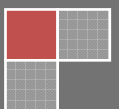




# Accessing Safety and Recovery Initiative (ASRI)

## Strategic Plan



# **Accessing Safety and Recovery Initiative (ASRI) Strategic Plan**

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# Introduction and Overview of the ASRI Collaboration

## INTRODUCTION

The ***Accessing Safety and Recovery Initiative (ASRI)***, a collaborative endeavor of six Illinois agencies, addresses the high rates of violence against women who are living with psychiatric disabilities and the lack of services that specifically address their concerns. ASRI is committed to ensuring that all survivors of domestic violence and other lifetime trauma who are experiencing psychiatric disabilities have access to the services and support they find most helpful, and that those services are available to survivors in their communities. This strategic planning document includes a description of the ASRI collaboration, an overview of the planning process including our needs assessment, and a detailed depiction of the strategic planning initiatives and activities that emerged from the needs assessment findings.

## DESCRIPTION OF THE ASRI COLLABORATION

ASRI collaborative partners include: the Domestic Violence & Mental Health Policy Initiative (DVMHPI), the Growing Place Empowerment Organization (GPEO; a mental health consumer advocacy organization), the Illinois Coalition Against Domestic Violence (ICADV), Life Span (a multi-service domestic violence agency), the State of Illinois Department of Human Services Division of Mental Health (IDHS-DMH), and Thresholds (a large, multi-service psychosocial rehabilitation agency).

### **DVMHPI**

The **Domestic Violence & Mental Health Policy Initiative (DVMHPI)** is a Chicago-based organization providing training, TA, and policy development to help create trauma-informed advocacy and mental health services for survivors of DV and trauma in Chicago, throughout Illinois and nationally since 1999. One of DVMHPI's primary goals is to build capacity to address the mental health issues faced by DV survivors and their children. DVMHPI and its National Center on Domestic Violence, Trauma & Mental Health's activities include an intensive planning, collaboration-building and needs assessment process, tailored trainings paired with ongoing consultation and/or technical assistance, and strategy development to improve policy and infrastructure. DVMHPI operates under the auspices of Hektoen Institute for Medical Research, LLC, a non-profit organization founded in 1943.

### **The Growing Place Empowerment Organization (GPEO)**

GPEO is a community-based, non-profit organization that grew out of the resolve of a group of consumers (persons with a history of psychiatric disabilities) to take personal responsibility for their mental wellness and their quality of life. GPEO offers several programs and services for consumers, including peer support groups, informal social events, empowerment and education programs, Wellness Recovery Action Plan™ (WRAP) groups, and advocacy and stigma reduction activities.

### **The Illinois Coalition Against Domestic Violence (ICADV)**

ICADV is an independent, non-profit, non-governmental domestic violence victim services organization representing 53 local domestic violence programs in the state of Illinois. Its mission is to end violence against women by advocating for survivors of domestic violence and their children, providing advocacy and support to local programs, and providing training and technical assistance to professionals working with survivors.

### **Life Span**

Life Span is a non-profit agency serving victims of domestic and sexual violence in Chicago and Cook County. Established in 1978, Life Span provides a core of services that include counseling for women and children, assessment and referral for collateral services, and criminal court advocacy. Life Span offers a wide range of enhanced services, including legal representation in family law cases, immigration matters, and civil sexual assault cases, counseling for teen boys, employment readiness training, pregnant and parenting teen groups, and economic literacy training.

### **The State of Illinois Department of Human Services, Division of Mental Health (IDHS-DMH)**

IDHS is dedicated to helping Illinois families achieve self-sufficiency, independence and health to the maximum extent possible. IDHS improves the quality of life of thousands of Illinois families by providing an array of comprehensive, coordinated services through: Community health and prevention programs; Programs for persons with developmental disabilities, mental illness, or substance abuse problems; Employment, training, and independent living programs for persons with disabilities; and Financial support, employment and training programs, and child-care and other services for families with low-incomes.

DMH administers the community based public mental health system through 5 geographically based Regions, as well as specialty service networks in Child and Adolescent mental health and Forensic mental health services. Service delivery is provided through 157 community mental health centers/agencies, and nine state-operated psychiatric hospitals.

### **Thresholds**

Thresholds has been providing community-based services to people with mental illness since 1959 and is the oldest psychosocial service agency in Illinois. Thresholds offers the following range of supportive services: psychiatric care, housing, financial management, medication monitoring, individual and group therapy, socialization, education, vocational training, job placement, parenting education, child care, substance abuse counseling, AIDS counseling, mobile assessment, Wellness Recovery Action Plan™ (WRAP) groups and more.

**ASRI** is funded by the US Department of Justice, Office of Violence Against Women, Disability Grants Program to address trauma and domestic violence in the lives of women with psychiatric disabilities by improving services and creating sustainable system change. It is part of a broader federal initiative to build the capacity of communities and organizations to meet the needs of Deaf women and women with disabilities who are victims of domestic violence, sexual assault, or stalking. The initiative was designed to build on the momentum of collaborative partnerships developed under the FY04 Education and Technical Assistance to End Violence Against Women

with Disabilities grant along with state-level efforts to build peer support recovery services in Illinois.

## **OVERVIEW OF THE PLANNING PROCESS: COLLABORATION CHARTER**

The FY 2007 OVW funding allowed ASRI partners to engage in an extensive planning and collaboration process in preparation for the implementation phase of the initiative. ASRI's planning process included the following: creating a collaboration charter that allowed us to strengthen our existing collaboration and map out key elements of collaboration-building for our initiative, narrowing our focus and selecting pilot sites, planning and conducting a needs assessment, and producing a needs assessment report to inform the development of our strategic plan.

While partners in ASRI had a long history of collaborative work, the process of developing a collaboration charter allowed us to solidify the vision and mission for this initiative, review and build consensus around our values, assumptions, and common definitions, and to define our work structure, develop confidentiality agreements and delineate our conflict resolution strategies.

### ***ASRI Vision & Mission***

During the process of creating its collaboration charter ASRI team members articulated the following vision and mission for the initiative:

#### **Vision**

We **envision** new capacity and changed systems within local communities in Illinois that will meet the needs of survivors of domestic violence and other lifetime trauma who are living with psychiatric disabilities. As part of this vision, survivors will have access to the full range of services and resources they want and need to achieve the outcomes that are important to them, including safety, recovery, connection and self-determination.

#### **Mission**

ASRI's mission is to work with local communities in Illinois to develop their capacity to meet the needs of survivors of domestic violence and other lifetime trauma who are living with psychiatric disabilities by:

- Building collaboration at the local level among DV agencies, community mental health centers (CMHCs), state psychiatric hospitals and peer-support service providers;
- Building on existing peer-support service delivery structures in Illinois to develop new, sustainable service delivery models and tools;
- Providing ongoing cross-training, consultation and TA, and facilitating the development of local capacity to provide ongoing cross-sector training, consultation and referral;
- Working with local partner agencies to change policies, practices and priorities so that they are empowering to survivors, providers and local systems and address these cross-cutting issues; and
- Working with state agency partners to support new cross-sector service delivery models

## I. Narrowing the Focus: Selecting the Pilot Sites

Once the collaboration charter was complete, ASRI began narrowing its focus and selecting pilot sites for the initiative. Thought was given to regions in the state that already had state hospitals and mental health centers with established peer support services and working relationships with each other, and where there was a local DV agency that had a particular interest in this work. Potential pilot sites agencies were contacted to ascertain their interest and commitment to this project.

The selection of pilot sites was based on several considerations. First, the member agencies of ASRI had significant experience in these issues, and wanted to build on lessons learned from previous work in which state hospitals, community mental health centers, and domestic violence service providers were brought together for training on understanding trauma and its effect on women's lives. Further, the state of Illinois has a notable focus on expanding and integrating peer support services into its credentialing and service delivery structure in state hospitals and community mental health centers.

Selection criteria for the pilot sites included: 1) feasibility (including travel-related considerations), 2) strengths of proposed pilot agencies (including demonstrated interest in and/or track record of addressing these issues, strong recovery-oriented, peer-run services and peer support providers who were interested in being part of this initiative), and 3) the sites' willingness to commit to the mission and expectations of the initiative (e.g. commitment to cross-sector collaboration and agency change, ability to engage in the work that will be entailed).

In order to be successful in creating real and sustainable change, *ASRI* decided to focus its efforts on two pilot communities in Illinois. In concentrating exclusively on two sites, ASRI can provide the depth and intensity of technical assistance and collaboration-building necessary to achieve these goals. ASRI's made its selection of the two sites with the goals of the project at the forefront of this decision making process, ensuring that the pilot agencies were optimal for the work of building cross-sector collaboration and developing and implementing service delivery models that better meet the needs of survivors who are experiencing psychiatric disabilities.

### **THE PILOT SITES**

#### **Rockford**

○State psychiatric hospital: Singer Mental Health Center (Singer MHC)

Singer MHC is located in Rockford, Illinois, a city 90 miles northwest of Chicago with a population of about 155,000. Singer MHC is funded for 76 inpatient beds and has 2 acute units and one step-down unit serving people who have stabilized at the maximum secure hospital, and are ready for services in a less restrictive environment with a focus on discharge planning. Singer MHC admitted 823 individuals during the last fiscal year (7/08-6/09). As a state psychiatric hospital, the primary population served includes individuals who are medically indigent and are unable to access services in private or community settings. Singer MHC serves a large

population with co-occurring mental illness and substance abuse disorders. Singer MHC played an active role in a SAMHSA-funded IDHS-DMH initiative to reduce seclusion and restraint in state hospitals by becoming more trauma-informed. Singer also has a recovery support specialist on staff who was involved in the SAMHSA initiative and provides trauma-informed peer support services. A Recovery Support Specialist (RSS) is a mental health consumer who has been trained to help other consumers identify and achieve specific life goals by assisting them in cultivating their own abilities to make their goals a reality and by serving as a role model for mental health recovery. Recovery Support Specialists are certified by the state of Illinois and work as professional staff in state hospitals and community mental health agencies.

○ Community Mental Health Center: Janet Wattles Center

Janet Wattles Center is a large and well-established agency that provides an array of recovery-oriented psychosocial rehabilitation services including assessment, treatment, and rehabilitation for adults, children and adolescents, including psychiatric services. The clinic provides group and individual therapy, financial assistance, living assistance and vocational help. Janet Wattles recently opened a Peer Resource Center and provides an array of peer support services. They also have a trauma specialist on staff.

○ Multi-Service DV Agency: Remedies Renewing Lives: Remedies Renewing Lives serves 1,825 clients annually (nearly 400 are children). In addition to shelter, walk-in, transitional housing, legal and medical advocacy and children's programs, Remedies Renewing Lives also provides services in other settings including an alternative jail site and the Winnebago County Courthouse. Remedies Renewing Lives also houses a separately run residential substance abuse program and has a specific commitment to serving women experiencing psychiatric disabilities and/or substance abuse.

## Chicago

○ State Psychiatric Hospital: Chicago-Read Mental Health Center (Chicago-Read MHC)

Chicago-Read MHC is located in the northwest side of Chicago serving the Northern Cook County and Lake County. Chicago-Read MHC is funded for 130 inpatient beds with 3 acute units and 3 specialty units including a Deaf and Hard of Hearing unit, a long-term unit serving individuals in need of extended hospitalization and a step-down unit serving individuals who have stabilized at the maximum secure hospital, and are ready for services in a less restrictive environment with a focus on discharge planning. Chicago-Read admitted 1,322 individuals during the last fiscal year (7/08-6/09). As a state psychiatric hospital, Chicago Read MHC serves individuals who are medically indigent and are unable to access services in private or community settings. Chicago-Read MHC also serves a large population with co-occurring mental illness and substance abuse disorders. Chicago Read MHC also participated in the SAMHSA Reducing Seclusion and Restraint Initiative, participated in cross-trainings as part of our FY 04 OVW grant and has a Recovery Support Specialist on staff who provided trauma-informed peer support services.

○ Psychosocial Rehabilitation Agency: Thresholds

Thresholds is a large and well-established agency that provides an array of recovery-oriented psychosocial rehabilitation services in their respective communities. Thresholds provides a comprehensive, individualized program of mental health services that include psychiatric rehabilitation and recovery programs, outreach programs, housing, educational advancement, social opportunities and employment services. The organization is committed to the use of evidence-based practices – techniques and services that are validated by up-to-date research. Because of Thresholds’ strong investment in providing innovative services, they have a particular interest in developing new recovery-oriented models for responding to trauma and DV that can ultimately be piloted, evaluated and incorporated into state-of-the-art practice. Thresholds has a well-established Peer Success Center as well as a peer Members’ Council and a peer Director of Recovery. Thresholds also has an internal trauma committee comprised of clinical and peer support leadership within the agency that has been working to raise awareness, develop training and create more trauma-informed services.

○ Multi-Service DV agency: Connections for Abused Women and Children, (CAWC)

Connections for Abused Women and their Children (CAWC) runs four programs, a DV shelter, walk-in services, DV advocacy services at a substance abuse program and a hospital-based advocacy project. CAWC served 3,254 adults and children in FY 08. CAWC has partnered with DVMHPI over the past 10 years to develop their internal capacity to provide trauma-informed DV services.

The next step in the planning process was to plan and conduct a needs assessment. In order to achieve the mission and goals of the initiative it was critical to develop an accurate picture of existing services, collaborations, organization structure, current barriers and unmet needs and potential opportunities and mechanisms for change. ASRI wanted to learn directly from women receiving services, direct care service providers, supervisors, and administrators. Detailed scripts for interviews and focus groups were developed and used to gather the information for our needs assessment report.

## **II. Needs Assessment**

We conducted a Needs Assessment to gather the information needed to achieve the vision and mission of the Project and to inform the strategic planning process. The Needs Assessment was designed to develop an accurate picture of existing services, organizational structures and collaborations in each pilot site, to identify current barriers and unmet needs, and to discover potential opportunities and mechanisms for change within the context of Illinois current economic and regulatory environment

The Needs Assessment explored key issues facing survivors in accessing safety and recovery - what they need, available services, the gaps in services, and the barriers to addressing their needs. We wanted to know survivors’ suggestions and recommendations for improving services, increasing self-determination and reducing violence and abuse in their lives. The Needs Assessment examined the current strengths and challenges of the systems and agencies serving

survivors who also experience psychiatric disabilities. To gather this information, we spoke to women themselves and to staff and administrators in the agencies that serve them. We looked at agency needs and resources, the structure of the organizations and at opportunities and strategies for change. Access to other community resources was also addressed.

ASRI partners developed a detailed Needs Assessment plan describing the steps that would be taken to conduct the needs assessment including the questions to be addressed, the methodologies for addressing them, and the safety precautions that would be taken. The Needs Assessment focused on the following four areas of inquiry from survivor, staff and agency leadership perspectives:

- What is the current state of services, policies and collaboration in each of the pilot sites and agencies?
- What are the current needs, gaps and barriers facing agencies and survivors?
- What are the current strengths and capacities of agencies and existing collaborations?
- What are the opportunities and strategies to improve services and collaboration, including potential opportunities and strategies to develop peer-support models to address safety and recovery?

### **NEEDS ASSESSMENT IMPLEMENTATION**

Once the Needs Assessment Plan was approved, ASRI staff contacted the 6 pilot agencies and worked with them to recruit participants and to set up the in-depth focus groups and interviews with women receiving services, direct service staff and administrators in the domestic violence program, community mental health agency and state psychiatric hospital partners in each of the two pilot sites (Chicago and Rockford, Illinois).

ASRI obtained information for the Needs Assessment in two primary ways: individual interviews and facilitated focus groups that were tailored to the specific audience and to the particular information being sought. Focus Groups provided the primary source of information gathering from women who were receiving services in the pilot agencies and from direct service staff and some supervisors and managers. Individual Interviews allowed us to gather information from senior leadership at the pilot sites as well as from one individual DV survivor who indicated she would feel more comfortable providing information in this format.

### **Number of focus groups and interviews by location and type of informant**

Site	Informant Type	# of Focus Groups	# of Focus Group participants	# of Individual Interviews	Total # of Key Informants
<b>Chicago-Read MHC</b>	Women receiving services	1	6	0	6
	Professional and Direct Care Staff	1	6	0	6
	Leadership/Administration	1	4	0	4
<b>Singer MHC</b>	Women receiving services	1	7	1	8
	Professional and Direct Care Staff	1	7	0	7
	Leadership/Administration	1	7	0	7
<b>Thresholds</b>	Women receiving services	2	6	0	6
	Professional and Direct Care Staff	1	6	0	6
	Leadership/Administration	0		7	7
<b>Janet Wattles</b>	Women receiving services	1	7	0	7
	Professional and Direct Care Staff	1	7	0	7
	Leadership/Administration	0		4	4
<b>CAWC</b>	Women receiving services	2	9	0	9
	Professional and Direct Care Staff	2	7	0	7
	Leadership/Administration	0		3	3
<b>Remedies Renewing Lives</b>	Women receiving services	1	8	0	8
	Professional and Direct Care Staff	1	4	0	4
	Leadership/Administration	0		3	3
<b>Total</b>		17	91	18	109

## **NEEDS ASSESSMENT REPORT**

Once the Needs Assessment was conducted, the ASRI team worked together to compile the data. ASRI partners analyzed the data and identified themes. Recurrent themes and issues which arose across the pilot agencies were discussed in ASRI's Needs Assessment Report. This report was written by ASRI staff and team members with the assistance of a research consultant experienced in qualitative research and knowledgeable about the issues involved. Once complete, the Needs Assessment Report was submitted to OVW for approval.

## **NEEDS ASSESSMENT KEY FINDINGS**

We found that women feel supported by both domestic violence and mental health service providers, although responses varied both within and among programs. Although agencies remain clear in their mission to provide the best possible services to their respective constituencies, in the midst of diminishing resources agencies' staffs do not feel sufficiently equipped to respond to issues that are not part of an agency's primary focus. Domestic Violence service providers struggled to respond to women with psychiatric disabilities. Mental health providers faced similar difficulties in responding to women with DV and trauma-related needs. The women who participated in our Needs Assessment highlighted the importance of welcoming, respectful, trauma-informed service environments. For them, having access to gender-specific programming on trauma and DV was a critical need. Pilot agency staff and administrators all said they needed additional resources to respond more effectively to the intersection of DV, trauma and psychiatric disabilities and to create more accessible DV and trauma-informed services. They cited a need for better cross-sector collaboration and for assistance in building internal agency capacity. This included ongoing cross-training and cross-consultation. Model policies, procedures, curricula and tools which would make this work possible were critical. The Key Findings are discussed in more detail below.

- **Women and service providers all said it was important to create a welcoming, accessible, trauma-informed environment:** We found that a welcoming, accessible service environment was important to women, particularly in mental health agencies. Communal residential settings (e.g. DV shelters, inpatient psychiatric units) can present challenges to privacy, dignity and autonomy. Providers also recognized the need for improvements in the physical, sensory and interpersonal aspects of the environment
- **Women said that a sense of safety was critical to their experience with service providers. This included both physical and emotional safety:** Safety and security in the service environment was of primary importance to most responders. DV program staff and administrators were concerned about safety issues that might arise in sheltering a woman with a psychiatric disability – concerns that are in part based on stigma-related fears and in part based on concerns about how the trauma responses of one woman may be triggering to another. For women receiving services in mental health settings, this included not feeling physically and emotionally safe in the presence of men receiving services in the same mixed-gender settings. They were aware that safety was not systemically addressed at the program level and often depended on individual staff support. Women also said that emotional safety (being seen as individuals and being respected, cared for and valued) was critical to service delivery.
- **Women in mental health settings wanted access to services and resources specific to women to address trauma and DV:** Women expressed a strong need for gender-specific DV and trauma services in mental health settings and the community. Access to community resources was limited due to lack of information, lack of assistance in accessing services, stigma from other providers and inadequate funding.

- **Service providers said that they needed better resources to address cross-cutting issues:** Both staff and administrators talked about the need to enhance their own ability to respond more knowledgeably to women dealing with ongoing domestic violence and/or the traumatic effects of abuse, in addition to mental illness. This included ongoing cross-training and cross-consultation plus model policies, procedures, curricula and tools. Staff in both DV agencies said that they did not feel they had the experience or expertise to optimally serve women who have psychiatric disabilities, despite their commitment to do so. Limited access to community mental health resources made this more challenging. Similarly, mental health providers said they did not have formal policies or procedures in place for responding to women experiencing current abuse, beyond initial screening questions. Staff wanted more training and supervision to increase their knowledge, comfort and skills. Program and clinical leadership (supervisors and administrators) wanted access to regular consultation with ASRI and/or pilot partners to help them develop the expertise needed to supervise staff and formally integrate appropriate responses to DV, trauma and mental health into agency policies, procedures and practice. Service providers said that having senior staff members who own or champion the initiative along with regular onsite training and consultation - whether through a designated staff member with expertise in these issues or an outside consultant - is a way to create more sustained agency change.
- **Building and/or enhancing collaborative relationships with pilot partners was important to service providers:** Collaboration among pilot agencies was limited due to differing missions (populations served), service gaps, funding constraints and in Chicago sites, lack of shared service area and purview although many have had cross-referral relationships either currently or in the past. DV agencies wanted access to both crisis and ongoing mental health services. Mental health agencies wanted to be able to refer more easily to DV agencies. Survivors wanted access to a full range of resources. All 6 pilot agencies were interested in strengthening existing collaborations and/or developing new ones. Pilot agencies were also interested in establishing cross-training, cross-consultation and cross-referral relationships and in considering co-located services depending on funding and confidentiality constraints. Additional recommendations included reinstating or enhancing mobile crisis outreach services for the two domestic violence shelters (i.e. Thresholds Mobile Assessment Unit (MAU) and Janet Wattles PATH program).
- **Women and service providers were interested in having more integrated approaches to domestic violence, trauma and recovery:** Adapting existing recovery-oriented service models to incorporate trauma and DV were suggested as ways to provide more integrated services to survivors with psychiatric disabilities. Recommendations included building on existing community support services (outreach services to engage people who have psychiatric disabilities in their community setting), and recovery support services (services provided by professional staff with lived experience of mental illness that focus on recovery). Participants thought that a recovery orientation, recovery-oriented treatment and peer support models could provide a strong foundation on which to build DV- and trauma-informed services. The involvement of peer support specialists and consumers/members in shaping and delivering services in some mental health sites could serve as a model for other partners.

In general, the domestic violence and mental health agencies that participated in the Needs Assessment are providing the services specific to their mission; that is, the domestic violence agencies are very good at providing domestic violence services and the mental health agencies do a very good job of meeting mental health needs. However, both women and service providers think that agencies could and should do better at providing cross-over services that address both domestic violence and mental health-related needs.

## **ASRI STRATEGIC PLAN**

*The following section provides a detailed description of our Strategic Plan, including 1) how it was developed, 2) the goals we hope to achieve, 3) the work structure and process for the ASRI team and the pilot sites, 4) the initiatives and activities that will be undertaken to achieve our goals and their rationale, including the products that will be developed, 5) how those activities will be accomplished and who will be responsible, 6) projected timelines for each initiative and activity, and 7) ASRI's longer-term initiatives. See Appendix I for a detailed work plan outlining the specific goals, initiatives, activities, person(s) responsible and timeline. The strategic plan also includes strategies for sustaining the work of the initiative and for achieving these longer-term goals.*

## **ASRI STRATEGIC PLAN**

Based on findings from the Needs Assessment, ASRI contacted each of the six pilot agencies to talk about the findings and to discuss the range of initiatives each site would be comfortable working on. ASRI then held a 1 ½-day strategic planning retreat with our Vera Institute TA provider during which we identified the goals and initiatives described below. The goals and initiatives were developed in direct response to our Needs Assessment findings and reflect ASRI's commitment to ensuring that all survivors of domestic violence and other lifetime trauma who are experiencing psychiatric disabilities have access to the resources they want and need to achieve both safety and recovery. They also reflect our commitment to ensuring that survivors and peer support providers play a central role in developing, implementing and evaluating services. Finally, they reflect steps that we consider to be feasible for both the ASRI team and the pilot sites within the timeframe of this project.

## **OVERVIEW OF PRIMARY GOALS**

During the implementation period ASRI will focus on three primary goals to assist pilot sites in better serving survivors of DV and other trauma experiencing psychiatric disabilities, including the development of models, tools and strategies that will lead to sustainable change in the two pilot sites. They are:

- 1) **Build and strengthen collaborations in each pilot site** (Chicago and Rockford) to improve provider knowledge, skills, and access to cross-sector resources, thereby enhancing their ability to serve women experiencing these cross-cutting issues.
- 2) **Build the internal capacity of each pilot agency within** those sites to address unmet needs and service delivery gaps and to develop strategies for instituting changes in policy and practice that better meet the needs of survivors who are living with psychiatric disabilities.
- 3) **Build, develop and refine ASRI's current work and future plans**

## **WORK STRUCTURE**

*The work involved in the implementation of the strategic plan is complex and will take place in two different pilot regions (Rockford and Chicago, Illinois), over a short period of time (12 months). Therefore, the ASRI team has articulated a formal work structure in order to achieve its goals. The approach we decided to take to structuring the work of the Initiative has three components: 1) the work structure for the ASRI's statewide collaboration team, 2) how ASRI's technical assistance (TA) to the pilot sites and agencies will be structured, and 3) the work structure for the pilot sites and agencies, themselves.*

### **ASRI's Statewide Collaboration Team Structure and Work Process**

In order to accomplish the work of the project, the seven ASRI team members and the new (TBH) project coordinator will meet monthly for a minimum of two hours in support of the collaboration and its work. Members will plan, direct, track, and evaluate project activities and ensure completion of specific tasks. These meetings will give the project coordinator and ASRI team members serving as pilot site liaisons the opportunity to review activities and plans with the entire team, to discuss issues that arise, and to continually assess and refine our TA process and strategies. Between the monthly meetings telephone and email communication will allow the team's members to stay in touch and to carry out specific tasks in support of the initiative.

An additional focus of the ASRI work process will be a process evaluation<sup>1</sup> of the project. At the end of each quarter the ASRI teams meeting will include a review of data reported after each collaboration contact. Tracking of collaborative meetings and other contacts will provide a rich body of data through which the process of this collaboration can be documented, its focus sharpened, and its model refined.

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**1Process Evaluation:** Process evaluation focuses on how a program was implemented and operates. It identifies the procedures undertaken and the decisions made in developing the program. It describes how the program operates, the services it delivers, and the functions it carries out. Like monitoring evaluation, process evaluation addresses whether the program was implemented and is providing services as intended. However, by additionally documenting the program's development and operation, it allows an assessment of the reasons for successful or unsuccessful performance, and provides information for potential replication. source: [http://www.ojp.usdoj.gov/BJA/evaluation/glossary/glossary\\_p.htm](http://www.ojp.usdoj.gov/BJA/evaluation/glossary/glossary_p.htm) OJP Bureau of Justice Assistance

The project coordinator will serve as the primary liaison between the ASRI team and the pilot sites. She will coordinate work flow, review and oversee tasks and timelines. The coordinator will be housed at DVMHPI and will be supervised by the Project Director. Weekly in-person or telephone meetings with the key DVMHPI members of the team (Project Director and Adult Trauma Specialist) will be scheduled to ensure timeliness of communication and task completion and to provide support, content expertise and oversight. Technical assistance to the ASRI Team and to the project as a whole will be available from The Vera Institute of Justice. The Project Coordinator will coordinate regular TA calls with our Vera TA Provider. The Project Director will serve as the primary point of contact between OVW and the Vera TA providers and will oversee the fiscal management of the project

Specific tasks such as curriculum review and revision, training and TA activities, and product development will be shared among ASRI team members, with specific assignments based on experience, expertise and scheduling. Other responsibilities (such as obtaining CEUs for trainings) will be organized by the project coordinator in conjunction with team members who have access to the relevant resources.

### **ASRI'S Technical Assistance Structure and Work Process**

Each of the two pilot sites (Rockford and Chicago) will be supported by the project coordinator who will serve as the primary liaison between ASRI and the site. She will attend monthly collaboration meetings, maintain ongoing monthly contact with agency workgroups, attend workgroups when requested, and coordinate TA between ASRI and the pilot sites and agencies. The project coordinator will be accompanied by at least one additional ASRI Team member who will participate in monthly pilot site meetings. Whenever possible, three ASRI team members will participate in pilot site meetings – one DV provider, one mental health/peer support provider and one DVMHPI representative to provide an integrated approach to these issues until sites have incorporated this into their own work. The ASRI Team will also work with the pilot sites to obtain input and feedback on the products to be developed for the initiative, including reviewing existing tools and training materials from the pilot sites as well as reviewing current policies and procedures.

The Team will also be charged with providing TA to the pilot site collaborations on the collaboration building structure and process and on the intersection of DV, trauma and psychiatric disabilities. Team members will also provide training and consultation as needed to individual pilot agencies. During the implementation year the Team will also have primary responsibility for organizing and conducting larger cross-training event in Rockford and for selecting the structure and venue for cross training Chicago. Because the travel constraints are different in the two pilot site cities distinct cross-training structures will be created for each site. Over the course of the implementation year, opportunities for ongoing training and TA will be identified so that pilot site collaboration partners, themselves, can assume the ongoing responsibility to offer cross- training and collaborative training within the two local sites.

### **Pilot Site Structure and Work Process**

Work in the two pilot sites themselves will involve (a) cross-agency collaboration meetings with key agency representatives, the project coordinator and ASRI liaison(s), and (b) intra-agency

workgroups. During pre-orientation, ASRI will meet with agencies to select representative(s) to the collaboration, identify internal workgroup members and ensure peer support representation to the extent possible. During the first 2-3 months, a communication structure will be established to ensure ongoing input and feedback between the two.

**Cross-Agency Pilot Site Collaborations:** The Pilot Site Collaborations will serve as the primary vehicle for the development of the change initiatives and for creating and sustaining the collaborative work of the project. Agency representatives to the Pilot Site Collaborations will serve as liaisons to their larger organizations and will be responsible for developing and overseeing the change initiatives described below. At least one consistent representative from each agency will participate in these monthly collaboration-building meetings (this will be someone in a senior management, administrative or supervisory role who is in a position to represent his or her agency). We anticipate that some agencies will be able to send more than one representative, including (for 3 of the 4 mental health agencies) a peer/recovery support specialist (Thresholds, Janet Wattles, Singer). These meetings will be staffed by the project coordinator and members of the ASRI collaboration team.

Work with the pilot sites will begin with a set of pre-orientation visits between ASRI team members and each of the six pilot agencies. The ongoing work will be then anchored by monthly meetings to be scheduled by the project coordinator in each pilot site (Chicago and Rockford) and through regular meetings of the internal agency workgroups. These will be face-to-face meetings (however the ILCADV member may attend/participate by telephone).

Monthly collaboration meetings of 2-4 hours (supplemented by interim conference calls, as needed) will be held in each of the pilot sites (more often at the 2 state psychiatric hospitals due to travel restrictions for state employees). The group will then determine and review the work processes and agreements for the coming year, as well as deciding how to handle issues of confidentiality (what stays within the group, what can be brought back to individual pilot agencies), how the group will handle decision making, the roles, responsibilities and contributions of each agency/member and ASRI, and identification of shared values. During the first two meetings (months 2 and 3), pilot sites will create an ongoing schedule and structure for the collaboration meetings.

**Internal Agency Workgroups:** Each pilot agency will also create an internal agency workgroup that will become the core team responsible for implementation of initiatives within each agency. They will determine their own meeting structure, in line with other meeting and agency structures. They will be in regular contact with the pilot site collaboration representative from their agency. The workgroups will coordinate the internal responsibilities for conducting the DV- and trauma-informed agency assessments, developing and implementing action plans and for the development and implementation of new internal agency policies.

## **SHORT-TERM GOALS, INITIATIVES AND ACTIVITIES**

*This section describes ASRI's short-term goals, initiatives and activities. The first set of initiatives focuses on building capacity within the two pilot sites; the second focuses on building capacity within individual pilot agencies and the third focuses on developing and refining ASRI's model for providing ongoing TA. Further, the goals and initiatives described below lay the groundwork for achieving the longer-term goals of the project including the development of new collaborative service delivery models in each pilot site that ultimately can be replicated throughout Illinois and the US. All of the initiatives will be carried out within the context of the work structure described above.*

### **Goal I. Build and Strengthen Collaborations in Each Pilot Site (Chicago & Rockford)**

A primary goal of the Accessing Safety and Recovery Initiative (ASRI) is to build a sustainable collaboration among the three participating agencies (DV program, state psychiatric hospital, community mental health agency) in each of the two pilot sites. Meeting this goal addresses one of the major findings that emerged from our Needs Assessment - the need for additional resources to help service providers respond more effectively to women experiencing DV, trauma and psychiatric disabilities. Building and sustaining a meaningful collaboration between the three service providers will increase resources for each collaboration member, and improve services provided to survivors in each community. Service providers said they needed ongoing cross-training and consultation as well as assistance in developing more standardized approaches to these issues that could be sustained within their agencies, regardless of staff turnover. Survivors were very clear about wanting access to DV and trauma services for women both in mental health settings and in the community. In addition, all 6 pilot agencies indicated a need to build and/or improve cross-sector collaboration between mental health and DV agencies in order to ensure that both survivors and service providers had access to the resources they needed. Providers viewed collaboration-building as a way to both improve referrals and enhance their own knowledge, comfort and skills. In Rockford, the three pilot agencies already have long-standing relationships but do not work together in any systematic way. In the Chicago site, there have been some cross-referral and/or linkage agreements between sites at various times, but without any real focus on these issues. While training and TA will be provided by the ASRI team, true long-term capacity building will rely on the relationships developed among pilot site partners, particularly in the Rockford site.

Key initiatives to achieving this goal include pre-orientation activities, monthly meetings, development of action and sustainability plans, and developing collaboration sustainability within the agencies, as described below.

#### **Goal I Initiative A. Conduct a pre-orientation for participating pilot agencies**

Initiative/Activities	Timeline (Months)												Post-Grant
	1	2	3	4	5	6	7	8	9	10	11	12	
<b>GOAL I : Strengthen Site Collaborations in Chicago and Rockford</b>													
<b>A: Pre-orientation for individual pilot agencies</b>	X												
Identify key representatives to collaboration meetings	X												
Review collaboration process, expectations, needs	X												
Review budgetary concerns and expectations	X												
Develop and sign sub-contracts	X	X											

The first step of the collaboration-building process will involve a pre-orientation for each pilot agency. Given the differences in structure, staffing and funding among pilot agencies we want to make sure that each agency is able to optimally use its resources to participate in the ASRI project and accomplish its goals. Once our Strategic Plan has been approved, we will contact each pilot agency to set up an in-person meeting to review the strategic plan, to describe the initiatives and collaboration-building process and to discuss the expectations and needs of each pilot agency as well as the expectations that ASRI has for the project. We will also review any budgetary concerns and expectations with administrative leadership, work with agencies to identify representatives to the collaboration meetings and the internal agency workgroup, and develop and sign subcontracts between each agency and DVMHPI. This process will begin during month one of the implementation period and be completed during month 2.

**Goal I Initiative B: Build collaborations in each pilot site through a series of structured monthly meetings**

Agencies must develop a structure and process that will nurture their collaborative endeavors, provide opportunities to share resources and learn from each other, develop common definitions and goals, create processes for safely addressing conflicts and challenges and to ensure that the work of the initiative moves forward in ways that will create real change and build toward sustainability. ASRI will lead the pilot agencies in developing their collaborations.

Initiative/Activities	Timeline (Months)												Post-Grant
	1	2	3	4	5	6	7	8	9	10	11	12	
<b>GOAL I : Strengthen Site Collaborations in Chicago and Rockford</b>													
<b>B: Monthly collaboration Meetings</b>		X	X	X	X	X	X	X	X	X	X	X	X
Determine work processes & agreements		X	X										
Offer orientation on collaboration philosophy, purpose & model		X											
Review NA findings & initiatives		X											
Generate agreement for participation in cross-trainings		X	X										
Review each others' curricula				X	X	X							
Monitor, review, give feedback to all aspects of collaboration				X	X	X	X	X	X	X	X	X	
collaboration group convenes and plans monthly meetings										X	X	X	

During the first meeting, ASRI will orient the pilot agencies on the purpose and philosophy of the collaboration (i.e. these are collaborations between organizations, not individuals) and will

review the Needs Assessment findings and initiatives with participants, and establish shared values and communication agreements.

During the 2nd meeting, each group will discuss cross-training needs and capabilities and develop a plan for participation in cross-trainings. This will include informal cross-trainings that will take place during the monthly collaboration meetings as well as more formal cross-trainings between agencies. Each site will develop a multi-tiered strategy for developing and instituting cross-trainings among pilot agencies and the collaboration team. This will include a plan for incorporating informal cross-trainings by participants and ASRI partners into the collaboration meetings, identifying opportunities for pilot agencies to participate in each other’s existing training offerings, and a plan for developing new cross-training materials (reviewing each other’s existing materials and curricula, adapting them and developing more integrated and/or tailored versions) and offering more formal cross-training activities. The work planned and accomplished in these meetings will address some of the almost universally expressed wishes described in the Needs Assessment for cross-training and collaborative service provision.

Once agency representatives have been identified, the Project Coordinator will schedule and coordinate the pilot site collaboration meetings with the goal of transferring this responsibility to the pilot sites by the last quarter of the implementation year. Doing so will support the ongoing relationships between the partner agencies and locate “ownership” of the work in the partner agencies and local collaborations.

**Goal I, Initiative C. Develop Action and Sustainability Plans**

Initiative/Activities	Timeline (Months)												Post-Grant	
	1	2	3	4	5	6	7	8	9	10	11	12		
<b>GOAL I : Strengthen Site Collaborations in Chicago and Rockford</b>														
<b>C: Action &amp; Sustainability Planning</b>			X	X	X	X		X	X	X	X	X		
Set ongoing meeting schedule and structure			X	X										
Plan & Schedule DV-/TI agency assessments			X											
Plan and Schedule Development and Roll out of Model Policies			X											
Plan and Schedule Development & Piloting of Safety Planning Tool			X											
Develop a sustainability plan											X	X		

In order to accomplish the project’s short-term initiatives in the timeframe available, it will be critical to develop a clear work structure and action plan. This is even more pressing in light of Illinois’ recent budget cuts that have reduced staffing levels in all of the pilot agencies, making clarity and efficiency even more critical. Pilot site collaborations will work to develop action plans for implementation of the agreed upon initiatives. During the first two meetings (months 2 and 3), pilot sites with the assistance of ASRI, will create an ongoing schedule and structure for the collaboration meetings. The Action Plan will also include implementation activities and timelines, including a plan for the development of a Culture, DV- and Trauma-

informed Agency Assessment Tool and for conducting the agency self-assessments; a plan for the development, piloting and refinement of a Safety Planning Tool for Survivors of DV and Other Trauma who have a Psychiatric Disability and a plan for the creation of Model Policies (1 per agency) and for rolling them out to working committees in each agency. The action plan will also delineate the roles of the collaboration team, the roles of the working committees within each agency, and the role of ASRI, as well as timelines for accomplishing these goals/completing these initiatives. During the last 2 months of the project (months 11 & 12), pilot site collaborations will also work with ASRI to develop a sustainability plan. This will include strategies for sustaining the changes made during the grant period and for building on them to continue to improve services within each agency and site.

**Goal I, Initiative D. Strengthening each pilot agency to sustain the collaboration**

Initiative/Activities	Timeline (Months)												Post-Grant	
	1	2	3	4	5	6	7	8	9	10	11	12		
<b>GOAL I : Strengthen Site Collaborations in Chicago and Rockford</b>														
<b>D: Strengthening Internal Capacity</b>				X										
Cultivate work groups in each agency				X										
Incorporate work groups into capacity building initiative				X	X	X	X	X	X	X	X	X	X	

While inter-agency collaboration is critical to building capacity within a given community or region to ensure appropriate knowledge, understanding and service delivery and to support changes in policy and practice within individual agencies, agencies themselves also need to develop their own internal structures to create and to support change. In addition, pilot agencies provide different types of services and need to find ways to incorporate enhanced responses to trauma, DV and into day-to-day practice and into their particular service and reimbursement structures.

As noted in the Work Structure section above, each pilot agency will form a workgroup to carry out the internal capacity-building aspects of the project. The intra-agency workgroups, in communication with the ASRI project coordinator and the local pilot site collaboration, will work to carry out the pilot site collaboration initiatives and activities within each agency. Identification of workgroup members for each agency will begin during the pre-orientation phase (month one) and will be built into agency sub-contracts.

The agency workgroups and their representative(s) to the pilot site collaboration will work with ASRI to create a clear communication structure to ensure that the workgroups are integrated into collaboration-building process and that information, thoughts, ideas and feedback flow both ways. The workgroups will provide the on-the-ground input to the pilot site collaborations on what is needed, what works and what doesn't as implementation proceeds. They will be the pulse of the project, keeping the pilot site collaboration and ASRI informed about how changes are affecting survivors, staff and supervisors and about ongoing training and consultation needs. The workgroups will also provide substantive input into other project activities including:

- The development of new tools and cross-training materials and incorporating them into agency policy and practice

- Conducting the Culture-, DV- and Trauma-Informed assessment,
- Providing input into agency policy reviews and the development of model policies, and
- Developing and sustaining cross-training, cross-consultation and cross-referral processes with their partner agencies.

## **Goal II. Building Internal Agency Capacity**

A critical finding from the ASRI strategic planning process was the importance of the environment in which services are provided to survivors of domestic violence who have also experienced psychiatric disability. Our strategic plan will address this important finding by supporting the overall sense of welcome and reducing inadvertent retraumatization in the six service sites, creating model policies to formalize new practices, increasing the level of knowledge of staff members in both DV and mental health programs, supporting their comfort in working with heretofore unfamiliar needs and concerns of the women they serve, and helping them to be more aware of the quality of their interactions with survivors. One vehicle for delivering this new content and experience is our strategy of building the ability of leadership in the DV and the mental health programs. These leaders will then be empowered to provide the ongoing clinical and program supervisory support that current and future staff members will need as they serve more women whose needs straddle the domestic violence/mental health boundary. Several additional strategies will help agencies to develop new resources and create institutional change. These include the development of a culture, DV- and trauma-informed agency assessment tool and working with pilot sites and workgroups to conduct agency assessments, identify gaps in policy and practice, create action plans to address these gaps and institute the development of a new model policy. In addition, ASRI in collaboration with the pilot sites will develop a safety planning tool for women who have a psychiatric disability. The tool and accompanying training will provide another vehicle for improving services. These internal capacity building initiatives will help to strengthen the six pilot agencies so that each is changed in ways that also strengthen the collaboration.

The five Initiatives described below, that will be developed under Goal II stem directly from our Needs Assessment findings. These are: A) Creating welcoming, culture-, DV- and trauma-informed environments, including the development and implementation of a Culture-, DV-, Trauma-Informed Agency Assessment Tool (CDVTI Tool), conducting agency assessments, and developing an action plan to address identified needs; B) Increasing staff comfort, knowledge and awareness to work at the intersection of DV, trauma and mental health; C) Building program/clinical leadership's (PCLs) ability to effectively support staff; D) Developing Model Policies to address cross-cutting issues; and E) Developing a Safety Planning Tool for Women who have Psychiatric Disabilities.

### **Goal II, Initiative A: Create welcoming DV-, trauma-informed environments in each pilot site agency**

One of the key issues that emerged from our Needs Assessment related to the nature of the service environment and what would feel welcoming and safe to survivors of DV and other

trauma who are experiencing psychiatric disabilities. Women in the focus groups at 3 of the 4 mental health agencies talked about the physical, sensory, programmatic and interpersonal aspects of their environments and clearly articulated what they found problematic and the changes they would like to see. For example, women talked about what felt

Initiative/Activities	Timeline (Months)												Post-Grant
	1	2	3	4	5	6	7	8	9	10	11	12	
<b>GOAL II: Build the Internal Capacity of Pilot Site Agencies</b>													
<b>A: Create Welcoming Environments</b>		X	X	X	X	X	X	X	X				
Develop Culture-, DV- and Trauma-Informed Assessments		X	X	X	X	X	X	X					
Review & Collect ASRI's existing knowledge and tools		X	X										
Develop assessment tool for multiple aspects of environment			X	X	X								
Get input from staff and survivors into tool			X	X	X								
Identify review team				X	X								
Assemble team(s) and train on conducting assessments					X								
Revise tool based on feedback						X							
Conduct reviews of each Pilot Site Agency							X						
Develop a report with prioritized recommendations								X					
Support collaborations in developing action plans									X				

welcoming and enlivening versus sterile or depressing, what felt soothing and comforting as opposed to chaotic and retraumatizing, how they were affected by the lack of a sense of safety in mixed-gender settings and about the need for gender-specific and gender-responsive services and attention by staff to these issues. They also talked about the need for clarity and transparency about what to expect in each service setting and of the importance of respectful caring interactions with staff and other service recipients. Given the clear opportunities for improvement in many of these domains, ASRI will work with pilot sites to create a Culture-, DV- and Trauma-informed Assessment Tool, conduct agency self-assessments, identify gaps and priorities and develop action plans for creating more welcoming CDVTI service environments. This will be accomplished through the following activities.

During months 2 & 3, ASRI will review its existing knowledge and tools and collect additional relevant materials for creating the new CDVTI assessment, including materials and expertise contributed by pilot sites. Once the information has been gathered and reviewed, ASRI will work with the pilot site collaborations and agency working committees to ensure that the tool reflects the collective wisdom and experience of our partners. The tools will be designed to assess multiple aspects of the environment (e.g. set of probing questions about the physical, interpersonal and sensory environment; agency culture; provider and survivor responses and perspectives), (months 3-5), obtaining input from the collaboration teams, agency working committees and survivors, throughout. Once the tool is developed and refined, a training protocol will be created by ASRI and review teams will be selected to receive the training and work with each agency to conduct the assessments, (months 4 & 5). During month six, the assessment tool will undergo one more set of revisions, based on feedback from the review team training. Agency assessments will be conducted during month 7. We view the assessment process, not only as a way to determine areas in need of improvement but also as a way to

engage leadership and staff within each agency in a process of reflection and self-assessment about the experience of receiving services in their setting and of engaging with the people who receive those services as partners in this process (as appropriate). Once the assessment has been completed, review teams and pilot site collaborations will develop a report identifying gaps in policy and practice and prioritizing recommendations for addressing them. Each pilot site will determine whether it wants these to be individual agency reports or one collective report. During month 11, ASRI will work with each collaboration to develop action plans to implement the recommendations. In addition, Initiatives B and C (increasing staff knowledge, comfort and awareness and supporting program and clinical leadership’s ability to support staff) will also contribute to the creation of more welcoming, CDVTI services.

This initiative provides another essential building block for accomplishing ASRI’s Needs Assessment-derived long-term goals of ensuring that survivors have access to welcoming CDVTI service environments wherever they turn for assistance and for creating an assessment tool and process that can be replicated throughout IL and nationally.

**Goal II, Initiative B: Increase staff comfort, knowledge and awareness to work at intersection of DV, trauma and mental health/psychiatric disabilities**

Initiative/Activities	Timeline (Months)												Post-Grant
	1	2	3	4	5	6	7	8	9	10	11	12	
<b>GOAL II: Build the Internal Capacity of Pilot Site Agencies</b>													
<b>B: Increase Staff Comfort, Knowledge, and Awareness</b>	X	X	X	X	X	X	X	X	X	X	X	X	
Work with supervisors to support staff			X										
Determine existing expertise in PS agencies	X	X											
Review, refine & adapt existing curricula/incorp agency curric		X	X	X									
Revise curricula based on PS feedback					X	X							
Send to OVW for approval							X						
Roll out training to key staff and supervisors with ongoing feedback								X	X	X	X	X	
Obtain CEU authority (offer CEUs and certificates)							X						

The Needs Assessment surfaced a lack of staff and supervisor knowledge and comfort in addressing the cross-cutting needs of survivors of DV experiencing psychiatric disabilities. At the same time, we are well aware that addressing staff capacity through training is not sufficient unless changes are integrated into ongoing agency practice and supported by supervisors and managers who create the conditions for new attitudes and learning to be incorporated into the day-to-day work of the program. The detailed strategies for building that supervisory capacity within our pilot sites and agencies are described below (Initiative C). At the same time that supervisory capacity is being strengthened, ASRI will develop a curriculum that can be used to support staff in developing their capacities to provide the quality of interactions that survivors clearly want and best practice demands.

We will begin this part of our internal capacity-building work with a careful review of the

strengths already in place. Each of the six agencies participating in ASRI were chosen for their clear commitment to the needs of women who are survivors and who live with psychiatric disability. We will work in this area by systematically reviewing these existing capacities including those which that emerged during the Needs Assessment process (e.g., a supervisor at one mental health organizations who has significant experience in DV work, another mental health organization with a well-established agency-wide trauma committee). During the first two months of the implementation phase, we will informally survey the six pilot agencies (through pre-orientation visits, telephone calls and emails) to identify the untapped knowledge of current staff at each agency and relevant training materials and curricula. After gathering these resources, members of the ASRI team with expertise in staff training will create a structure for reviewing the in-house training materials, our own existing curricula (including those supported by previous OVW funding) and trainings developed by the ASRI team, itself.

From this collection of materials we will develop a training curriculum linked to specific training objectives for this initiative. By the end of month four this curriculum will be available (in draft form) and presented for review by pilot site representatives and agency workgroups. Feedback from the pilot sites will be incorporated and a final curriculum will be submitted to OVW for its review by the end of month seven.

After we receive OVW approval we will apply for CEU certification through IDHS-DMH and Thresholds and roll out the training in venues and at times that will allow for optimal participation of staff, program and clinical leaders (PCLs) and supervisors from the six pilot agencies. We anticipate that in Rockford we will be able to hold at least one large group cross-agency training of staff and supervisors from Janet Wattles, Singer and Remedies between months 8 and 12. In Chicago, considerations of geography, staffing and travel freezes will determine the best delivery plan and schedule to ensure optimal participation from Thresholds, Read and CAWC staff and supervisors. As part of the of our work, we will solicit feedback from both the trainers who use the curricula and the attendees, with an eye to any future revisions or distribution of materials derived from this project after the funding period has ended.

**Goal II, Initiative C. Build Program/Clinical Leadership’s (PCLs) Ability to Effectively Support Staff**

Initiative/Activities	Timeline (Months)												Post-Grant	
	1	2	3	4	5	6	7	8	9	10	11	12		
<b>GOAL II: Build the Internal Capacity of Pilot Site Agencies</b>														
<b>C: Build Prog. &amp; Clinical Leaders' Ability to Support Staff</b>	X	X	X	X	X	X	X	X	X	X	X	X		
Engage PCLs in pilot site collaboration	X													
Involve PCL in pilot agency's working committees	X	X	X	X	X	X	X	X	X	X	X	X		
Solicit Feedack on curriculum from PCLs				X										
Provide training and as-needed support							X	X	X	X	X	X		
Contribute to the development of model policy key elements									X	X	X	X		
Facilitate cross-sector consultation among PS Agencies					X	X	X	X	X	X	X	X		

Our Needs Assessment process gave added strength to our understanding that solid program/clinical leadership is the bedrock on which the incorporation new approaches and services will rest. In the Needs Assessment, PCLs consistently articulated a need to receive ongoing training and TA themselves, (from ASRI and/or from pilot site partners) to feel comfortable assisting staff and to institutionalize new practices within their agencies. Therefore, in working to build the two collaborations in Rockford and Chicago, we will focus considerable attention on strengthening supervisors as the purveyors of new knowledge and the day-to-day source of leadership in these new efforts to respond to the needs of DV survivors who have psychiatric disabilities. From the very beginning of this implementation year we will engage leaders within each of the six program sites who offer direct programmatic or clinical supervision to staff who have direct contact with women. Because each of the six programs have distinct administrative and program structures, we will identify these leaders by their roles and responsibilities rather than by job title. Our goal is to have these leaders (PCLs) as active participants in the agency workgroups. In some instances these PCLs will also be the regular attendees at the monthly pilot site collaboration meetings.

The ASRI collaborative will support the PCLs in a number of ways across the twelve-month implementation period. As the workgroups are charged with assignments and tasks related to the collaboration, the PCLs attending will be exposed to new information and new questions related to the cross-sector services we envision. PCLs will be actively solicited to provide input and feedback in the curriculum gathering, development and review process described above. Consultation on content and supervisory process (reflective supervision) will be provided individually by ASRI collaborative members in the early months of the project.

By month five we will have received feedback from the PCLs on the training curriculum. We expect that the processes of engaging in workgroup tasks, curriculum gathering and curriculum feedback will heighten PCL's awareness of the needs and issues related to serving survivors of DV who have psychiatric disabilities. Also, in month five we will begin to facilitate cross-sector consultation. In the initial cross-sector collaboration contacts, ASRI staff will play a more active role by shaping discussions and providing subject matter expertise on cross-over issues. However in subsequent months, ASRI team members will shift from a consultative to a facilitative role.

Finally, in the last quarter of the implementation phase our attention will shift from consultations and curriculum development to policy development (see section D, below) and training. Here again the participation of PCLs from the six sites will help build their knowledge and expertise. Focusing on policy development and attending the ASRI training will also enhance their understanding and knowledge. Ongoing coaching in supervision on these issues will continue through the life of the project.

In sum, the program and clinical leaders of the six pilot sites will be engaged in a rich and multi-faceted immersion process that, through a range of channels and activities, will enhance their knowledge and expertise. At the same time, this initiative of building PCLs capacity to support

staff will provide valuable information and insight to both the pilot sites and ASRI on refining and replicating this strategy for building agency capacity to address DV, trauma and psychiatric disability.

**Goal II, Initiative D. Develop Model Policies**

Initiative/Activities	Timeline (Months)												Post-Grant
	1	2	3	4	5	6	7	8	9	10	11	12	
<b>GOAL II: Build the Internal Capacity of Pilot Site Agencies</b>													
<b>D:Develop Model Policies</b>									X	X	X	X	
Use Culture, DV-, TI assesement to determine gaps in policies									X				
Collect and review relevant existing policies									X	X			
Facilitate a process with PS collabs to prioritize 1 policy/agency									X	X			
Draft Policy											X	X	
Revise policy												X	X
Implement policy													X
Evaluate policy													X

The Needs Assessment also identified key gaps in policies. For example, while both DV agencies have eligibility policies that are inclusive of survivors with psychiatric disabilities, they do not have policies regarding the provision of individually tailored accommodations. All four mental health agencies have intake and screening policies that include questions about trauma and DV, yet they lack policies and procedures on how to respond if a woman indicates that she is being abused. In addition, survivors and providers all agreed that creating more welcoming and trauma-informed service environments was a priority. A number of the pilot agencies have already made strides in this direction but do not have formal ways to assess their progress. ASRI will use the Culture, DV- and TI assessment and a review of existing agency policies to identify gaps and facilitate a process for agencies to prioritize one model policy that they want to work on developing. For example, ASRI may assist DV programs in developing a model accommodations policy for women who have psychiatric disabilities that builds in the use of peer support specialists and/or mental health outreach services (e.g. community support services, Mobile Assessment Unit or PATH) as reasonable accommodations. We know, however, that finalization, approval and formal implementation of new policies is likely to fall outside the timeframe of the grant period, depending on each agency’s approval process.

As part of the CDVTI agency self-assessment, we will ask agencies to identify gaps in policies as well as areas for improvement in physical, sensory, programmatic and interpersonal aspects of the service environment. Once the CDVTI agency self-assessment has been completed and agencies have identified areas for improvement (month 7), ASRI will collect and review existing agency policies related to the intersection of DV, trauma and mental health/psychiatric disabilities (months 8 & 9). Analysis of the policies will be discussed with the agency workgroup in preparation for discussion at the pilot site meetings (months 9 & 10). ASRI will then facilitate a process with the collaboration teams to prioritize the development of 1 model policy per agency (month 10). Cross-sector input will be provided at the collaboration meetings and

collaboration team representatives will work closely with their agency workgroups and other key leadership staff and administrators, including peer recovery support specialists, to draft policies and to collect appropriate feedback and input (months 11 & 12). Policies will be revised during the feedback process. We anticipate that formal approval, implementation and evaluation of the policies will take place after month 12.

Model policies developed under this initiative will be refined, implemented and evaluated during the post-grant period and will contribute to an array of strategies that will be made available to other communities in Illinois and nationally.

**Goal II, Initiative E. Develop a Safety Planning Tool for women who have psychiatric disability that addresses both physical and emotional safety.**

Another key initiative will be the development of a safety planning tool for women who are experiencing DV, other trauma and psychiatric disabilities. The tool will address both physical and emotional safety-related needs and concerns. It will be designed to integrate DV safety planning strategies with

Initiative/Activities	Timeline (Months)												Post-Grant	
	1	2	3	4	5	6	7	8	9	10	11	12		
<b>GOAL II: Build the Internal Capacity of Pilot Site Agencies</b>														
<b>E: Develop a Safety Planning Tool</b>		X	X	X	X	X	X	X	X	X	X	X		
Collect and review existing tools & materials		X	X											
Develop draft of SP tool				X	X	X								
Get Pilot Site Collaboration input and feedback				X	X	X								
Obtain consumer/survivor input and review				X	X	X								
Revise based on feedback							X	X						
Pilot safety planning tool									X	X	X			
Revise based on feedback from piloting												X		

trauma-related emotional safety and recovery-oriented planning. It will build on personal safety plans already being utilized by Recovery Support Specialists in our pilot agencies, initially developed as part of a SAMHSA-funded initiative on reducing seclusion and restraint. *Recovery Support Specialists* are people with lived experience of mental illness who work as professional staff in state psychiatric hospitals and community mental health agencies.<sup>2</sup>

In our Needs Assessment, women expressed a need for gender-specific DV and trauma services and access to community resources for addressing trauma and DV. They were also very clear about aspects of their service environment that made them feel physically and emotionally unsafe. In DV settings, while survivors did not specifically raise these issues, staff voiced

<sup>2</sup> Recovery Support Specialists work to promote recovery-focused, wellness-based, trauma-informed services that enhance personal recovery. As part of their role, RSS provide recovery-based training and education, develop and provide supportive services, ensure consumer involvement and empowerment, identify and disseminate recovery-based resources and information for consumers and providers of mental health services and through sharing their own journeys with MI, serve as living examples of recovery).

concerns about serving women with psychiatric disabilities whose behaviors made other people feel physically or emotionally unsafe (other survivors and staff). Developing a tool that addresses both physical and emotional safety for survivors experiencing DV, trauma and psychiatric disabilities has the potential not only to improve women’s safety but also to improve their experience of services. It will provide a way to help support women with psychiatric disabilities in DV shelter settings and to provide a respectful, empowerment-based vehicle for partnering with survivors to address multiple aspects of safety, including safety within communal settings. It will also provide a way for mental health agencies, including clinicians and peer/recovery support specialists to incorporate DV safety planning into existing recovery tools. Part of ASRI’s strategy for achieving sustainable cross-sector change in service delivery is to develop tools and accompanying practice guidelines that offer more integrated approaches to working with survivors who are dealing with multiple cross-cutting issues and that will increase staff and PCL comfort and skill in working with DV survivors experiencing psychiatric disabilities.

During months 2 & 3, ASRI staff, with input from pilot site collaborations will review and collect existing tools and materials relevant to this issue. During months 4 through 6, ASRI members will develop a draft of the safety planning tool, obtaining feedback from pilot site collaborations and survivors throughout this process. ASRI will then revise the tool based on the input and feedback provided (months 7 & 8). After review by the pilot site collaborations, decisions about where and how the tool will be piloted will be made, key staff will be trained and the tool will be piloted (months 9 through 11). Depending on timing, training on use of the safety planning tool may be incorporated into formal or informal cross-sector trainings. A feedback mechanism will be developed by the pilot site collaborations for evaluating the ease of use and effectiveness of the tool by staff and survivors. Based on feedback from the pilot, final revisions will be made and the safety planning tool will be submitted to OVW for approval (month 12).

**Goal III. Build, Develop and Refine ASRI’s Current Work and Future Plans**

Our third goal is to build, develop and refine ASRI’s model for providing technical assistance to support the work of this initiative and to support our long-term goals.

**Goal III, Initiative A. A New Technical Assistance Model**

Initiative/Activities	Timeline (Months)												Post-Grant
	1	2	3	4	5	6	7	8	9	10	11	12	
<b>GOAL III: Build, Develop and Refine ASRI’s Current Work and Future Plans</b>													
<b>A: Develop and Document a New Technical Assistance Model</b>													
Provide liaison to PS collabs to capture, document & report ideas & activities	X	X	X	X	X	X	X	X	X	X	X	X	
Integrate Peer Support and Empowerment Advocacy Approaches	X	X	X	X	X	X	X	X	X	X	X	X	
Facilitate development of sustainability plans			X	X	X	X	X	X	X	X	X	X	

ASRI’s TA model has evolved through previous collaborative work among project partners and through the work of DVMHPI and the National Center on Domestic Violence, Trauma & Mental Health – work designed to build collaboration between the DV and mental health provider

communities and to develop integrated trauma-informed models for responding to survivors with both DV and mental health-related needs. Our current ASRI partnership emerged through these efforts to build collaboration in Illinois to better address trauma and domestic violence in the lives of women living with psychiatric disabilities.

ASRI's statewide TA model builds on several aspects of our current approach. These include:

1. Facilitating cross-sector partnerships to bridge gaps and to build collaboration between previously disparate service sectors;
2. Fostering in-depth reflection and assessment within and between service sectors to examine needs, gaps, barriers, successes, opportunities and strategies for change;
3. Offering training, consultation and support to build internal agency capacity to provide accessible, DV- and trauma-informed services and to assist providers in translating knowledge and skills into practice;
4. Assisting agencies in developing the infrastructure needed to support supervisors and staff in doing this work;
5. Developing integrated approaches to a range of complex issues faced by survivors and their children;

We are excited about the opportunity offered by this project to further refine our model and to develop new approaches to serving survivors experiencing both DV and psychiatric disabilities. Our Needs Assessment deepened our understanding of what work needs to be done, an understanding developed from the extensive experience of ASRI partners in working on these issues. The voices of survivors, consumers, and those who help them realize their goals of safety and recovery, have offered a remarkably clear and consistent vision for ASRI's work going forward:

- Domestic violence service providers need powerful and effective resources to serve women with psychiatric disabilities.
- Mental health service providers need training, partnership, and the opportunity to develop expertise to effectively serve women experiencing trauma and DV.
- Women with psychiatric disabilities eloquently recognized that the lack of domestic violence and trauma resources in mental health settings profoundly affected their safety and recovery, and expressed the desire to access Domestic Violence services in the community, if only they had the chance to do so.

ASRI has created a nuanced and innovative Technical Assistance component as part of the work of this project. This TA model was developed after giving careful thought to all of the concerns that emerged from our Needs Assessment and previous work. The ASRI team was struck by the shared principles and goals of separate modalities used in mental health services and in domestic violence services. Although the peer support model used in mental health service provision developed independently of the empowerment-based domestic violence advocacy approach, they share basic elements and are remarkably compatible. ASRI believes that principles of respect for the knowledge and experience of survivors and consumers, recognition that solutions to problems within systems can be found at the heart of those systems, and the appreciation that change which occurs through partnerships can be lasting, should be part of a

new way of providing technical assistance. This innovative TA approach will take peer support and empowerment service provision models, which have been so successful for survivors and consumers, and broaden and expand them to help pilot agencies, in collaboration affect lasting systemic change at the pilot sites. The elegance of this technical assistance model is that it is a natural fit and a logical evolution of the pilot agencies’ services approaches.

**Goal III, Initiative B. Ongoing Evaluation as a Key Component**

Initiative/Activities	Timeline (Months)												Post-Grant	
	1	2	3	4	5	6	7	8	9	10	11	12		
<b>GOAL III: Build, Develop and Refine ASRI’s Current Work and Future Plans</b>														
<b>B: Conduct Process Evaluation of Technical Assistance</b>			X	X	X	X	X	X	X	X	X	X		
Review & compile process data - apply to ongoing work			X			X			X				X	
Develop and provide training (& consultation?) to key staff and administrators								X	X	X	X	X	X	

ASRI looks forward to developing this peer-based TA model as part of this project. In our work with the pilot sites, we anticipate learning from, evaluating and refining this innovative technical assistance initiative. Integral to developing and refining our TA model will be a mechanism to evaluate this aspect of our work in a time frame that is contemporaneous, or nearly so, with the provision of the TA.

ASRI will create an evaluation of our technical assistance work which systematically captures, and documents critical information about the TA provided, including:

- The subject or issue, its complexity, broadness, and other factors
- How the request was made
- What activities constituted the TA
- Who performed those activities
- The short-term outcome(s) of the TA
- Implications for the long-term.

This information will be gleaned as ASRI provides its technical assistance. We will review and analyze this data to understand the impact of our technical assistance based on regular input and feedback from the pilot site collaborations and agencies. Engaging in this process will allow us to continuously learn from the pilot sites about what is helpful and what is not, and to adapt and refine our TA provision throughout the course of the project. Creating a vehicle for two-way feedback and analysis of lessons learned will enhance pilot sites’ ability to provide ongoing local TA as well as our ability to more effectively replicate these models in other communities.

**LONGER-TERM INITIATIVES AND FUTURE PLANS**

The short-term initiatives described above are designed to lay the groundwork for achieving ASRI’s longer-term vision ensuring that survivors of DV and other trauma who have a psychiatric disability have access to the resources they want and need to achieve both safety and recovery -

resources that are gender-responsive, culturally-attuned, recovery-oriented, trauma-informed, attend to DV-specific concerns and incorporate a social justice perspective.

There are a number of ways we envision our work proceeding over the longer-term. These include the broadening and deepening of collaborative work in the 2 pilot sites; the further refinement, piloting, evaluation and replication of models and tools developed during the current grant period, building on the work of ASRI and the pilots in the coming year to create new integrated service models and to incorporate them into existing reimbursable evidence-based and informed practices throughout IL, and to incorporate the lessons learned in refining ASRI's TA model into our ongoing work in Illinois and nationally.

More specifically,

1. **Broadening and deepening collaborations in current pilot sites:** During the post-grant period we hope to evaluate, refine and further institutionalize the collaborative models that have been developed and have pilot sites engage in the following activities: engage other organizations (e.g. medical school, private hospitals with psychiatric units, other mental health and substance abuse providers) that will enhance the collaboration, continue to expand the pool of practitioners who are knowledgeable about these issues and able to provide cross-training and consultation, expand cross-referral resources, and develop co-located services where feasible.
2. **Piloting and replication of the collaboration model, statewide:** We also expect ASRI's collaboration model to be effective, so over the longer-term we will develop strategies for piloting and replicating the collaboration model, statewide. We anticipate doing this in several ways. When we were initially planning this project there were already a number of communities in IL who were interested in developing similar partnerships. One strategy would be after finalizing the CDVTI assessment and/or Safety Planning Tools to provide a year of consultation to other communities on how to use the tools effectively across programs while building collaboration among agencies who are learning to use the same tool. A second strategy would be to enhance the capacity of pilot sites to provide training and TA to other providers in the state through a number of venues including local trainings, trainings within each constituency (ILCADV trainings, IDHS DMH video-conferencing) and by bringing pilot site agencies and local collaborations into a broader network of partners across the state of IL. We will also utilize the tools, experience and lessons learned in the Center's national capacity-building work
3. **Developing replicable strategies for creating welcoming CDVTI environments through the CDVTI Assessment Tool and Model Policies developed under this initiative:** These will be refined, implemented and evaluated during the post-grant period and will contribute to an array of strategies that will be made available to other communities in IL and across the US. For example, one longer-term initiative will be to send the CDVTI tool for review by national experts as well as DV and mental health programs, peer support providers and survivors; create guidelines, training materials and sample action

plans to accompany the tool; and make this available online and throughout IL through ASRI (including IL DHS DMH and ILCADV) and nationally through DVMHPI's National Center on Domestic Violence, Trauma & Mental Health (the Center). Similarly, model policies developed by pilot agencies (e.g. model accommodation policy for DV survivors experiencing psychiatric disabilities) will be further evaluated, reviewed and made available along with training on their adoption through similar venues.

4. **Incorporation of cross-training materials, curricula and strategies into ongoing staff and supervisor training:** Cross-training materials, curricula and strategies developed for this initiative and lessons learned regarding the most effective strategies for enhancing staff knowledge, skill and awareness will be made available to support ongoing collaborative work and in-house trainings in each pilot site, will be used to enhance ASRI's effectiveness in increasing staff capacity in other sites in Illinois and will feed into the development of train-the-trainer curricula and toolkits through ASRI and/or the Center's future work. Similarly, lessons learned and insights gleaned through ASRI's efforts to build PCLs' capacity to support staff in incorporating new knowledge and skills and the further development and refining of ASRI's TA model will inform ASRI's use of these strategies in its future provision of TA in other parts of Illinois and in other locations, nationally.
5. **Finalization, evaluation and replication of the enhanced/supplemental DV/ Trauma Safety Planning Tool for Women Experiencing Psychiatric Disabilities:** The development of the enhanced DV/Trauma Safety Planning Tool for Women Experiencing Psychiatric Disabilities during the coming year will serve as the basis for finalization and evaluation of the tool during the post-grant period in preparation for additional piloting and widespread distribution along with training on its use. Once we have tested our Safety Planning tool for women experiencing DV, trauma and psychiatric disabilities, we will pilot it in both sites and refine it, send it out for review by national DV, mental health and peer support experts and survivors and will then want to replicate it across IL. In order to do so, we will partner with the necessary entities (ILCADV, IDHS-DMH) to ensure its integration into approved practices and standards of care.
6. **Developing integrated service models and building on existing recovery-support and DV service delivery structures in Illinois to develop new, sustainable DV- and trauma-informed service delivery models and tools.** The new Safety Planning Tool will also serve as the basis for developing a DV version of WRAP™ through other funding sources that can be formally incorporated into reimbursable WRAP™ training and facilitation in IL and across the US. The creation of a DV version of WRAP™ will also be part of a longer-term initiative to develop more formal integrated services models and tools that eventually become part of evidence-based and/or -informed mental health practice. Because funding for mental health services, particularly when funding is limited, often prioritizes evidence-based models, it is one of ASRI's long-term goals to develop, pilot, refine and evaluate integrated DV, trauma & mental health services that can be widely replicated and incorporated into standard mental health practice. The second model we

hope to develop, also stemming directly from our Needs Assessment is a DV/Trauma module for the Illness Management Recovery (IMR) program (renamed Wellness Management Recovery by Thresholds) - a program that assists individuals to recover, or rediscover, their strengths and abilities, to cope effectively with symptoms, to pursue personal goals and to develop a sense of identity outside of having a psychiatric disability. Additional activities to ensure sustainability of new policies and practices include working with ILCADV and the IDHS Bureau of Domestic and Sexual Violence Prevention to incorporate new policies and standards into the Illinois Domestic Violence Service Provider Guidelines that can be written into state contracts with DV agencies and incorporated into ILCADV's women's advocacy trainings every year as well as developing policies and procedures for DV programs on working with local mental health agencies. Finally, we would work with IDHS to create a state level advisory committee with a goal of creating inter-division agreements to fund and implement local collaborations and new integrated models.

During the coming year we plan to gather feedback and learn as much as possible from our pilot partners and survivors regarding all of the tools and models we develop through our collaboration, about what is helpful and what is not and how to best develop integrated models to ensure that survivors have access to resources that holistically meet their needs.

### **Funding**

All of the activities described in the project grid will be accomplished without the need for additional funding beyond the resources provided by the OVW Grant. Funds to support contracts between ASRI and the six program sites are included in the project budget.

### **Conclusion**

Because the Initiative places a strong emphasis on the creation of real and sustainable change, ASRI is focusing its efforts on two pilot communities in Illinois in order to provide the depth and intensity of technical assistance and collaboration-building necessary to achieve these goals. Ultimately, however, we anticipate that the successes and lessons learned from this initiative will be expanded to other communities throughout the state.

## **APPENDIX - ASRI Strategic Planning Grid**

## ASRI Strategic Planning Grid

Initiative/Activities	Timeline (Months)												Post-Grant
	1	2	3	4	5	6	7	8	9	10	11	12	
<b>GOAL I : Strengthen Site Collaborations in Chicago and Rockford</b>													
<b>D: Strengthening Internal Capacity</b>				X									
Cultivate work groups in each agency				X									
Incorporate work groups into capacity building initiative				X	X	X	X	X	X	X	X	X	
<b>GOAL II: Build the Internal Capacity of Pilot Site Agencies</b>													
<b>A: Create Welcoming Environments</b>		X	X	X	X	X	X	X	X				
Develop Culture-, DV- and Trauma-Informed Assessments		X	X	X	X	X	X	X					
Review & Collect ASRI's existing knowledge and tools		X	X										
Develop assessment tool for multiple aspects of environment			X	X	X								
Get input from staff and survivors into tool			X	X	X								
Identify review team				X	X								
Assemble team(s) and train on conducting assessments					X								
Revise tool based on feedback						X							
Conduct reviews of each Pilot Site Agency							X						
Develop a report with prioritized recommendations								X					
Support collaborations in developing action plans - choose									X				
<b>B: Increase Staff Comfort, Knowledge, and Awareness</b>	X	X	X	X	X	X	X	X	X	X	X	X	
Work with supervisors to support staff			X										
Determine existing expertise in PS agencies	X	X											
Review, refine & adapt existing curricula/incorp agency curric		X	X	X									
Revise curricula based on PS feedback					X	X							
Send to OVW for approval							X						
Roll out training to key staff and supervisors with ongoing feedback								X	X	X	X	X	
Obtain CEU authority (offer CEUs and certificates)							X						
<b>C: Build Prog. &amp; Clinical Leaders' Ability to Support Staff</b>	X	X	X	X	X	X	X	X	X	X	X		
Engage PCLs in pilot site collaboration	X												
Involve PCL in pilot agency's working committees		X	X	X	X	X	X	X	X	X	X	X	
Solicit Feedback on curriculum from PCLs					X								
Provide training and as-needed support							X	X	X	X	X	X	
Contribute to the development of model policy key elements									X	X	X	X	

Facilitate cross-sector consultation among PS Agencies					X	X	X	X	X	X	X	X	
<b>D: Develop Model Policies</b>									X	X	X	X	
Use Culture, DV-, TI assessment to determine gaps in policies									X				
Collect and review relevant existing policies									X	X			
Facilitate a process with PS collabs to prioritize 1 policy/agency									X	X			
Draft Policy											X	X	
Revise policy												X	X
Implement policy													X
Evaluate policy													X
<b>E: Develop a Safety Planning Tool</b>		X	X	X	X	X	X	X	X	X	X	X	
Collect and review existing tools & materials		X	X										
Develop draft of SP tool				X	X	X							
Get Pilot Site Collaboration input and feedback				X	X	X							
Obtain consumer/survivor input and review				X	X	X							
Revise based on feedback							X	X					
Pilot safety planning tool									X	X	X		
Revise based on feedback from piloting												X	

<b>GOAL III: Build, Develop and Refine ASRI's Current Work and Future Plans</b>													
<b>A: Develop and Document a New Technical Assistance Model</b>													
Provide liaison to PS collabs to capture, document & report ideas & activities	X	X	X	X	X	X	X	X	X	X	X	X	
Integrate Peer Support and Empowerment Advocacy Approaches	X	X	X	X	X	X	X	X	X	X	X	X	
Facilitate development of sustainability plans			X	X	X	X	X	X	X	X	X	X	
<b>B: Conduct Process Evaluation of Technical Assistance</b>													
Review & compile process data - apply to ongoing work			X			X				X			X
Develop and provide training (& consultation?) to key staff and administrators							X	X	X	X	X	X	
<b>LONG TERM GOAL: Develop Integrated Service Model</b>													