon proposes to serve expecting mothers and parents of children aged 0-4. In the past three fiscal years (FY), the numbers of heads of household served by the DVSP are: 1,112 (FY13), 908 (FY14), and 795[1] (FY15). Of these clients, those who fit the proposed target population include: 644 (FY14) and 508 (FY15) – the only two years for which such data exists.

The DVSP receives its funding from the NYC Human Resources Administration (HRA), which reimburses us based on the rate of beds that are occupied in any given night. There is no contract for the services rendered in the DVSP. Over the past three years, the DVSP has had utilization rates of 84 percent (FY13), 84 percent (FY14), and 88 percent (FY15).

e. *CBO applicants should not currently have mental health specific services on-site serving the target population. Confirm that the CBO does not have these services. Overall the CBO applicant should have limited experience in delivering mental health services.*

The DVSP currently has no on-site staff devoted to the identification or treatment of mental health issues presented by residents. Direct service staff have a particular challenge working with clients who exhibit behaviors that the program knows stem from traumatic events, which is exacerbated by the fact that these behaviors may previously have been misdiagnosed. These staff need training in the prescribed modalities of the Core Mental Health Package in order to identify and work with clients who suffer from the effects of trauma and other mental health issues.

<u>For the MHP</u>

a. *The history and mission of the MHP entity, and its track record in the community proposed to be served, if applicable, and with low-income populations. Describe numbers served over*

[1] In 2014, several discharge freezes were issued due to capacity issues at NYC Department of Homeless Services shelters. This has limited new clients. The most recent freeze, issued in mid-September 2014, has not yet been lifted.

the past three years and the portion of those that are low-income and/or related to the target community. Describe participant outcomes tracked and achieved.

For the proposed C2C project, Safe Horizon will utilize staff at the Safe Horizon Counseling Center (SHCC) as well as the agency's Training Department in the role of the "MHP," to train DVSP staff in the prescribed core modalities. (Please see section B.MHP.e., below, for a description of the Training Department.) When discussing the training component of this project, this proposal will refer to this combined MHP structure as "the SHCC."

The SHCC was established in 1988. It is the only NYS-licensed outpatient mental health clinic that specializes exclusively in the evidence-based, trauma-focused treatment of child and adult survivors of crime and abuse. The SHCC continuously receives the highest ratings from the NYS Office of Mental Health (OMH). The clinic has no geographic or age limitations on service provision. Clients come from the five boroughs of NYC and beyond, and range in age from seven months to 78 years old. In the previous fiscal year, SHCC provided nearly 8,000 hours of trauma-focused treatment to nearly 600 unduplicated individuals. The vast majority (75 percent) of clients receive Medicaid or Medicaid Managed care, indicating that they are low-income.

All SHCC clients have been traumatized by crime or abuse. Nearly half of our clients are referred from other Safe Horizon programs, including the DVSP. During intake, we use nationally validated, age-appropriate measures of PTSD to establish a baseline. These include the Trauma History Questionnaire[2] and the Posttraumatic Stress Disorder Check List[3]. The measures are re-administered during quarterly, collaborative reviews to inform the direction of treatment.

One of the most important tracked outcomes within the SHCC's client population is high risk behavior, including suicidality. The National Center for PTSD cites numerous studies linking trauma and suicidal risk.[4] The National Center for PTSD also reports that trauma-focused therapy, the same practice employed at the SHCC, is associated recovery from suicidal thoughts. This is reflected in our client data. Though approximately 33 percent of SHCC clients report thoughts of self-harm, SHCC has an incident rate – defined as the need for emergency (hospital-based) assessment or intervention – of less than one percent. This is attributed to the menu of highly-regarded evidenced-based trauma treatments that SHCC staff expertly administer.

b. The MHP's experience with the core C2C modalities listed on page 5 and with any additional modalities proposed for C2C. Describe the training and credentials of staff in these areas, the supervision of staff in delivering these interventions, and any other relevant background in these areas.

The trauma of interpersonal violence experienced by the target population necessitates that we administer an augmented psychoeducation modality for this project, in order to address their full range of unique mental health needs. Therefore, this project will train all staff in Risking Connection (RC)[5][6], a trauma informed care framework with which SHCC has many years of

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[2] PTSD: National Center For PTSD. *U.S. Department of Veterans Affairs.* Link: http://www.ptsd.va.gov/professional/assessment/te-measures/thq.asp

[3] Ibid. Link: http://www.ptsd.va.gov/professional/pages/assessments/ptsd-checklist.asp

[4] Ibid. Link: http://www.ptsd.va.gov/professional/co-occurring/ptsd-suicide.asp

[5] Tokayer, N., 2001. A Brief Note on Research Support for the Risking Connection Approach. Sidran Institute Press.

[6] Risking Connection (RC) provides a framework in which survivors of traumatic experiences can begin to heal and grow. RC is designed to help clients identify and understand the impact of trauma on the brain, to develop practical coping mechanisms for trauma-related stress, and to facilitate healing and empowerment. RC is based in constructivist self-development theory, a clinical approach to working with trauma victims that emphasizes the importance of clients' histories in shaping their experiences with trauma. RC incorporates concepts with broad empirical support, for example, by focusing on therapeutic relationships between victims and staff as central to

experience. RC provides highly effective psychoeducation on trauma that provides a context for the provision of screening tools and is highly effective at empowering and establishing collaboration with sometimes difficult-to-engage trauma survivors. RC includes a component that allows the practitioner to screen for trauma and distinguish trauma reactions from symptoms of other mental health conditions, and will be administered using the nationally validated tools mentioned in section B.MHP.a. For the proposed target population, RC provides an appropriate and necessary underlying service matrix for the remaining core C2C modalities of screening, Mental Health First Aid (MHFA), and Motivational Interviewing (MI).

The proposed project will employ four experts who are certified to provide RC training. They are our Training Department director, SHCC's senior clinical director, an SHCC therapist, and a former SHCC employee who will support this project as a consultant. These staff have trained staff at the SHCC, the entire Safe Horizon Community Program staff, Safe Horizon's Domestic Violence Hotline supervisors, senior DVSP leaders, and several members of Safe Horizon's executive leadership in RC—more than 150 people in the past year alone. Safe Horizon has a certified MHFA trainer, and two Training Department staff have had training in MI, including the director who is a certified MI trainer. These staff will work with the SHCC to deliver training in the Core Mental Health Package. They will be supervised by our vice president of mental health treatment, who directs the SHCC and will oversee the MHP portion of the C2C project.

Through C2C, DVSP staff will be trained to identify clients who are in need of trauma-focused mental health treatment, and refer them to SHCC for more in-depth services, as necessary. Clients receiving C2C core services who are identified as needing ongoing treatment will have access to the SHCC's full range of mental health services. SHCC clinicians specialize in a range of evidence-based, trauma-focused treatments. (For the credentials of staff who will provide trainings, please see the attached staffing plan, resumes, and certifications.)

c. The MHP's current level of performance and how it has effectively used data to make significant programmatic changes in operations.

As described above, each year, SHCC serves nearly 600 survivors of crime and abuse. SHCC has a robust quality improvement (QI) program that is facilitated by our licensed quality improvement specialist. The major activities of the QI program include participation in state and federal quality improvement initiatives as well as in-house program evaluation. The SHCC is a member site of the National Child Traumatic Stress Network (NCTSN), to which we contribute utilization and training data on a quarterly basis. The SHCC also participates in the OMH quality improvement initiative, the Psychiatric Services and Clinical Knowledge Enhancement System. SHCC received recognition from OMH on using the system's monthly tracking data to significantly reduce the number of individuals who accessed emergency services for primary medical care. In addition, the SHCC participates in Safe Horizon's In-Depth Case Review (IDCR) process, which uses data and case studies to ensure consistent, effective, and client-centered practice. (Please see section C.1.a. for more information on IDCR.)

d. The MHP's experience training lay (non-mental health) staff and/or providing technical assistance. Describe any specific experience with the modalities described in this RFP. If the MHP is engaging a TA partner or vendor, describe the experience of the partner or vendor.

Safe Horizon's Training Department utilizes the expertise of agency staff to provide training in several treatment frameworks, including RC and MHFA. These staff have experience training

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healing. Numerous research studies have found that a client's perception of the strength of this connection is an excellent predictor of their success in treatment. For our clients, the strength of these relationships can lead to safer, more productive interactions, enabling clients to more quickly recover from their traumatic experiences.

Safe Horizon victim advocates, most of whom are not mental health professionals and have no experience in any of the four prescribed modalities. For example, the Training Department has trained in RC Safe Horizon's Community Program staff – the majority of which have non-mental health training. The SHCC also has provided external training in the screening and identification of trauma in infants and toddlers to 75 paraprofessional childcare staff at Head Start programs in five Brooklyn neighborhoods through a project with the NYC Administration for Children's Services. Finally, the bulk of MHFA and MI training provided by the C2C project's trainers was provided to audiences that included non-mental health participants.

e. The configuration of its mental health service professionals, including the number of mental health delivery staff and current capacity for taking on new participants.

The Safe Horizon Counseling Center (SHCC) – At our main clinic in downtown Brooklyn, SHCC clinical staff includes eight full-time and 22 part-time licensed master social workers and licensed clinical social workers, and a practicing physician specializing in trauma who is board certified in child and adult psychiatry. In addition, the SHCC is expanding into two satellite clinic operations, co-located within existing Safe Horizon locations, and will apply for two additional satellite locations by the end of 2015. Thus, not only does the SHCC have capacity at our main location to provide trauma-focused mental health treatment to any new clients who are identified through C2C, we also have experience collaborating with direct service staff at on-site locations throughout NYC, engaging new clients and creating new referral pathways.

The Training Department – Safe Horizon is committed to continuous staff development to ensure quality service delivery across our programs. The agency's Training Department provides all direct service employees with foundational training appropriate to their role. In addition, all employees are trained to identify and respond to child abuse and neglect. Monthly client-centered practice skills labs provide another support for staff around their work with crime victims, and offerings are expanded and refined based on staff input and emerging priorities. Trainings are designed to engage employees as adult learners, with many opportunities for hands-on and interactive learning experiences. The Training Department will utilize staff who have experience delivering trainings in all four core C2C modalities, and time needed to create curricula and plan for training has been taken into consideration in the proposed budget.

f. The MHP's (and any additional partner/vendor) experience participating in and/or managing collaborations.

Safe Horizon has managed highly effective collaborations with external and internal partners. In 2008, we partnered with the Yale University Child Study Center on the Child and Family Traumatic Stress Intervention (CFTSI), an evidence-based intervention developed at Yale that has been proven to prevent PTSD in children who have experienced a recent trauma.[7] Since then, Yale has provided CFTSI training to direct service staff in Safe Horizon's five, borough-based Child Advocacy Centers, and four SHCC staff are completing a program with Yale to become the first certified national trainers of CFTSI. Given this successful collaboration to serve trauma survivors, the SHCC is well-positioned to undertake the proposed collaborative C2C project.

In addition, as mentioned in section B.MHP.d., above, the SHCC has recent experience expanding mental health services through satellite Safe Horizon programs across NYC.

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[7] Berkowitz, SJ, CS Stover & SR Marans. "The Child and Family Traumatic Stress Intervention: secondary prevention for youth at risk of developing PTSD." *The Journal of Child Psychology and Psychiatry, and Allied Disciplines.* September 24, 2010. Source: http://www.ncbi.nlm.nih.gov/pubmed/20868370

C. Organizational Capability

1. Program Management (of lead applicant CBO)

a. Describe and demonstrate the effectiveness of how the applicant currently uses data to support decision-making in existing programs.

Safe Horizon is dedicated to utilizing data to support decision-making across all programs. The agency uses the following two quality improvement initiatives to ensure consistency.

In-Depth Case Review (IDCR): The annual IDCR process is designed to advance a client-centered, trauma-focused, culturally responsive approach to safety assessment and risk management across all programs by increasing communication, clarity, alignment, and accountability among program managers at all levels. IDCR presents a unique opportunity for staff from all levels of the program to discuss case practice issues, portray site and program data, review supervisory and case documentation, and discuss recorded client interactions. The DVSP held its most recent IDCR in May 2015. During this process, program leaders discussed the ways in which clients' violent experiences (along with the development of acute and/or post-traumatic responses to the abuse experiences), often leave staff feeling ill-equipped to support clients' mental health and trauma needs. It was this discussion that prompted both the DVSP team and the organization at large to commit to investing in and implementing an evidence-based model of trauma and mental health within the DVSP.

Quality Improvement Planning (QIP): The annual QIP process follows IDCR. Programs' senior management and site supervisors collaborate to develop a quality improvement plan, which they then implement over the following year. The Quality Improvement Plan is a guidance document that explains how each program will manage, deploy, and review quality throughout the program. The plan outlines the processes and activities that will be put into place to ensure that quality services are provided consistently to clients. This process is not a one-time event, but rather one of continuing improvement. Each plan includes measurable short and long-term goals that are reviewed quarterly by senior management and revised as needed.

b. Demonstrate how the applicant has effectively used data to make significant programmatic changes in operations. Provide two specific examples. Provide any relevant results of prior evaluations or examples of how evaluation findings influenced service delivery. Include any examples of experience with previous external evaluation activities, if any.

Last year, Safe Horizon organized a year-long quality improvement initiative in the DVSP to increase shelter revenue while maintaining quality services. The agency formed a cross-department shelter utilization team that met monthly to analyze data and implement program enhancements. These included, among other changes: reconfiguring the staffing model to increase weekend availability at the sites, fine-tuning our "flip process" of making rooms available once residents exit in order to provide faster room availability to new clients, and improving communications between the Domestic Violence Hotline and the DVSP.

Safe Horizon also utilizes client feedback to make program improvements. Over the past year, the DVSP collaborated with Safe Horizon's Research & Evaluation Department to conduct a longitudinal needs assessment of 83 clients residing in emergency shelter. A common theme that arose in the data was the profound need for trauma and mental health services. Utilizing the Center for Epidemiological Studies' Depression scale, the assessment identified that 69 percent of the sample met the clinical cut-off score for being at high risk for clinical depression. In addition, 88 percent of the sample reported experiencing "flashbacks or sudden, vivid distracting memories," 80 percent reported "having trouble sleeping or concentrating," and 60 percent

reported "feeling jumpy or easily startled." All these symptoms describe acute or post-traumatic stress reactions. Finally, 68 percent indicated interest in receiving counseling services.

Thus, by analyzing data, the DVSP has identified that training staff to be able to address the trauma and mental health issues of our clients is a programmatic priority.

c. *Demonstrate the applicant's capability to successfully perform the administrative responsibilities related to the delivery of the proposed services, including fiscal management, data collection, reporting and records management in an efficient, accurate and timely manner.*

Safe Horizon has nearly four decades of experience in the victim services field. The agency's departments collaborate to ensure consistent services to clients. These departments include:

Program Administration – Program Administration sets the agenda for program operations and provides direction and oversight. All programs, including the DVSP, use a trauma-informed client-centered practice (CCP), at the core of their work with clients. CCP is an evidence-informed approach that promotes each client's self-determination in safety assessment and risk management planning. It is a dynamic, ongoing process that begins with a comprehensive assessment of threats to the client's physical and emotional safety and a review of the client's current protective actions, resources, and barriers. Staff partner with each client to develop a risk management plan that is responsive to the client's priorities and achievable given the client's resources and challenges. In order to support this high quality practice across all our programs, Safe Horizon pays particular attention to implementing quality supervision. Every client-facing employee at Safe Horizon receives dedicated individual supervision with their supervisor a minimum of two times per month. This develops case practice skills, supports professional development, and attends to vicarious trauma and self-care. Program staff members also participate in group supervision, and supervisors routinely observe client interactions.

Research and Evaluation (R&E) – R&E performs quality assurance and program evaluation that measures program efficacy alongside research that identifies best practices. R&E leads program services research, quality assurance, evaluation design, program monitoring, and outcomes measurement for the organization. R&E assesses program quality through the IDCR and QIP processes, described in section C.1.a., which include structured observation of service provision, analysis of client service data, review of service documentation, and client satisfaction surveys. These measures are used to assess fidelity to CCP, ensure compliance with funder requirements, and inform decision-making about service provision and staff training. In addition, R&E regularly collaborates with outside researchers on research and evaluation projects.

Information Systems and Technology (IST) – IST not only purchases and maintains the computer and telephony technology to support operations, but also plays a critical role in developing and maintaining data systems that protect client confidentiality, allow program reporting, and support our quality assurance efforts.

Client Management System: To ensure accurate and efficient data tracking and help standardize services across the agency, Safe Horizon utilizes a web-based, password-protected Client Management System (CMS) in its programs to document client information and service provision. CMS is customized to each program model, supporting staff to document their work efficiently while meeting funder requirements. CMS also significantly enhances Safe Horizon's ability to evaluate and report accurately on client data, track clients and service trends within and across programs, develop services to meet clients' evolving needs, and protect client data.

Finance – The Finance Department has established an effective and efficient system to manage and report on approximately 140 active grants and contracts and 25 program and

departmental budgets. As part of our corporate governance, the Finance Department reports regularly to the Finance and Audit Committees of Safe Horizon's Board of Directors, which provide oversight on the budget, on the agency's overall financial health, and on the management of its financial operations and governance. Please see section C.2.c. for more information.

Human Resources (HR) – Safe Horizon's program leaders work closely with HR to ensure that qualified and skilled individuals are recruited and hired for vacant positions. All new employees undergo basic background checks as a condition of employment. Depending on a position's specific duties and funder requirements, HR may obtain a more extensive background check through law enforcement and other authorities. This may entail a fingerprint check, verification of academic degrees or attendance, review of motor vehicle records, New York State Central Register check, review of medical documentation, and/or credit information.

Facilities – The Facilities Department works to ensure that client services are delivered in appropriate environments. In locations that Safe Horizon rents or otherwise controls, such as our shelters, we ensure the environments are safe, clean, and welcoming for our clients and staff.

d. Demonstrate technological capacity and data security systems to protect participants' personal identifiable information.

As mentioned in section C.1.c., Safe Horizon's CMS enables the agency to protect client information. The system was recently outfitted to be utilized by the DVSP. Safe Horizon recognizes the importance of keeping clients' personably identifiable information secure in CMS. To that extent, a number of precautions are taken to ensure only specific personnel have access to client records. Access is controlled through a role assignment capability, such that only employees from specific programs have access to relevant clients' records. Social Security numbers are masked to display only last 4 digits. Case notes are not shareable across different programs, and access is limited in the production system to one senior IST architect role. Finally, all data in the test system is scrambled to mask clients' identities.

In addition, clients are protected by agency protocols that govern how our public-facing staff access and talk about Safe Horizon's work with our clients. This is most salient for our Development, Marketing & Communications, Program, and R&E Departments, which alter details to protect clients' identifies in "case studies". To ensure confidentiality when using client information, Safe Horizon has a Confidentiality Policy, which, among other restrictions, limits access to client information to direct program staff in most cases. Finally, as Safe Horizon clients often visit our website to seek initial information and resources, we display policies regarding web and information safety and security, which are accessible by any site user.

e. Describe and demonstrate how executives at the applicant's organization will be able to and have the availability to play an effective role in developing, implementing, assessing and overseeing the program.

As stated in section C.1.c., key Safe Horizon departments, led by Program Administration, Finance, and Development, are intimately involved with the development and management of all Safe Horizon program initiatives. Key initial planning and budget development meetings are led by our Chief Executive Officer, Deputy Chief Executive Officer & Chief Program Officer, Chief Administrative & Financial Officer, and Chief Development Officer. The Deputy Program Officer will provide additional guidance for the C2C project (please see attached staffing plan).

f. Describe experience managing collaborations, and recent successful collaborations that have benefitted the applicant's participants. Describe the capability to manage this project.

The DVSP has a long history of partnering with internal and external programs to enhance the scope of services available to our residents. For example, a monthly collaboration with Safe

Horizon's Domestic Violence Law Project enables residents to meet with an attorney on-site at the shelter to receive legal consultation. Additionally, we have partnered with arts organizations such as Art Start and Gina Gibney Dance to bring regular workshops to our residents. Finally, through the annual IDCR process, the DVSP works with R&E to gather data to evaluate the DVSP's provision of trauma-informed, client-centered, and culturally responsive services. Please see Attachment 3 Background/Capacity Form and all requested supporting documents.

2. Fiscal Capability

a. *Describe the applicant's experience managing government grants or contracts, if any*.

In its 37 year history, Safe Horizon has built and maintained the infrastructure to support program operations. Across more than 50 program locations (including stand-alone operations and partner co-located program sites), 600 employees contribute to Safe Horizon's success. Safe Horizon has an annual budget of approximately $56 million.

Safe Horizon has extensive experience implementing performance-based contracts. Our R&E and IST Departments develop data systems that track key performance measures across multiple programs and sites, while program staff monitor performance against funder requirements. Our Finance Department has extensive experience in managing such performance-based contracts, utilizing program data to accurately report on performance. Safe Horizon utilizes a web-based, password-protected Client Management System (CMS) to document client information and service provision. CMS is customized to each program model, supporting staff to document their work efficiently while meeting funder requirements.

b. Describe whether current financial management systems are in compliance with 2 C.F.R. 200.302(b) and capable of identifying costs by grant, by program year and by budget category, and to differentiate between direct and indirect costs. If not, describe what changes or technical assistance would be required.

Safe Horizon's financial system is in compliance with 2CFR 200.302(b). Safe Horizon: 1) can identify all federal awards received and expended under the program they were received; 2) can accurately and completely disclose financial results of each federal award and program; 3) can adequately identify the source and application of federally funded activities; 4) has effectively controls over accountability for all funds, property and other assets; 5) compares expenditures to budget amounts for each federal award; and 6) has written procedures to implement requirements of 200.305 (disbursement to non-federal entities).

c. Demonstrate that the applicant has the requisite financial strength and resources to handle a project of this scale and scope; and ability to comply with federal requirements.

The Finance Department maintains a computerized fund accounting system that conforms to Generally Accepted Accounting Principles (GAAP). All contractual grant awards are accounted for individually based on their contracted criteria in the grant. Annually, we undergo an outside audit, currently by our external audit firm, Marks Paneth, which includes an agency audit in accordance with GAAP and an audit of federal funds in conformance with OMB Circular A-133. The Finance Department prepares and submits fiscal reports to funders under the supervision of the senior director of grants, the controller, and the chief financial and administrative officer. The Finance staff conduct regular reviews of departmental budgets and spending and meet regularly with departmental staff to review variances against funder budgets and the agency budget. As part of corporate governance, the Finance Department reports regularly to the Finance and Audit Committees of the agency's Board of Directors, which provide oversight on the agency's budget and overall financial health, and the management of its financial operations and governance.

d. If the applicant has received federal awards in the past, summarize expenses or costs disallowed in the last three years and the corrective actions taken.
The have been no disallowances in the past three years.

3. Leveraged Funding

a. Demonstrate how the applicant will help leverage additional private or public (non-federal) funding sources for the program. As noted earlier, this grant includes a 1 to 1 cash match requirement. Organizations without a fully-developed fundraising plan are invited to apply, as Mayor's Fund will provide some technical assistance or other support to awarded SIF C2C subgrantee providers toward their fundraising requirements. The strongest proposals will demonstrate the applicant's capacity to raise the required match levels.

Safe Horizon will leverage current funding that supports the work of the DVSP. Matching funds are reimbursement fees from HRA, which fund the day-to-day operations of our State-regulated shelters and the entire DVSP staff. This funding is unlike most public funding, as there is no contract or deliverables. The funding is not restricted, except to the DVSP – the "CBO" for the purposes of the proposed project; within the program, the funding is unrestricted.

D. Proposed Program Approach

a. An overall summary of the proposed approach for implementing Connections to Care.

Safe Horizon will use C2C funding from the Mayor's Fund To Advance NYC to create a partnership of Safe Horizon programs, in order implement much-needed trauma and mental health training for direct service staff and supervisors at seven domestic violence shelters (one of our shelters will soon pilot an on-site mental health "satellite" clinic, in collaboration with the SHCC). These shelters are within Safe Horizon's Domestic Violence Shelter Program (DVSP) – the so-called "CBO" of the partnership. The C2C project will utilize clinical experts from within Safe Horizon's Counseling Center (SHCC), the agency's Training Department, and collaborating staff (together, referred to as "the SHCC") – the so-called "MHP" of the partnership – to conduct training in the prescribed Core Mental Health Package. The entire project will be overseen by the DVSP's associate vice president and the SHCC's vice president of mental health treatment.

At the outset of the grant, the DVSP will hire a project coordinator to manage the partnership, all training and ongoing implementation, and all data review and evaluation activity. This project coordinator will establish a C2C team, made up of key staff involved in the training, implementation, and evaluation of the C2C project, which will meet monthly throughout the project. During the first three years of the grant, the SHCC will train DVSP staff in Risking Connection (i.e., psychoeducation; see section B.MHP.b.), how to update initial screenings to be trauma-informed, and how to employ Motivational Interviewing and Mental Health First Aid to effectively work with domestic violence victims is crisis. (Please see section D.g.vii., for details on the C2C project's implementation of these modalities.) In order to ensure the sustainability of the program's utilization of these methods, supervisory staff will attain fluency in years four and five of the project. Please see section D.o., for a schedule of activities supported by this project.

The C2C team will review current DVSP practices to identify areas where current practices can be modified to be more responsive to our clients' trauma and mental health needs. These areas include modifying intakes and clinical assessments, looking into ways to incorporate C2C initiatives into the program's formal quality improvement processes, identifying how we provide ongoing support to DVSP staff through supervision, continuing to develop referral processes with outside providers, and developing staff trauma and mental health resource materials.

b. A description of the target population to be served and how this aligns with the definition of 'low-income community' on page 6.

The C2C project will serve expectant mothers and parents of children ages 0-4 who have survived domestic violence. This group comprises over 60 percent of DVSP clients.

Nearly all of DVSP clients meet the definition of a low income community. In Safe Horizon's most recently completed fiscal year, 30 percent of DVSP clients were under the age of 25; ninety-eight percent were female; eighty-seven percent identified their race as African-American/Black; and 33 percent identified their ethnicity as Hispanic. Thirty-nine percent of the residents had less than a high school degree, 35 percent have a high school degree as their highest level of education, and over half (58 percent) had no work history. Almost all of the clients (97 percent) reported an annual income of less than $18,000, while the majority had an income of less than $6,000 a year. Most clients qualify for and receive public assistance benefits, including cash assistance and the Supplemental Nutrition Assistance Program (SNAP) benefit.

c. The mental health service needs of your participants as identified through quantitative data collected by your organization and/or qualitative data that illustrates the need for this intervention at the CBO.

In 2014, the quality improvement staff of the SHCC conducted a needs assessment at Rose House, Safe Horizon's largest domestic violence shelter. In this study, 15 voluntary adult participants completed measures of trauma for themselves and for 32 of their children. The data showed that 53 percent of the adults met full diagnostic criteria for PTSD, 44 percent of children over the age of six met diagnostic criteria for PTSD, and 36 percent of children six and under met diagnostic criteria for PTSD. Of the children who did not meet full criteria for PTSD, 67 percent endorsed symptoms that warranted treatment for anxiety due to exposure to violence.

In addition, a collaborative research project between the DVSP and R&E showed a similar need. The data revealed that a large majority of shelter residents are experiencing mental health symptoms and often staff, particularly non-clinical staff, felt ill-equipped to help residents manage these symptoms. The research showed that 69 percent of the sample met the clinical cut-off score for being at high risk for clinical depression as defined by the Center for Epidemiological Studies-Depression Scale. Additionally, 88 percent reported experiencing "flashbacks or sudden, vivid, distracting memories," 80 percent reported "having trouble sleeping or concentrating," and 60 percent reported "feeling jumpy or easily startled." These are all symptoms of acute or post-traumatic stress reactions.

d. A description of need for mental health capacity-building among staff proposed to be trained through C2C. Because this initiative is designed to bring mental health services into settings where they are not currently available, the CBO applicant should have limited experience delivering mental health services. CBO applicants also should not currently have mental health specific services on-site serving the target population.

There is significant need in Safe Horizon's seven DV Shelters – where there is no on-site mental health service provision – to increase the capacity of staff to engage, screen, identify, and effectively intervene with clients. Safe Horizon seeks C2C funding to build capacity among staff to intervene with young mothers and their children who are experiencing a significant trauma and mental health issues. While all DVSP staff receive training in working with victims of domestic violence, current training practices do not adequately prepare direct service staff to be responsive to the mental health needs of shelter residents, especially those stemming from unaddressed trauma. Given the 24-hour availability of the DVSP, non-clinical staff are often faced with residents experiencing mental health crises during evening, overnight, or weekend hours when clinical staff are not on-site. This is a significant gap in our service delivery.

Thus, in keeping pace with state and national trends toward the provision of trauma-informed care, Safe Horizon intends to train DVSP staff in trauma and mental health responses. Understanding when a resident is experiencing symptoms of mental health issues and responding appropriately can help facilitate a successful linkage to appropriate care and avoid unnecessary hospital trips. Additionally, staff will have the ability to engage residents in a meaningful way regarding their symptoms without residents feeling judged or misunderstood by staff.

e. Roles of CBO, MHP, and any other partners and how the two (or more) organizations will partner together. Describe the proposed relationship between the CBO and the MHP. How will CBO staff be trained, coached, and mentored in an ongoing continuous manner by the MHP and how will TA be delivered? Describe the strategy for implementation and the frequency of contact.

CBO: The DVSP will partner with the SHCC to provide training and technical assistance to our staff in the Core Mental Health Package. In the first year of the project, the DVSP will hire a project coordinator to manage the trainings in the core modalities and formalize a referral pathway to the SHCC. In the first two years of the project, all DVSP staff will be trained in psychoeducation and screening. In years two and three, DVSP supervisory staff will be trained in Mental Health first Aid (MHFA) and Motivational Interviewing (MI). Once implementation of the mental health modalities has begun, DVSP staff will identify trauma responses during client interactions, and make referrals for clients who require additional mental health treatment, including trauma response, to the SHCC. Throughout the project, DVSP supervisory staff will ensure direct service staff fluency with the core modalities through weekly supervision.

MHP: The SHCC and the Training Department will provide training in the core C2C modalities: screening for trauma, psychoeducation within a trauma framework, MHFA, and MI. Regular supervision, coaching, and technical assistance will be provided monthly by SHCC to DVSP staff through the provision of monthly Risking Connection study groups. These will be co-facilitated by SHCC and DVSP staff in order to ensure sustainability, with the intention of transferring sole facilitation of the study groups to DVSP staff toward the end of the project.

f. A description of how the program and the partnership will be managed, and how the CBO/MHP management will interact.

The C2C project will feature monthly meetings that will include staff from both programs, as well as staff from Safe Horizon's Research & Evaluation Department (R&E), to regularly evaluate the partnership and identify any areas that need modification. These meetings will be led by the C2C project coordinator, and any challenges identified by the CBO or MHP will be raised and solutions will be identified. The C2C project coordinator will work as the direct liaison between the DVSP and the SHCC and will be responsible for all aspects of project management. This includes, in years 1 and 2, coordinating and scheduling the initial roll out of training to DVSP staff, and in future years, managing the schedule of training for new DVSP employees. Additionally, the project coordinator will work closely with R&E to monitor and track outcomes from the implementation of mental health training. Please see the attached signed partnership letter and staffing plan for more information about the roles of each partner.

g. Details on the proposed plan that include:

i. The number of participants to be served by C2C.

As a result of the training supported by the C2C project, the DVSP will serve approximately 600 expectant parents and mothers of children 0-4.

ii. The service location and the geographic area to be served by C2C.

Safe Horizon will reach clients in seven confidential shelters, serving all boroughs of NYC.

iii. Estimates of the target population sizes and rationale for the estimates.

In 2014, the DVSP sheltered 644 clients (64 percent of total program population) who were either pregnant or had children under four years old. Safe Horizon data from previous years shows comparable rates of residents who fit the project target population. As a result, we anticipate reaching similar numbers of participants over the five years of the C2C project.

iv. The program services into which C2C will be integrated. Include those programs' funding sources and start/end dates.

C2C will be integrated into DVSP programming, which includes intakes, assessments, support groups, case management sessions, childcare, housing assistance, and crisis intervention. The DVSP receives ongoing funding from HRA, which reimburses the program according to a per diem rate per bed. This is consistent, secure funding that will exist throughout the grant.

v. The strategies the CBO will use to engage participants in these services. How will the CBO recruit participants as they newly enroll at the CBO? How will the CBO enroll existing participants?

Most clients are referred to the DVSP in one of two ways; crisis shelter clients are referred primarily by the NYC Domestic Violence Hotline (which is operated by Safe Horizon), while all Tier II residents are referred by HRA, the funding agency of the program. Upon intake, clients are greeted by DVSP staff who provide an intake and orientation to the facility. At this time the client is assigned a case manager with whom they will meet on a weekly or bi-weekly basis. Additionally, since staff are on-site 24 hours per day, all clients have regular, daily contact with staff members including residential specialists, childcare workers, housing specialists, and social workers. As C2C training in the core modalities will be infused into <u>all</u> client interactions, opportunities to impact existing clients will arise immediately after initial training in Risking Connection begins. As such, there will not be formal "enrollment" of clients in C2C.

vi. The strategies the CBO will use to retain participants in these services and follow-up with participants if they stop attending the CBO. How will the CBO maintain contact with participants to keep them engaged in services and in the research study?

As stated in section B.CBO.b., the average client stays in the DVSP between three and six months, though some clients may stay for up to one year. When residents discharge, they are still eligible to be served through other Safe Horizon programs, such as the SHCC. Upon discharge, DVSP staff will obtain up-to-date contact information for each resident so that we will be able to continue C2C-funded research with as many residents as possible. Given the transient nature of shelter residents and their ongoing safety needs, there may be residents whom we are not able to reach after they discharge. However, through C2C, it is our goal that residents will have more positive engagement with staff in relation to their trauma and mental health needs, and that former clients will choose to engage in ongoing services despite no longer living in our shelters.

vii. A clear explanation of how the core package of services will be implemented (if additional services are being proposed, provide a justification of their evidence from a peer reviewed journal of a randomized control study or quasi-experimental study); the fit between these services and their anticipated use with the needs of participants targeted; justification for any proposed adaptations to the core package or additional evidence based services.

As stated in section D.a., the core C2C competencies will be integrated within a trauma-informed framework in order to address the most common and pressing needs of our clients. By training all levels of DVSP staff in aspects of the Core Mental Health Package, Safe Horizon will have the capacity to respond to any client experiencing trauma and/or mental health symptoms.

Psychoeducation (Risking Connection): Risking Connection (RC) has a growing body of evidence for its effectiveness as a curriculum for promoting trauma-informed care, and there are currently several state and federally funded outcome studies underway on its impact on clients and staff. It is vital that we implement the Core Mental Health Package within an RC framework, because a significant portion of the clients served at Safe Horizon have complex trauma histories. For nearly 25 years, there has been recognition that complex trauma survivors are often misdiagnosed with psychiatric conditions such as psychosis and bipolar disorder.[8] RC provides a framework and effective intervention skills that address some of the most worrisome trauma reactions and psychiatric symptoms such as suicidal ideation and aggressive behavior. These are behaviors that may result in poor outcomes for clients, including ineffective and excessive use of hospital-based emergency intervention or premature discharge from needed services. While RC addresses a broad range of frequently misdiagnosed symptoms, we expect the incorporation of psychoeducation will produce dramatically improved outcomes for the target population.

During the first two years of the project, SHCC staff will train all direct service staff at the seven shelters in RC. This training is typically conducted over five half-day sessions but will be modified to ensure that overnight and weekend staff receive the full training. RC requires no modification or adaptation for implementation, though, because it was designed for domestic violence survivors. In the last three years, we will continue to train new staff who join the DVSP.

Screening: As this project will serve expectant mothers and parents of very young children living in domestic violence shelters, it is vital that screening for trauma is a first-line intervention. As described above, trauma is often misdiagnosed as other mental health conditions. If it is established, however, that a client has experienced intimate partner violence and s/he screens positive for various trauma reactions, this supports linkage to further trauma-focused treatment as necessary. Thus, the proposed project will support incorporating trauma screening into the existing shelter intake assessment process.

The SHCC RC trainers will provide a one-day training in trauma screening to the clinical supervisors in DVSP. All of the clinical supervisors will be trained in the first grant year, and one training session will be provided in each subsequent year to new supervisors. In order to ensure fidelity to evidence-based practices, the SHCC will use a selection of nationally validated measures (see section B.MHP.b.). These instruments require no adaptation for the C2C project.

Mental Health First Aid (MHFA): Applying RC enables us to implement MHFA with less risk of reinforcing a misinterpretation of symptoms presented by complex trauma survivors. Within the trauma-informed RC framework, MHFA can be a powerful tool for clients to use to envision their own recovery, especially as recent iterations of MHFA have incorporated some content on PTSD. Therefore, it is not anticipated that MHFA will be adapted in any way, but rather, it will follow RC training. The SHCC will present an eight-hour MHFA training to DVSP supervisory staff. As with screening, MHFA training will be provided to all supervisors in the second and third grant years, and once per year to new supervisors in subsequent grant years.

Motivational Interviewing (MI): Similarly, MI is balanced by RC and Safe Horizon's CCP (described in section C.1.c.). MI is highly effective in helping individuals self-identify their position in the stages of behavioral change. Implemented correctly, MI is intended to be a client-centered approach in which clients are assisted to define their own priorities for behavioral change. However, when clients are engaged in worrisome behaviors, a high level of self-awareness will be required on the part of DVSP staff in order to resist pressing their own change

[8] Herman, J. (1992) "Complex PTSD: A syndrome in survivors of prolonged and repeated trauma." *Journal of Traumatic Stress*. 5 (3), 377–391

agenda. Because MI is such a powerful and effective tool, without this self-awareness, MI can also become an instrument of coercion. Thus, RC and CCP will provide systematic safe guards to ensure that MI is implemented in the most correct and staff-reflective way for the domestic violence survivors that compose our target population. The SHCC will provide one-day MI trainings for DVSP supervisory staff in the second and third years of the project.

viii. The number of front-line staff at the CBO that the CBO anticipates training and supporting in implementing mental health services through this initiative and their roles within the organization. Provide the ratio of the direct service staff that will participate to the service population size.

There are currently 98 DVSP front-line staff. Through the C2C project, we will train all these staff in part or all of the Core Mental Health Package. Staff include: residential specialists (RS), supervising residential specialists (SRS), case managers, social workers, supervising social workers, housing specialists, shelter directors, and childcare workers. Across the DVSP, there is a 1:6 staff-to-client ratio. Please see the attached organizational chart and staffing plan.

h. Staffing:

i. Overall, how does the CBO propose to staff this project to effectively enable direct service staff to take on these new tasks on top of their existing programmatic responsibilities? What additional staff will be needed by the CBO to support implementation of this program?

In order to ensure that this project is effectively managed, the DVSP will create a new full-time project coordinator position. This individual will be responsible for all aspects of project coordination. In addition, if attendance in training results in gaps in coverage, the DVSP will dispatch temporary employees to shelter sites to ensure that there is not a disruption in services.

ii. Identify key staff that will manage the program (include resumes as attachments) including point of contact for data and evaluation. Describe any experience the CBO staff has currently with research and evaluation and in delivering any of the mental health modalities proposed, if any. Please note: staff are expected to have limited experience in delivering the mental health modalities in their current role.

The C2C project will be directly overseen by the associate vice president of the DVSP. This position will manage the overall design of the project. In order to ensure the successful implementation of the project and to enhance the project's efficacy through ongoing staff training, managing the collaboration with the SHCC, monitoring of client outcomes, and conducting evaluation and reporting with the Mayor's Fund Collaborative, Safe Horizon will hire a C2C project coordinator. This position will be the point of contact for all data and evaluation and will report to the associate vice president of the DVSP. Safe Horizon's vice president of mental health treatment will manage the SHCC's participation in the project, including all training in the Core Mental Health Package. R&E will assist the C2C project coordinator in ongoing project evaluation and reporting to the Mayor's Fund Collaborative.

DVSP staff are experienced with data collection and have worked with R&E to conduct in-depth evaluations of their practice. DVSP direct service staff are not experienced in the delivery of the mental health treatment modalities proposed for this project. Please see attached resumes.

iii. Experience and background of all key staff members, demonstrating that they comply with staff experience requirements laid out in Section III.B. The experience of managers selected to launch and lead the project.

Associate Vice President of DV Shelters Rachel Goldsmith, LCSW-R, is a licensed clinical social worker with more than 10 years of experience working with survivors of domestic

violence and other trauma. Rachel has held several leadership positions, including her current role. Currently, she oversees shelters for over 700 residents and approximately 160 staff. Vice President of Mental Health Treatment Dr. Victoria Dexter, LCSW, has nearly 20 years of experience as a clinic administrator, trauma therapist, and teacher.

The DVSP will recruit C2C project coordinator with a social service and administrative background. This individual will hold a master's degree in social work and have had an educational focus on administration or program management. This skill set will enable the project coordinator to have a framework for understanding mental health issues while also having exposure to research, project management, and data collection.

iv. Demonstrated senior level commitment and staff level buy-in and skills to integrate mental health services into the existing service framework.

The DVSP has included in its work plan for the current fiscal year to bring increased training in mental health and trauma models to the DVSP. This plan was approved by the agency's senior leadership, and the vice president of the program is responsible for keeping senior leadership informed regarding our progress in this area. Staff buy-in for the project will be secured through ongoing supervision, during which the use of C2C modalities will be a priority area of focus.

v. Describe and demonstrate how executives at the CBO will play an effective role in developing, implementing, and overseeing the program.

Both Safe Horizon's DVSP and the SHCC are contained within Safe Horizon's Program Administration Department, which is overseen by the Deputy CEO & Chief Program Officer. Further assistance and oversight is provided by the Deputy Program Officer, who also directly supervises R&E and the Training Department. Both positions will be involved in the ongoing development of the project, including design, implementation, and evaluation. Please see the attached C2C organizational chart, resumes, job description, staffing plan, and C2C letter of partnership between the DVSP and the SHCC.

i. Where will participants receive mental health services on-site at the CBO? How will confidentiality be ensured?

All shelters use private office spaces for individual sessions with case managers, social workers, and program directors. RS and SRS staff also have access to office spaces that can be used when a resident presents with an issue or crisis situation. Shelters are heavily regulated by two NYS agencies: OCFS and OTDA. The regulations set forth by these agencies include requirements to ensure the confidentiality of all resident information, and both OCFS and OTDA regularly audit our shelter programs to ensure compliance with these regulations.

j. How will the CBO and MHP handle emergencies or cases where participants reveal something reportable (e.g., suicidal/homicidal intent, child abuse or neglect, elder abuse or neglect)?

Safe Horizon has existing agency protocols to address emergencies with residents, including suicidal and homicidal ideation and child abuse and neglect. Both the CBO and MHP partner follow these same protocols.

k. What mental health services will be provided on-site and what services will be delivered at the MHP location? How closely located are the CBO and MHP and how will participants be supported in making the transition in the case of external referrals? How will CBO participants be supported and encouraged to engage in off-site care if needed? How will the CBO enhance current referral protocols and management systems to make this connection to off-site care more successful? In the case of external referrals, how will data be shared between the CBO and MHP while ensuring compliance with HIPPA?

The core C2C modalities will be delivered on-site at the shelters. However, when clients are identified as needing outpatient mental health treatment or higher levels of mental health care, clients will be linked to off-site services. For those shelters within proximity of the SHCC main clinic in Brooklyn or the SHCC satellite clinics in Manhattan, clients will be linked to SHCC services. All DVSP staff have experience making referrals, and the project coordinator will facilitate a formalization of this process for the C2C project. Every client will have a case manager on-site who will ensure client consent is procured for data sharing between the DVSP and any mental health service provider. In compliance with federal HIPAA and state mental hygiene laws, no client data or information will be shared without client consent.

l. Anticipated impact and strategy for measuring and achieving the following goals:

i. Goals and rationale for improvement in ongoing performance areas. What specific programmatic measures in the areas specifically focused on the sub-population(s) that the CBO plans to work with does the CBO anticipate improvement in through the addition of these services?

As a result of the C2C project, the DVSP envisions improvement in several areas. Through training, staff will be able to provide brief mental health and trauma interventions. We anticipate that this will increase client engagement in DVSP programming, including greater attendance in workshops, individual sessions, and program activities. This increased engagement will stem from our ability to better respond to the mental health needs of our residents. Rather than clients feeling stigmatized by their trauma or mental health symptoms, staff will have meaningful interventions with clients, helping them to feel supported and as a result, more willing to participate in DVSP programming. We believe that this engagement will lead to increased self-sufficiency, which will be demonstrated by clients' ability to make strides toward obtaining permanent housing, express their needs and actively seek help, and plan for life after shelter.

ii. Goals and rationale for mental health service access and improvement. How will the CBO define success of this initiative both in terms of quantitative goals and in terms of increased organizational capacity?

As a result of the proposed training, DVSP staff will be able to more accurately identify clients in need of additional mental health treatment and make appropriate referrals to the appropriate providers as necessary. We will identify success as achieving the following goals:

- Engage 600 clients in the C2C program;
- Measure number of staff trained in each modality, each year.
- Measure staff confidence in addressing resident mental health needs;
- Measure implementation through supervision logs by tracking the percentage of supervisory sessions that address the trauma or mental health needs of shelter clients; and
- Formalize referral methods for DVSP staff who encounter clients with PTSD; and
- Provide referrals to 75 percent of clients identified to need further mental health services.

iii. Goals and rationale for improved outcomes for the service population. Although the evaluator will measure impact on participant mental health outcomes across sites, CBOs individually should monitor a small number of feasible outcome measures as part of program performance-management.

The DVSP tracks certain client outcomes, such as housing, employment, and participation in DVSP programming. The DVSP will modify our current data collection methods to incorporate new outcome measures related to the clients' mental health needs. We will also add a mental health/trauma component into our annual quality improvement plan. In order to track client and programmatic success, the DVSP will collaborate with R&E to measure the following outcomes:

- Number of residents who felt their emotional needs were met by staff;
- Number of residents who felt their mental health needs were met by staff;
- Number of residents who secured permanent housing; and
- Number of residents who secured employment.

m. Describe how the partnership will make use of performance data in programmatic decisions.

The partnership will implement two data evaluation practices: a) the DVSP will conduct the IDCR and QIP processes, described in section C.1.a., which will focus on major programmatic themes and program enhancements; and b) a C2C project team will meet monthly, utilizing real-time data to focus on detailed program enhancements for each shelter site. The C2C project team will consist of key members of the DVSP, the SHCC, and R&E (see attached staffing plan).

In order to prepare for the IDCR, the DVSP and R&E will conduct three months of preparatory work. This will include a comprehensive analysis of annual program data, a review of all supervisory records, a review of all training records, an analysis of recorded staff/client interactions, and an in-depth conversation around strengths and growth areas. After the IDCR, the DVSP will meet quarterly with R&E to develop their annual QIP, which will incorporate lessons learned from the IDCR to identify targeted objectives for improving mental health and trauma services, the activities that need to occur to meet the objectives, a timeline of implementation, and measurement tools to assess progress.

In addition, the C2C project team will develop a plan to evaluate the impact of the proposed training on the DVSP. We will do this by reviewing DVSP data related to the trauma and mental health needs of clients, shelter utilization data (e.g., lengths of stay and administrative discharge rates), training records vis-à-vis the Core Mental Health Package, supervisory records regarding increased knowledge and confidence of staff, and a trauma and mental health-informed rubric to code client/staff interactions. These data will also be presented during DVSP's annual IDCR.

Finally, utilizing real-time data during the C2C team's monthly meetings will allow us to make detailed program enhancements that can be catered to each site. At the start of the grant, we will identify staff, client, and program data that need to be collected in order to evaluate the implementation and sustainability of the new trauma/mental health screening and interventions. Staff data may include training data, staff feedback, and staff supervision data. Client data may include demographics, client engagement in service, client trauma/mental health needs and referrals, client quality of life, and client self-sufficiency (e.g., housing, income, basic needs, safety, and health). Program data may include length of residents' stay, and administrative discharges and reasons. In order to track these data points in real-time, R&E and IST will work on revising the DVSP's CMS interface in order to reflect these new data. During each monthly meeting, the team will then review the data, identify strengths and areas for program enhancements, and discuss timelines and roles. Monthly meeting notes, activities, and timelines will be stored on a shared drive for all team members to access and will be reviewed monthly.

n. Describe how participant and front-line staff feedback will be utilized to improve the service delivery and program implementation.

In 2015, R&E conducted a longitudinal needs assessment of a sample of clients from the DVSP's emergency shelters. While most clients reported the DVSP was helpful in addressing their safety needs and the safety needs of their children, only 65 percent reported the DVSP addressed their emotional needs. Only 55 percent felt that their mental health counseling needs had been met. Through C2C, we will increase the percentage of clients whose emotional and mental health counseling needs are met by staff. In order to collect client feedback, we will modify our current program exit survey to solicit feedback on the C2C modalities.

In order to collect staff feedback, the C2C team will develop and implement staff surveys that will be distributed immediately after the proposed trainings to assess the knowledge learned. During years two through five, an annual staff survey will be conducted to assess for knowledge and confidence around trauma/mental health assessment and intervention, and to request recommendations on ways to further support staff in utilizing their new skills.

The C2C team will review the results of both client and staff surveys quarterly during year one, and annually during years two through five. Lessons learned from the surveys will be incorporated into the C2C project team's improvement efforts.

o. Include a feasible work plan/timeline for program start-up and implementation that includes clear outlines for how service delivery will occur. Identify any potential challenges or barriers to implementation and suggest potential strategies for avoiding or overcoming them.

Year	Goals	Objectives	Activities	Output	Staff
Year 1			Hire project coordinator		DVSP AVP / HR
	Assess and address clients' mental health/trauma needs	Staff are equipped to address mental health needs of clients	Train DVSP staff	All DVSP staff participate in 20 hours of RC training	SHCC staff/ consultant
	Coordinate C2C programming across shelter sites		Implement monthly check-in meetings	Identification of C2C project areas that need modification or TA	C2C project coordinator
	Track outcomes	Identify the effectiveness of trainings	Develop outcome measures for residents and staff	C2C project data	C2C project coordinator with R&E
Year 1-3	Implement service practice changes to be more responsive to clients' needs	Find DVSP practices that can be updated with C2C learnings	Review paperwork and CMS data reports to find areas for improvement	Modified intake/case notes and modified CMS data reports	C2C project coordinator
Year 2-5	Assess and address clients' mental health/trauma needs	Staff more equipped to address mental health needs of shelter residents	Train DVSP staff	DVSP supervisory staff participate in 8 hour MHFA training DVSP supervisory staff participate in MI training	Training Center staff
	Refer high-need clients to outside mental health/ trauma agencies for treatment	Develop a strong referral network	DVSP staff identify referral needs of their residents		C2C project coordinator
Year 3-5	Increase capacity to provide ongoing training to DVSP staff	Some DVSP staff become certified RC trainers to train after grant period	Train select staff to become RC trainers	DVSP staff trainers to train future new DVSP staff	SHCC staff and DVSP trainers

One potential challenge may be that direct service staff will struggle to incorporate a new method of service delivery. DVSP supervisors will encourage staff during weekly supervision, and any effective tactics will be discussed and shared during weekly C2C team meetings.

p. Describe the activities the partnership will undertake to support evaluation activities (including designating staff as points of contact for evaluators, collecting data, etc.).

Safe Horizon has a history of collaborating with outside researchers to conduct research and/or evaluation projects. We are currently collaborating on five such projects with outside researchers. Safe Horizon's experience in collaborating with outside researchers, supporting the development of evaluation plans, and assisting in the collection and/or access of client de-identified data equips us to support the research and evaluation activities of the C2C project.

Starting in year one of this project and continuing throughout the grant, Safe Horizon will collaborate with the outside researcher to independently evaluate the implementation and impact of this project. The C2C project coordinator, along with R&E, will support the researcher to develop and implement an evaluation plan, collect and access de-identified data, and understand the data as it relates to our programs, staff, and clients. These staff will also support the researcher in understanding the data we currently collect and will provide these de-identified data to the researcher in year one to conduct a baseline evaluation. In addition, during the first year of the project, these staff will work with the outside researcher in identifying a comparison group. Throughout the project, the project coordinator and R&E will meet regularly with the outside researcher and be easily accessible in between meetings for additional contact as needed.

q. The evaluation will include a quasi-experimental study: A comparison of outcomes for C2C participants against outcomes for a similar population that does not receive services through C2C. External evaluators will determine how to identify and define the comparison group of non-C2C participants, and the input of potential subgrantees is welcome. Does your organization serve members of the target population who will not be reached by C2C (for example at another service site location) that could potentially serve as a comparison group, or does your proposal reach all of the population served by your organization? If proposing to serve a subset of the target population, please describe the projected numbers of C2C participants and the projected numbers of non-C2C participants during the grant period. Indicate whether the non-C2C participants could potentially serve as a comparison group for the evaluation, or why not.

The project coordinator and R&E will collaborate with the outside researcher to assess the options for comparison groups and decide on an appropriate comparison group for this project evaluation. Presently, Safe Horizon recommends our Community Program for a comparison group. The Safe Horizon Community Program provides risk assessment, safety planning, information and referrals, advocacy, and supportive counseling to victims of crime and abuse. Like the DVSP, the Community Program operates in all five boroughs of NYC. In 2014, the Community Program provided services to 1,817 clients. The majority of these clients were low-income, many were not employed, and many had young children. Currently, the Community Program utilizes the same practice model that is utilized by the DVSP, and both programs' staff are similarly trained. The Community Program could therefore serve as a comparison group as they serve a similar population, have a similar practice approach, and have a similar staffing model. Furthermore, both programs utilize CMS, enabling feasible data access and collection.