ELEVATE
A POLICY LAB TO ELEVATE MENTAL HEALTH AND DISRUPT POVERTY

MOMS PARTNERSHIP
Every Mother Matters

Yale SCHOOL OF MEDICINE

NYC DHS MOMS Partnership℠

Pilot Evaluation Report

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Elevate: A Policy Lab to Elevate Mental Health and Disrupt Poverty

Yale School of Medicine

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Preface

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NOTE ON LANGUAGE

The Mental health Outreach for MotherS (MOMS) Partnership® was established with the conviction that the unique socioeconomic, cultural, and psychological implications of gender and sex, particularly for parenting and caregiving individuals, demand mental health programming tailored to the experiences of mothers and women. This language is imperfect, though. While we use the term *mother* and *woman* as shorthand in this report, the individuals who participate in MOMS Partnership programming — in the NYC DHS MOMS Partnership℠ and other sites nationwide — have diverse identities and roles in the lives of the children for whom they are caregivers: kin and non-kin, custodial and informal. In this pilot, eligibility involved self-identification as *women*; this language, too, may not perfectly describe the gender identities of all MOMS participants, nor all those who have the social and biological experiences of pregnancy, motherhood, or categorization as female.

We are cognizant, too, that the language of *homelessness* bears a fraught history, and that it encompasses varying experiences of housing and shelter. The participants in the NYC DHS MOMS Partnership were clients residing in NYC Department of Homeless Services shelters for families with children, operated by the organization BronxWorks. We describe these clients as experiencing homelessness.

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Executive Summary

OVERVIEW

The New York City Department of Homeless Services (DHS) partnered with Elevate Policy Lab to establish and pilot the NYC DHS MOMS Partnership℠ (NYC DHS MOMS), bringing the Mental Health Outreach for MotherS (MOMS) Partnership® model and MOMS Stress Management (SM) course to Tier 2 shelters for Families with Children. The NYC DHS MOMS Pilot was implemented in two shelters operated by BronxWorks, a non-profit human services organization serving the Bronx community. Eighty (80) BronxWorks clients participated in MOMS SM over the course of the pilot's 6 course sessions, which took place between August 2021 and November 2022.

Elevate worked with DHS and BronxWorks to design and carry out an evaluation of the pilot, including a pre-post study of participant outcomes. This report describes the NYC DHS MOMS Pilot and the results of the pre-post evaluation study, which includes data from a subset of 69 pilot participants. The evaluation examined participation in and satisfaction with NYC DHS MOMS, as well as outcomes from participant self-reported data. Self-reported data were collected at three time points: before participation in MOMS SM (Baseline), immediately following Class 8 (Endpoint), and three months after Class 8 (Follow-Up).

The pre-post evaluation aimed to answer the following questions:

- Did NYC DHS MOMS participants experience improvements in measures of mental health following participation in the MOMS SM course?
- Did NYC DHS MOMS participants experience increased social support following participation in MOMS SM?
- Did NYC DHS MOMS participants experience increased parenting confidence and self-esteem following participation in MOMS SM?
- Did NYC DHS MOMS participants experience improvements in economic security and mobility following participation in MOMS SM?

KEY FINDINGS

Participant Characteristics

Almost all clients who completed an eligibility screening were determined to be eligible for participation in the pilot. Of 80 participants in the NYC DHS MOMS Pilot, 69 were included in analysis. More than 80% of participating clients identified as Black or African American, and nearly 30% of participants identified as Hispanic/Latino. The majority of participants were the sole adult in their household, and about half had three or more children under 18 in their household. At the start of participation in NYC DHS MOMS, very few — 15% — were working for pay, and almost one quarter said they had needed but not received mental health services at some point in the past year.

Participation

Participant attendance at MOMS SM classes was high, with participants attending a median 6 of 8 classes; nearly 20% attended all 8 classes. Participants overwhelmingly reported that they were satisfied or very satisfied with MOMS SM at the Endpoint assessment.

Mental Health and Wellbeing

Participants experienced significant improvements across a number of mental health measures at the Endpoint assessment and at Follow-Up three months later. Participants' depressive symptoms and depression severity decreased significantly between Baseline and Endpoint and remained significantly lower at Follow-Up; by Follow-Up, almost one-half scored below the threshold for risk of clinical depression. Anxiety symptoms similarly decreased and remained significantly lower, while measures of perceived stress and traumatic stress decreased between Baseline and Follow-Up. No differences were detected in analyses of measures related to emotional regulation and general self-efficacy.

Social Support

Participants experienced significant increases in perceived social support, across all types of support measured and overall. In addition, participants reported significantly greater instrumental support — support to meet concrete and tangible needs — at Endpoint and Follow-Up compared to Baseline.

Parenting Confidence and Self-Esteem

No changes were detected in participants' scores on measures parenting sense of competence or subscales of parenting confidence and efficacy.

Economic Security and Mobility

The percentage of participants experiencing high financial stress decreased significantly between Baseline and Follow-Up. At Endpoint and Follow-Up, fewer participants reported trouble paying for items like clothes and shoes compared to Baseline. Similarly, the proportion reporting trouble paying for hygiene products also decreased significantly from Baseline to Follow-Up.

CONCLUSION

The NYC DHS MOMS Pilot demonstrated the successful implementation of MOMS services within two BronxWorks shelters and suggested positive outcomes for participating clients. Overall, BronxWorks clients were very engaged with the pilot and MOMS SM course, with high levels of enrollment, attendance, and satisfaction with the program. While this study was limited by its sample size and observational pre-post design, the evaluation findings indicate that participation in MOMS SM was associated with several key outcomes for which the pilot aimed, particularly improvements in participant mental health and social support. These results are encouraging, particularly given the prevalence of mental health challenges and low social connectedness among women experiencing homelessness — and the potential benefits of improved mental health and social support for both women in shelter and their children. BronxWorks has continued to offer MOMS SM past the conclusion of the pilot, and Elevate is preparing for the future implementation and evaluation of Spanish-language MOMS services at BronxWorks. Elevate and DHS are currently planning for a

second pilot phase to investigate the feasibility and effectiveness of expanding MOMS services to new provider sites.

Introduction

BACKGROUND

In January of 2020, approximately 12,000 Families with Children were residing in New York City's Department of Homeless Services (DHS) shelters. At the time of this report's preparation — which comes after months of a migrant influx to the city — the number of families has reached more than 15,800.[1] Currently, the largest provider of temporary housing for Families with Children is DHS's network of Tier 2 shelters, which combine apartment-style housing with integrated case management and other supportive services for clients.

Mental health challenges, particularly depression and traumatic stress, are pervasive among mothers experiencing homelessness. Research suggests that nationwide, a large majority of mothers in homeless shelters have experienced early trauma and adverse childhood experiences.[2] In New York City, domestic violence is among the most common reasons families seek DHS shelter.[3] And research suggests that postpartum depression significantly increases the risk of homelessness in the years after a child's birth, regardless of housing security at the time.[4] The experiences of housing insecurity and homelessness further exacerbate psychological distress among mothers.[5] Along with housing insecurity, maternal depression and parenting stress increase the risk of future depression and anxiety for children.[6]

In 2016, as part of the mental health initiative ThriveNYC, DHS introduced the placement of licensed master's-level social workers (LMSWs) and licensed clinical social workers (LCSWs) in shelters serving Families with Children. As Client Care Coordinators (CCCs), LMSW and LCSW shelter staff administer mental and behavioral health assessments and coordinate access to care for shelter clients. In 2020, CCCs had been placed in more than 100 family shelters.[7]

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[1] Department of Human Services (2023). *Individual census by borough, community district, and facility type* [Data set]. NYC Open Data.

[2] Bassuk, E. L., & Beardslee, W. R. (2014). Depression in homeless mothers: Addressing an unrecognized public health issue. *American Journal of Orthopsychiatry*, *84*(1), 73–81. FRANCIS Archive.

[3] *Oversight hearing regarding HPD's coordination with HRA/DHS to address the homelessness crisis before the Committee on Housing and Buildings jointly with the Committee on General Welfare*, New York City Council (2017) (testimony of Steven Banks). https://legistar.council.nyc.gov.

[4] Curtis, M. A., Corman, H., Noonan, K., & Reichman, N. E. (2014). Maternal depression as a risk factor for family homelessness. *American Journal of Public Health*, *104*(9), 1664–1670.

[5] Bogard, C. J., McConnell, J. J., Gerstel, N., & Schwartz, M. (1999). Homeless mothers and depression: Misdirected policy. *Journal of Health and Social Behavior*, *40*(1), 46–62.

Marcal, K. E. (2018). Timing of housing crises: Impacts on maternal depression. *Social Work in Mental Health*, *16*(3), 266–283.

[6] Hatem, C., Lee, C. Y., Zhao, X., Reesor-Oyer, L., Lopez, T., & Hernandez, D. C. (2020). Food insecurity and housing instability during early childhood as predictors of adolescent mental health. *Journal of Family Psychology, 34*(6), 721–730.

Marçal, K. E. (2022). Pathways from food and housing insecurity to adolescent behavior problems: The mediating role of parenting stress. *Journal of Youth and Adolescence*, *51*(4), 614–627.

[7] New York City Mayor's Office of Operations. (2020). *Mayor's Management Report: Fiscal 2020.*

That same year, DHS partnered with Elevate Policy Lab at Yale School of Medicine (Elevate) to bring the Mental Health Outreach for MotherS (MOMS) Partnership® to Tier 2 shelters for Families with Children. Launched in New Haven in 2011, the MOMS Partnership is a program model and package of principles and approaches that, when brought together, have the potential to significantly reduce depressive symptoms among under-resourced, over-burdened pregnant women and mothers, and increase the social and economic mobility of their families. The focus of MOMS programming is on directly strengthening maternal mental health in order to bolster family stability, economic, and social mobility. Since 2018, Elevate has worked to scale the model through partnerships that embed the MOMS Partnership in human services agencies and public safety net programs — meeting mothers where they are to bring mental health services within reach.

In establishing the NYC DHS MOMS Partnership℠ (NYC DHS MOMS), DHS aimed to broaden shelters' capacity to support the mental health of clients and to address related barriers to leaving shelter. In the pilot phase (NYC DHS MOMS Pilot), the program was implemented in two shelters operated by the DHS-contracted provider BronxWorks, a non-profit human services organization serving the Bronx community. The pilot launched in August 2021 and concluded in November 2022. Following the conclusion of the NYC DHS MOMS Pilot, BronxWorks is continuing to offer NYC DHS MOMS programming.

To assess the impact of NYC DHS MOMS, Elevate worked with DHS and BronxWorks to design and carry out an evaluation of the pilot, including a pre-post study of participant outcomes. This report describes the NYC DHS MOMS Pilot and the results of the pre-post evaluation study.

MOMS PARTNERSHIP MODEL

The MOMS Partnership is a program designed to reduce depressive symptoms and meet the mental health needs of low-income women who are primary caregivers and are experiencing mild to moderate depressive symptoms. Preliminary evidence suggests that those who participate in the MOMS Partnership can experience reduction in maternal depressive symptoms, an increase in perceived social support, an increase in maternal employment, and an increase in an ability to meet their family's basic needs.

At the core of the model is the MOMS Stress Management (MOMS SM) course. MOMS SM is a manualized, cognitive behavioral therapy-based group course that meets once per week for 8 weeks. The course was originally adapted from *The Mothers and Babies Course*[8] for the population of mothers served by the MOMS Partnership. MOMS SM encourages active participation and skill acquisition through interactive exercises, discussion, and practice. Participants learn:

- skills to recognize their mood;
- skills to change their mood through intentionally changing thoughts and behaviors; and
- effective functioning skills including response inhibition, metacognition, and flexibility.

The MOMS SM course is co-delivered by a mental health clinician (MOMS Clinician) and a Community Mental Health Ambassador (MOMS CMHA), a member of the staff who is also a parent or caregiver from the local community and shares lived experience with program participants.

[8] Le, H.N. Le & Muñoz, R.F. (2011). *The Mothers and Babies Course: Instructor's manual.* George Washington University. Muñoz, R. F., Ghosh Ippen, C., Le, H. N., Lieberman, A. F., Diaz, M.A., & La Plante, L. (2001). *The Mothers and Babies Course: A reality management approach* (participant manual).

Unlike traditional mental health services in a clinical setting, MOMS Partnership programming is offered in community locations identified as convenient, accessible, and safe for participants. MOMS SM may also be delivered virtually. The MOMS Partnership model includes incentives to compensate participants for their time — including class, recruitment activities, and assessments — and to support them in meeting their family's material needs.

NYC DHS MOMS PILOT

NYC DHS MOMS began with the pilot implementation of the MOMS model and delivery of the MOMS SM intervention in two BronxWorks Tier 2 shelters for Families with Children. Planning for NYC DHS MOMS began in early 2020, with BronxWorks identified as the shelter provider for the pilot in June 2020. BronxWorks, a Bronx-based human service organization, operates three family shelters as well as adult shelter and outreach services as a DHS-contracted shelter provider. Evaluation of the NYC DHS MOMS Pilot was supported by the Robin Hood Foundation Fund for Early Learning (FUEL). Implementation was supported by DHS and the Robin Hood Foundation FUEL.

Program Design and Implementation

The NYC DHS MOMS Pilot was implemented by BronxWorks with support from DHS and technical assistance from Elevate. Program setup — including contracting, planning, and staff training — took place between June 2020 and July 2021.

Two shelters were chosen for on-site delivery of pilot services to clients: Jackson Family Residence (Jackson), which offers 95 family housing units, and Nelson Family Residence (Nelson), which offers 79 units.

The NYC DHS MOMS Pilot aimed to enroll and deliver MOMS SM to 100 BronxWorks clients at the Jackson and Nelson sites over multiple sessions of the eight-week course.

The core staff positions and roles for the NYC DHS MOMS Pilot (MOMS staff) were defined in the planning stage. DHS and BronxWorks committed to furnishing the following dedicated staff positions:

- **MOMS Manager**, typically an employee of the partnering government agency, to direct and oversee the set-up and implementation effort;
- **MOMS Program Coordinator**, to provide program coordination, including MOMS program set-up, training, and implementation;
- **MOMS Data Specialist**, to collaborate on defining indicators of interest, to obtain administrative data as necessary, to obtain data from participants, and to share data with Elevate;
- **MOMS Clinical Supervisor**, a licensed clinician to serve as a clinical supervisor to MOMS Clinicians and CMHAs;
- One or more **MOMS Clinician,** a licensed clinician (social worker, counselor, or psychologist) to deliver MOMS services; and
- One or more **MOMS Community Mental Health Ambassador (MOMS CMHA)**, a community member and mother who shares lived experience with the participant population, to co-deliver MOMS services.

The pilot plan called for nearly all positions to be filled by existing DHS and BronxWorks staff; the MOMS CMHA was the only new position, established at BronxWorks specifically for NYC DHS MOMS Pilot. Staff shortages and turnover posed some challenges for staffing the NYC DHS MOMS Pilot, addressed in detail in the **Challenges** section of this report. Most staffing changes, however, occurred between set-up and program launch; the clinical staff delivering MOMS SM remained the same throughout the period of service delivery, though the MOMS Clinician for the Jackson site also delivered the final session of MOMS SM at Nelson.

BronxWorks staff comprised the majority of the MOMS staff, with DHS staff carrying out the responsibilities of the MOMS Manager position. The individuals who comprised the MOMS staff and their roles in the MOMS pilot are described in **Table 1.**

Table 1: NYC DHS MOMS Pilot staff (MOMS staff)

STAFF MEMBER	MOMS PILOT ROLE(S) *% FTE funded for pilot, if applicable*	PILOT RESPONSIBILITIES
Associate Commissioner, DHS[a]	MOMS Manager –	• Oversight and coordination of program setup and implementation with DHS • Coordination of administrative infrastructure, including contracts, budget, and human resources
Program Coordinator, BronxWorks	MOMS Program Coordinator; MOMS Clinician –	• Oversight and coordination of program setup and implementation at BronxWorks • Coordination of MOMS staff recruitment, training, and onboarding • Supervision of CMHAs • Outreach, recruitment, and delivery of MOMS SM
Director of Clinical Supervision, BronxWorks	MOMS Clinical Supervisor –	• Weekly reflective supervision of MOMS Clinicians and CMHAs • Consultation on clinical questions and concerns
Program Developer, BronxWorks	MOMS Data Specialist –	• Deidentification and sharing of BronxWorks administrative data for evaluation

STAFF MEMBER	MOMS PILOT ROLE(S) *% FTE funded for pilot, if applicable*	PILOT RESPONSIBILITIES
Client Care Coordinator, BronxWorks	MOMS Clinician –	• Outreach, recruitment, and delivery of MOMS SM
CMHAs (2), BronxWorks	MOMS CMHAs *100% FTE (each)*	• Outreach, recruitment, and delivery of MOMS SM

[a] The staff member departed from the agency after contracting and pilot planning had concluded; after this point, other DHS staff, including a Deputy and Associate Commissioner, continued to carry out the responsibilities of the role.

Theory of Change

Elevate engaged BronxWorks and DHS, as well as Jackson and Nelson shelter clients, to develop a theory of change specific to the NYC DHS MOMS Pilot. After an initial discussion with BronxWorks staff about short- and long-term goals for client outcomes, and barriers to these outcomes, BronxWorks staff administered a brief, voluntary, and anonymous survey to clients. The survey included three open-ended items:

- What are your goals for this month?
- What are your goals for this year?
- What things do you think need to change in your life for you to reach those goals? What would help you reach them?

The survey aimed to ensure that the outcomes envisioned for the NYC DHS MOMS Pilot, and the pathways to these outcomes, aligned with the goals that clients held for themselves; additionally, the survey offered an opportunity to raise themes that may have been overlooked. BronxWorks staff collected responses from 20 clients. Based on conversations with BronxWorks and the responses to this survey, Elevate prepared a draft of the theory of change for review from BronxWorks and NYC DHS, then incorporated this feedback. The resulting theory of change is provided as **Appendix A**.

Recruitment and Eligibility

After successful completion of program set up and training, the NYC DHS MOMS Pilot began recruitment for MOMS SM in August 2021. Recruitment was held prior to each MOMS SM session and involved three steps: (1) **Outreach** to inform clients of the program and generate interest; (2) **Screening** of interested clients for eligibility; and (3) an **Engagement Session** meeting with each eligible client to confirm interest, availability, and commitment to participating in the upcoming MOMS SM course.

Outreach methods included on-site tabling events; presentations and informational materials at shelter intake meetings; flyers and promotional materials displayed in shelter; and door-to-door outreach and direct outreach to shelter clients. Interested clients were referred to MOMS staff for Screening to assess eligibility for participation. Screening was administered as an interview by

BronxWorks staff with clinical credentials and experience (i.e., MSW-level staff) following training by Elevate. Each client received a $25 cash gift card for completion of the Screening (a full schedule of incentives is provided in **Appendix B**).

A client who met the criteria indicated in **Table 2** at the time of recruitment for a MOMS SM session was eligible to participate in the NYC DHS MOMS Pilot. The eligibility criteria were assessed during Screening.

Table 2: NYC DHS MOMS Pilot participant eligibility criteria

CATEGORY	CRITERION
Administrative criteria	Is at least 18 years of age
	Identifies as a woman
	Is a primary caregiver to a child under 18 years of age and/or currently pregnant
	Is a resident at Jackson or Nelson and does not have a planned move-out date within the period of the MOMS SM session
Clinical criteria	Is experiencing depressive symptoms, measure by a score ≥ 16 on the Center for Epidemiologic Studies Depression (CES-D) scale[9]
	Is not experiencing current, acute psychotic symptoms, assessed by clinical interview using the PRIME Screen[10]
	Is not experiencing current, acute suicidality, assessed by clinical interview using question 9 of the Patient Health Questionnaire-9 (PHQ-9)[11]

If a client was eligible for participation, they were scheduled to attend an Engagement Session with either a MOMS Clinician or CMHA prior to the MOMS SM course. The goals of the Engagement Session included:

- increasing investment in MOMS SM course participation;
- communicating key class guidelines;
- addressing individual barriers to participation, including instrumental barriers (e.g., childcare, technology) as well as psychological or cultural barriers to engaging mental health services;
- conveying understanding of clients' individual and culturally embedded perspectives;
- helping clients recognize how the potential benefits of participation aligned with their own priorities and concerns; and
- ensuring that the client could meet the expectations of participation.

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[9] Radloff, L. S. (1977). The CES-D scale: A self report depression scale for research in the general population. *Applied Psychological Measurements*, *1*, 385–401.

[10] Miller, T.J. & Cicchetti, Domenic & Markovich, P.J. & Woods, Scott. (2004). The SIPS Screen: A brief self-report screen to detect the schizophrenia prodrome. *Schizophrenia Research*, *70*(Suppl. 1), 78.

Kobayashi, H., Nemoto, T., Koshikawa, H., Osono, Y., Yamazawa, R., Murakami, M., Kashima, H., & Mizuno, M. (2008). A self-reported instrument for prodromal symptoms of psychosis: Testing the clinical validity of the PRIME Screen-Revised (PS-R) in a Japanese population. *Schizophrenia Research*, *106*(2-3), 356–362.

[11] Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606–613.

Clients who intended to participate completed a consent form for both participation in MOMS SM and the associated evaluation study. Consent was administered by the MOMS Clinician or CMHA conducting the Engagement Session.

Service Delivery

MOMS SM was delivered in eight-week sessions in a closed group setting at each site. Groups met once per week for 90 minute "class" meetings. Each MOMS SM group can include 3 – 10 participants; the NYC DHS MOMS Pilot aimed to enroll 8 – 10 participants per group. Classes were held in-person in a dedicated, private space at each shelter, with the exception of virtual service delivery for occasional classes in response to Covid-19 risk or other environmental factors. Each class was co-facilitated by the MOMS Clinician and CMHA according to a lesson plan outlined in the MOMS SM curriculum. Participants received a $20 cash gift card for attendance at classes 2 – 7.

A client scheduled for participation in a MOMS SM session was required to attend at least the first or second class in order to participate in subsequent classes; any client who attended at least the first or second class was considered enrolled in the session. An illustration of the flow of clients from Recruitment to course enrollment, including evaluation activities, is included in **Figure 2** in the **Evaluation** section of this report.

MOMS SM sessions were offered simultaneously at each site. Participants in simultaneous sessions at the two shelters were considered to be a single "cohort". Six cohorts participated in NYC DHS MOMS over the course of the pilot, with services beginning September 2021 and ending November 2022. Six sessions of MOMS SM were held at the Nelson site; at Jackson, one of six scheduled sessions was cancelled due to a significant number of participant shelter exits, resulting in five complete sessions of MOMS SM held at the Jackson shelter. Over the course of the pilot, a total of 80 clients enrolled in MOMS SM.

Figure 1 indicates the timeline of MOMS SM sessions and corresponding cohort numbers for the NYC DHS MOMS Pilot.

Figure 1: MOMS SM Sessions and Cohorts

MOMS SM SESSIONS															
COHORT	2021				2022										
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
1	Jackson														
	Nelson														
2				Jackson											
				Nelson											
3						Jackson									
						Nelson									
4								*Jackson cancelled*							
								Nelson							
5											Jackson				
											Nelson				

6													Jackson
													Nelson

Challenges, Adaptations, and Unique Features

The NYC DHS MOMS Pilot was the first-ever replication of the MOMS Partnership within a homeless services system and the first instance of MOMS SM service delivery in a shelter setting. The pilot provided an opportunity to assess and address challenges, to make adaptations where fidelity to the core model permitted, and to understand unique features of MOMS implementation and service delivery in this context.

Staffing

Staff shortages and turnover at BronxWorks — which reflect a larger system-wide trend — were both anticipated and encountered. Two MOMS CMHAs hired during program set-up left BronxWorks prior to service launch, necessitating the hiring and training of their replacements shortly before service delivery began. BronxWorks experienced shortages of staff in CCC positions, originally identified as the pool of potential MOMS Clinicians for the pilot. As a result, the BronxWorks staff member acting as Program Coordinator, who had completed the appropriate trainings and had the requisite qualifications, served as the MOMS Clinician for one of the shelter sites. Towards the end of the pilot, BronxWorks agreed to manage a sanctuary shelter in response to the influx of migrants and asylum-seekers arriving in New York City. The shortage of MSW-level staff was exacerbated by the transfer of some shelter employees to the sanctuary shelter; as a result, the Program Coordinator acted as MOMS Clinician for both sites for the final session of MOMS SM.

Scheduling & Target Enrollment

Implementation of the NYC DHS MOMS Pilot required the execution of a memorandum of understanding between Yale University (on behalf of Elevate) and NYC DHS. The length of this initial contracting process delayed the launch of services, setting the pilot behind the initial schedule and goal to enroll to 100 participants within the first year. After service launch, the time between consecutive sessions of MOMS SM was reduced in an effort to maximize the number of clients served; the slow rate of client exit and entry from shelter, however, meant that the pool of clients who had not already participated and might be eligible for participation decreased with each round of recruitment. Originally, five cohorts of participants were planned to reach target enrollment. The pilot was extended for an additional session of MOMS SM at each shelter, or six total cohorts, reaching a total enrollment of 80 participants.

Covid-19 Pandemic

Since the onset of the pandemic, MOMS SM has been successfully delivered as a virtual program in several sites prior to the NYC DHS MOMS Pilot, and MOMS staff at BronxWorks received training in virtual service delivery. At the time of service launch, public health measures in shelter allowed for the in-person service delivery; however, the size of the available space at one shelter meant that the maximum number of participants was capped at eight for the first sessions of MOMS SM, rather than the initially planned maximum of ten. On a handful of occasions, MOMS staff determined that increased rates of Covid-19 in the community or the exposure of staff or clients increased the risk of in-person services, and class was held remotely for one to two weeks.

Language Barriers

For the purpose of this small-scale pilot, NYC DHS MOMS programming was limited to English-language services, which required that participants have sufficient fluency in English to engage in MOMS SM. Language was a barrier to participation for a number of BronxWorks clients. At the time of recruitment for Cohort 3 in January 2022, BronxWorks found that approximately 30% of prospective participants (parenting or caregiving women who had not yet participated in MOMS SM) were ineligible due to a language barrier.[12] By Cohort 6 recruitment in the fall of 2022, following an increase in the number of recent immigrants and asylum-seekers entering shelter beginning in the spring of 2022, this proportion had grown to about 50%.

Integration of the MOMS CMHA Role

Unlike other MOMS staff, the MOMS CMHA was a new position within the shelter established specifically for the NYC DHS MOMS Pilot. The MOMS CMHA engages with participants within and outside of class time for the duration of the MOMS SM session, helping participants to identify and solve problems, supporting connections to needed resources, and acting as an advocate for participants. Initially, shelter staff expressed concern about overlap or conflict between the MOMS CMHA's work responsibilities and preexisting staff roles. In response to these concerns, Elevate and MOMS staff at BronxWorks met with BronxWorks supervisors and leadership to discuss the MOMS CMHA role and the place of the MOMS CMHA within the shelter staff structure. BronxWorks initiated additional efforts to coordinate work between MOMS CMHAs, case managers, and CCCs and provided additional onboarding to increase MOMS CMHAs' familiarity and comfort within the work environment. These efforts were successful in helping to resolve initial concerns and promoting the collaboration of MOMS CMHAs and other staff to effectively serve MOMS participants and support broader shelter activities.

Shelter Exit during MOMS SM Participation

Shelter staff are continuously working to facilitate families' transition to permanent housing. To prevent disruptions to participation, eligibility required that a client did not have a planned move-out date during the eight-week period of the MOMS SM course at the time of recruitment. Still, several unanticipated shelter exits did occur during course participation. BronxWorks and Elevate determined that when feasible, participants who exited shelter before the end of the session could attend the remaining MOMS SM classes in person.

Service Delivery in the Shelter Setting

Among MOMS Partnership sites, the shelter setting is distinct in fully embedding the MOMS staff in a residential community of participants. There were straightforward benefits to this context for facilitating outreach and recruitment, and the setting may have helped reduce barriers to participant engagement and attendance. The shelter setting also made MOMS staff highly accessible to participants outside the hours of MOMS SM class or additional time designated for MOMS program

[12] Estimates of language barriers come from recruitment tracking tools created by BronxWorks staff. Prior to each round of recruitment, MOMS staff identified all households with adult women who had not yet participated in MOMS and were not scheduled for move-out during the upcoming cohort. For non-native English speakers, conversational ability in English was assessed through insight from assigned shelter staff and/or client outreach by the MOMS Clinician or CMHA. Records prior to Cohort 3 recruitment were not immediately available.

work. This was especially the case for MOMS CMHAs in the NYC DHS MOMS Pilot, whose workspaces were located in more heavily trafficked areas of the shelter sites. Participants in current and former MOMS SM sessions would frequently seek out the support of MOMS CMHAs, not unexpectedly: the MOMS CMHAs share unique lived experience with BronxWorks clients; in addition, participants may have perceived MOMS CMHAs as separate from the authority and formality of the shelter or the disciplinary functions associated with other human services staff.

This accessibility created initial challenges for the MOMS CMHAs, however, both in terms of managing their responsibilities and in setting necessary boundaries with former participants. In consultation with Elevate, BronxWorks staff developed processes and strategies for establishing more defined boundaries for MOMS CMHA time and effort, including approaches to responding to communication and requests from former participants and efforts to promote uninterrupted work time. Staff also found that additional efforts to prepare participants for the end of the MOMS SM session were successful in helping to establish and maintain these boundaries. As part of this preparation, the MOMS Clinician and CMHA introduced the subject of termination earlier in each MOMS SM session, supported by guidance from the Clinical Supervisor; they also worked to encourage and facilitate clients' engagement with their assigned CCCs, Case Managers, and Housing Specialists.

Evaluation

This report describes findings from a pre-post evaluation of self-reported outcomes measures, including outcomes related to participant mental health and wellbeing, social support, parenting confidence and self-esteem, and economic security and mobility, before and after participation in NYC DHS MOMS. Approval for this evaluation study was granted by the Department of Social Services (DSS) Office of Research and Policy Innovation.

PURPOSE

Evaluation of the NYC DHS MOMS Pilot aimed to test components of the program's multi-generational theory of change (**Appendix A**), which rests on the premise that MOMS Partnership programming leads to short-term improvements in maternal mental health and well-being, thereby improving outcomes for children, families, and communities in the long-term. The theory of change, constructed collaboratively by Elevate, DHS, and BronxWorks, represents the joint thought process on the outputs and outcomes that guided the NYC DHS MOMS Pilot.

Evaluation Questions

The pre-post evaluation addressed the following primary evaluation questions:

Did NYC DHS MOMS participants experience improvements in measures of mental health following participation in the MOMS SM course?

Did NYC DHS MOMS participants experience increased social support following participation in MOMS SM?

Did NYC DHS MOMS participants experience increased parenting confidence and self-esteem following participation in MOMS SM?

Did NYC DHS MOMS participants experience improvements in economic security and mobility following participation in MOMS SM?

The evaluation also examined participants' characteristics, MOMS SM class attendance, and level of satisfaction with MOMS SM.

METHODS

Measures and Data Collection

Self-reported data were used to evaluate changes in outputs and outcomes measures for BronxWorks clients before and after participation in MOMS SM. These measures were collected through assessment questionnaires at three time points, indicated in **Table 3**, administered using the

Research Electronic Data Capture (REDCap) platform.[13] Participants received a $50 cash gift card for completion of each assessment questionnaire.

Table 3: Assessment time points

ASSESSMENT	TIME POINT	ALLOWABLE COMPLETION WINDOW [a]
Baseline	Prior to Class 1	Between screening and first week of MOMS SM attendance [b]
Endpoint	Immediately after Class 8	Up to 21 days following Class 8
Follow-Up	Three months after Class 8	Between 84 and 112 days following Class 8

[a] For purposes of evaluation. Participants may have been allowed to complete an assessment outside of the window and receive the associated incentive at the discretion of MOMS staff in the interest of equity.

[b] This may have been Class 1 or Class 2, the latest possible opportunity to enroll in the MOMS SM session.

Assessment questionnaires reflected a collaborative decision-making process among Elevate, BronxWorks, DHS, and DSS partners. Initially, a set of measures was identified to test the short-term outcomes indicated in the Theory of Change. Elevate proposed drafts of the assessments to DHS and DSS for review and approval. NYC DHS MOMS staff had the opportunity to explore and test the assessments and additional data collection forms in the REDCap platform and debrief with and provide direct feedback to Elevate. Based on this feedback and discussion, Elevate and NYC DHS MOMS staff decided on changes to be implemented. These changes included modifications to user interface (for instance, the addition of a progress bar) as well as edits to language for clarity and relevance to the client population.

The assessments asked participants about items related to mental health and wellbeing, social support, parenting, and economic security and mobility. **Table 4** on the following page describes the specific items measured within each category and instruments of measurement used.

[13] Harris, P.A., Taylor, R., Thielke, R., Payne, J., Gonzalez, N., & Conde, J.G. (2009). Research electronic data capture (REDCap) – a metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics, 42*(2), 377–381.

Harris, P. A., Taylor, R., Minor, B. L., Elliott, V., Fernandez, M., O'Neal, L., McLeod, L., Delacqua, G., Delacqua, F., Kirby, J., & Duda, S. N. (2019). The REDCap consortium: Building an international community of software platform partners. *Journal of Biomedical Informatics*, 95.

Table 4: Outcomes measures and instruments of measurement

CATEGORY	ITEM MEASURED	INSTRUMENT OF MEASUREMENT
Mental Health and Wellbeing	Depressive symptoms	CES-D
	Depression severity [a]	PHQ-9
	Perceived stress	Cohen Perceived Stress Scale 4-Item (PSS-4)[14]
	Anxiety symptoms	Generalized Anxiety Disorder 7-Item Scale (GAD-7)[15]
	Traumatic stress symptoms	Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)[16], Question 1 PTSD Checklist for DSM-5 (PCL-5)[17]
	Emotional regulation	Difficulties in Emotion Regulation – Short Form (DERS-SF)[18]
	Self-efficacy	New General Self-Efficacy Scale[19]
Social Support	Perceived social support	MOS Social Support Survey (MOS-SSS)[20]
	Perceived instrumental support	*Questions adapted from research by Jackson et al., 2000*[21]

[14] Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*(4), 385–396.

[15] Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097.

[16] Prins, A., Bovin, M. J., Smolenski, D. J., Marx, B. P., Kimerling, R., Jenkins-Guarnieri, M. A., Kaloupek, D. G., Schnurr, P. P., Kaiser, A. P., Leyva, Y. E., & Tiet, Q. Q. (2016). The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5): Development and evaluation within a veteran primary care sample. *Journal of General Internal Medicine*, *31*(10), 1206–1211.

[17] Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress*, *28*(6), 489–498.

[18] Kaufman, E. A., Xia, M., Fosco, G., Yaptangco, M., Skidmore, C. R., & Crowell, S. E. (2016). The Difficulties in Emotion Regulation Scale Short Form (DERS-SF): Validation and replication in adolescent and adult samples. *Journal of Psychopathology and Behavioral Assessment, 38*(3), 443–455.

[19] Chen, G., Gully, S. M., & Eden, D. (2001). Validation of a new general self-efficacy scale. *Organizational Research Methods, 4*(1), 62–83.

[20] Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social Science & Medicine*, *32*(6), 705–714.

[21] Jackson, A. P., Brooks-Gunn, J., Huang, C. C., & Glassman, M. (2000). Single mothers in low-wage jobs: Financial strain, parenting, and preschoolers' outcomes. *Child Development*, *71*(5), 1409–1423.

CATEGORY	ITEM MEASURED	INSTRUMENT OF MEASUREMENT
Parenting	Parenting confidence and self-esteem	Parenting Sense of Competence (PSOC)[22]
Economic Security and Mobility	Employment status	*Questions developed or adapted for MOMS Partnership research & evaluation*
	Financial stress	
	Basic needs	
Program Satisfaction	MOMS SM course satisfaction	*Questions developed or adapted for MOMS Partnership research & evaluation*

[a] Earlier evaluation documents may also have referred to this item as "Major depressive episode."

Some participant demographic data and data on length of shelter stay were provided by BronxWorks from records in the CARES database used by DHS. All client data were deidentified prior to collection by Elevate and linked using a unique ID number assigned to each individual at the time of Screening.

Participant Sample

Over the course of the NYC DHS MOMS Pilot, a total of 94 BronxWorks clients completed Screening for eligibility; 93 (98.9%) were determined eligible to participate. Of 88 eligible and scheduled for a MOMS SM session, a total of 80 clients (90.9%) ultimately enrolled in MOMS SM. Among those who did not enroll, 4 of the clients had exited shelter before the first MOMS SM class.

Of 80 clients who enrolled, **69** were included in some component of the study analysis. Eleven participants were excluded for the following reasons:

- **Participation in more than one MOMS SM cohort (7 participants)**

  In certain circumstances, participants may be unable to continue attending the MOMS SM session in which they initially enrolled. Participants in NYC DHS MOMS who had attended no more than two classes as part of their original cohort were allowed to complete Screening again during a later round of recruitment and, if eligible, re-enroll in that MOMS SM session. Five participants in the NYC DHS MOMS Pilot completed a second Screening and enrolled as part of a new cohort following their initial class attendance. A further two participants re-enrolled after the fourth session of MOMS SM at Jackson was cancelled following Class 2; in this case, participants were not required to complete a second Screening.

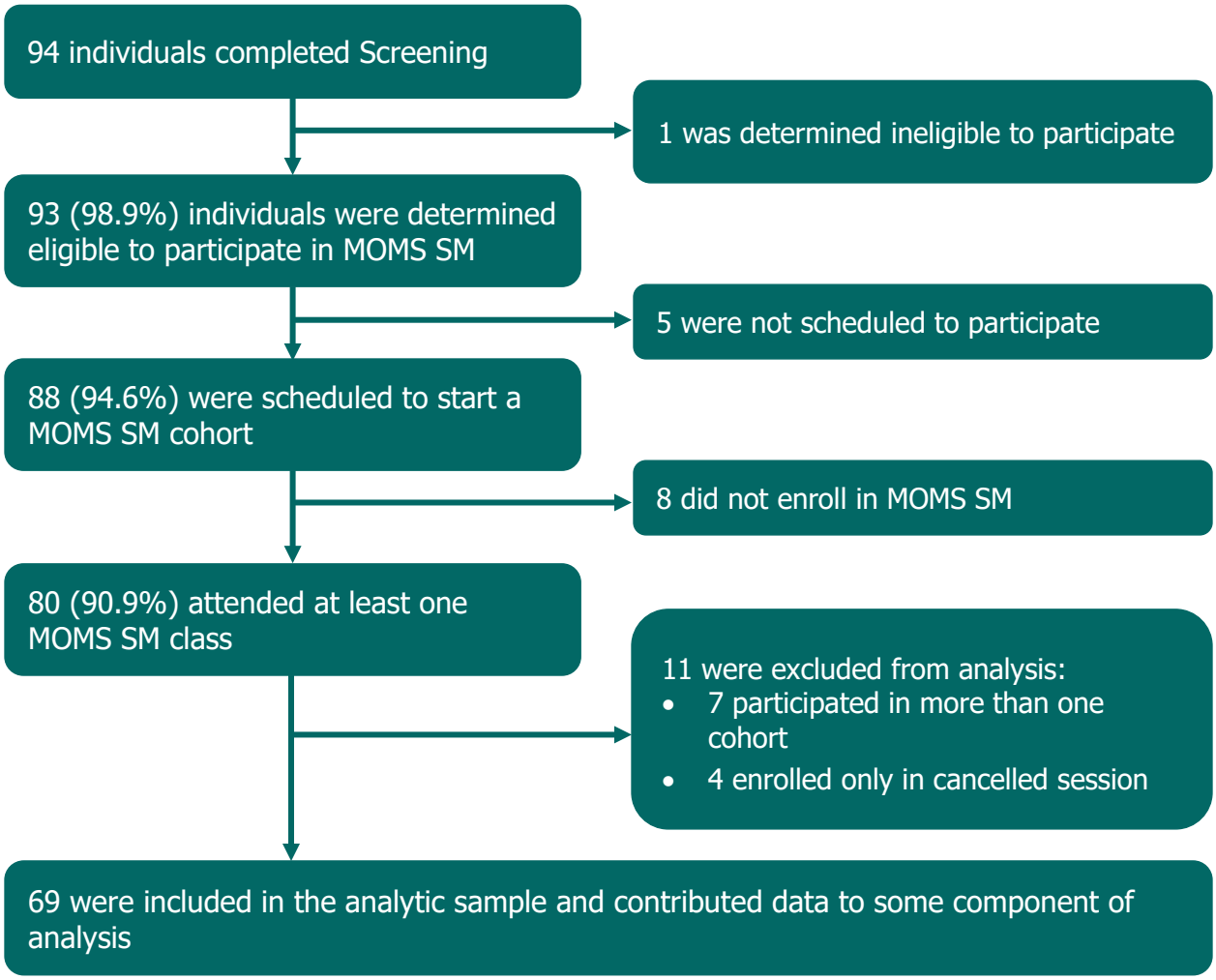
- **Participation in cancelled MOMS SM session (4 participants)**

  In addition to those who re-enrolled, four participants who had enrolled only in the cancelled MOMS SM session at Jackson were excluded from analysis.

[22] Gibaud-Wallston, J. (1977). *Self-esteem and situational stress factors related to sense of competence in new parents.* (Unpublished doctoral dissertation). Nashville: Vanderbilt University. [See also: Johnston, C., & Mash, E. J. (1989). A measure of parenting satisfaction and efficacy. *Journal of Clinical Child Psychology*, *18*(2), 167–175.]

An illustration of the flow of clients from Recruitment to course enrollment, including evaluation activities, is included in **Figure 2** on the following page.

Figure 2: Flow of Individuals from Screening through Participation



Analysis

Descriptive statistics used to summarize data in this report are given in **Table 5**. The sample size of participants (n) for each set of analyses is provided in the table heading. If the sample size is different for one or more measures in the table — e.g., if some participants did not respond to a particular question — the sample size for those measures is indicated in the table.

Table 5: Descriptive statistics and examples

VARIABLE TYPE	STATISTICS REPORTED *Format*	EXAMPLE	
Continuous data that is normally distributed	Mean, standard deviation *Mean (SD)*	PSS-4 scores at Baseline (n=59)	Mean (SD)
			7.7 (2.29)
Continuous data that is not normally distributed	Median, 1st quartile, 3rd quartile *Median (Q1, Q3)*	CES-D scores at Screening (n = 62)	Median (Q1, Q3)
			25 (19, 35)
Categorical data	Frequency, percentage *n (%)*	Currently working for pay (n = 65)	n (%)
		Yes	10 (15.4%)

Statistical analyses were used to test for differences between pre- and post-participation outcome measures. These include paired t-tests for continuous, normally distributed data; Wilcoxon signed-rank tests for continuous data that was not normally distributed; and McNemar's tests for dichotomous (binary) categorical data. Statistical significance is considered to be $p<.05$ in this report. For cases where pre-post tests were conducted, significance level is given in the *Sig.* column using the following notation: * $p<.05$, ** $p< .01$, *** $p<.001$.

Of 69 individuals in the participant sample, 65 completed the Baseline assessment; among them, 61 completed at least one subsequent assessment (Endpoint or Follow-Up). Participants were not required to respond to each question and may not have provided sufficient data to calculate a score for some outcome measures. Missing data were addressed using pairwise deletion to maximize the sample size available for each analysis; analyses of change between two assessments include all participants for whom data was available. Sample sizes for comparisons between Baseline and Endpoint and Baseline and Follow-Up reflect this missingness. An example is given below.

Table 6 compares CES-D scores at the Baseline and Endpoint assessments and at the Baseline and Follow-Up assessments. The left-most column provides the sample sizes for each comparison.

Table 6: CES-D scores, Baseline to Endpoint & Follow-Up

	BASELINE Median (Q1, Q3)	ENDPOINT Median (Q1, Q3)	FOLLOW-UP Median (Q1, Q3)	SIG.
CES-D (n=52)	24 (17, 32.5)	19 (12, 29)	–	**
CES-D (n=49)	25 (17, 34)	–	20 (10, 29)	***

The table indicates that CES-D scores at both Baseline and Endpoint were available for 52 participants, and CES-D scores at both Baseline and Follow-Up were available for 49 participants. There may not be complete overlap between these samples.

In this case, the analyses represent 57 distinct participants. Of the 52 participants in the Baseline-Endpoint comparison, 44 had CES-D scores available at Follow-Up; 8 did not. The Baseline-Follow-Up comparison includes 5 participants who had scores available at Follow-Up but not at Endpoint. Additional participants completed each of these assessments, but CES-D scores could not be calculated due to missing responses on the instrument.

For clarity, these details are not provided for each analysis in the report but are available upon request.

Limitations

There are several limitations that should be considered while interpreting the evaluation results. Participants were not required to complete assessments, and the Endpoint and Follow-Up assessments were only administered to customers who attended at least one class. Analyses of some self-report outcomes measures are impacted by small sample size, which may decrease the ability to detect differences between time points.

Some sources of potential bias to consider when interpreting the results of this evaluation include the following:

- Clients were incentivized for participation in the NYC DHS MOMS Pilot, including eligibility screening, attendance, and assessments.
- Completion of assessments was voluntary, and the kinds of outcomes studied in the evaluation may be associated with participants' likelihood of completing the assessments.
- Outcomes were assessed using self-report measures, which are subject to bias.
- The Baseline assessment did not represent a perfect baseline measurement, as the assessment was completed after several points of interaction with MOMS staff.

This report indicates whether statistically significant change was found for participant outcomes, but this does not always translate to meaningful change. At the same time, the absence of a statistically significant finding does not always mean the absence of change. Finally, the pre-post design of this evaluation means that significant findings in this report indicate an association between NYC DHS MOMS participation and change in outcomes but do not establish causation.

Participation in the NYC DHS MOMS Pilot

PARTICIPANT CHARACTERISTICS

KEY POINTS

Participants had been residing in BronxWorks shelter for an average 22 consecutive weeks at the start of MOMS SM, and for nearly 40 consecutive weeks in *any* shelter.

More than 80% of participating clients identified as Black or African American, and nearly 30% of participants identified as Hispanic/Latino.

Nearly 70% of participants were the sole adult in their household, and about half of participants had at least 3 children in their household.

Only 15% of participants reported working for pay at the start of MOMS SM.

Nearly a quarter of participants said they had needed but not received mental health services at some point in the year before MOMS SM.

Demographics and Weeks in Shelter

Data on demographics were collected through the Baseline assessment and from CARES database records for the 69 participants included in analysis.

Table 7: Demographic characteristics of NYC DHS MOMS participants

CHARACTERISTIC	MEAN (SD)
Age in years (n=69)	31.5 (8.2)
Consecutive weeks residing in BronxWorks shelter (n=69)	21.8 (20.7)
Consecutive weeks residing in any shelter (n=65)	39.4 (59.2)
CHARACTERISTIC	**n (%)**
Race and ethnicity [a] (responses are non-exclusive; n=69)	
Black or African American	57 (82.6%)
Hispanic/Latino	20 (29.0%)
White	12 (17.4%)

CHARACTERISTIC	n (%)
Place of birth (n=63)	
In the U.S.	54 (85.7%)
Not in the U.S.	9 (14.3%)
Number of adults in household, inclusive of participant (n=69)	
1	47 (68.1%)
2 or more	22 (31.9%)
Number of children under 18 in household (n=69)	
1 [b]	16 (23.2%)
2	19 (27.5%)
3	21 (30.4%)
4+	13 (18.8%)
Highest level of education completed (n=65)	
Less than high school	10 (15.4%)
Some high school or some GED classes	12 (18.5%)
High school graduate or GED completed	25 (38.5%)
Some college or vocational school	11 (16.9%)
College graduate	7 (10.8%)
Currently working for pay (n=65)	
Yes	10 (15.4%)
No	55 (84.6%)

[a] Racial/ethnic categories that represent fewer than 5 participants are excluded from the report to protect participant identities.

[b] Includes clients who were pregnant at the time of NYC DHS MOMS participation without other children in the household.

Public Assistance and Basic Need

The Baseline assessment asked participants about their receipt of public assistance and benefits as well as basic need and material hardship in the past 12 months. Most participants (88%) were receiving SNAP benefits, 63% were enrolled in Medicaid or Essential Plan, and about 59% received Cash Assistance. The large majority of participants (92%) reported going without needs in the past year because they were short of money, and 63% said they had experienced running out of food before the end of the month.

Table 8: Public assistance and basic need among NYC DHS MOMS participants

CHARACTERISTIC	n (%)
Currently receiving the following benefit (responses are non-exclusive; n=65) *Note: receipt was self-reported by participant, not based on administrative records*	
SNAP (Food Stamps)	57 (87.7%)
Medicaid or Essential Plan	41 (63.1%)
Cash Assistance	38 (58.5%)
Children's Medical or Child Health Plus	19 (29.2%)
WIC	15 (23.1%)
"Have you or your family gone without things you really needed in the past year because you were short of money?" (n=65)	
Yes (sometimes or often)	60 (92.3%)
No	5 (7.7%)
"In the past year, has your family…" (responses are non-exclusive; n=65)	
Run out of food before the end of the month	41 (63.1%)
Borrowed food or money from family or friends	41 (63.1%)
Used a food bank	21 (32.3%)
Pawned or sold something	16 (24.6%)
Gone without food sometimes	11 (16.9%)

Past Mental Health Service Utilization

The Baseline assessment also included questions about participants' use of mental health services in the past twelve months, adapted from questions used in the National Survey on Drug Use and Health.[23] Most participants (83%) had not received mental health services in the past year, while nearly a quarter of participants (23%) indicated that they needed mental health care but did not receive it at some point in the past year.

Table 9: Past-year receipt of mental health services

CHARACTERISTIC	n (%)
Received outpatient mental health services during past 12 months (n=64)	
Yes	10 (15.6%)
No	54 (84.4%)
Received any mental health services during past 12 months [a] (n=64)	
Yes	11 (17.2%)
No	53 (82.8%)
"During the past 12 months, was there any time when you needed mental health treatment or counseling for yourself but didn't get it?" (n=64)	
Yes	15 (23.4%)
No	49 (76.6%)

[a] Endorsed either inpatient or outpatient mental health care in past year, not including medication alone.

[23] Center for Behavioral Health Statistics and Quality. (2014). *2015 National Survey on Drug Use and Health (NSDUH): CAI specifications for programming (English version)*. Substance Abuse and Mental Health Services Administration.

CLASS ATTENDANCE

KEY POINTS

The median class attendance was 6 out of 8 total classes.

Nearly 20% of participants attended all eight classes.

The MOMS SM course was delivered as eight 90-minute classes once per week. A client must have attended either Class 1 or Class 2 to participate in the remaining classes for the MOMS SM cohort. Median attendance was six out of eight MOMS SM classes, and about 19% of participants attended all eight classes. **Figure 3** provides a breakdown of total attendance for participants included in analysis. **Table 10** summarizes mean and median class attendance for participants included in analysis by shelter and overall.

Figure 3: SM class attendance (n = 69)

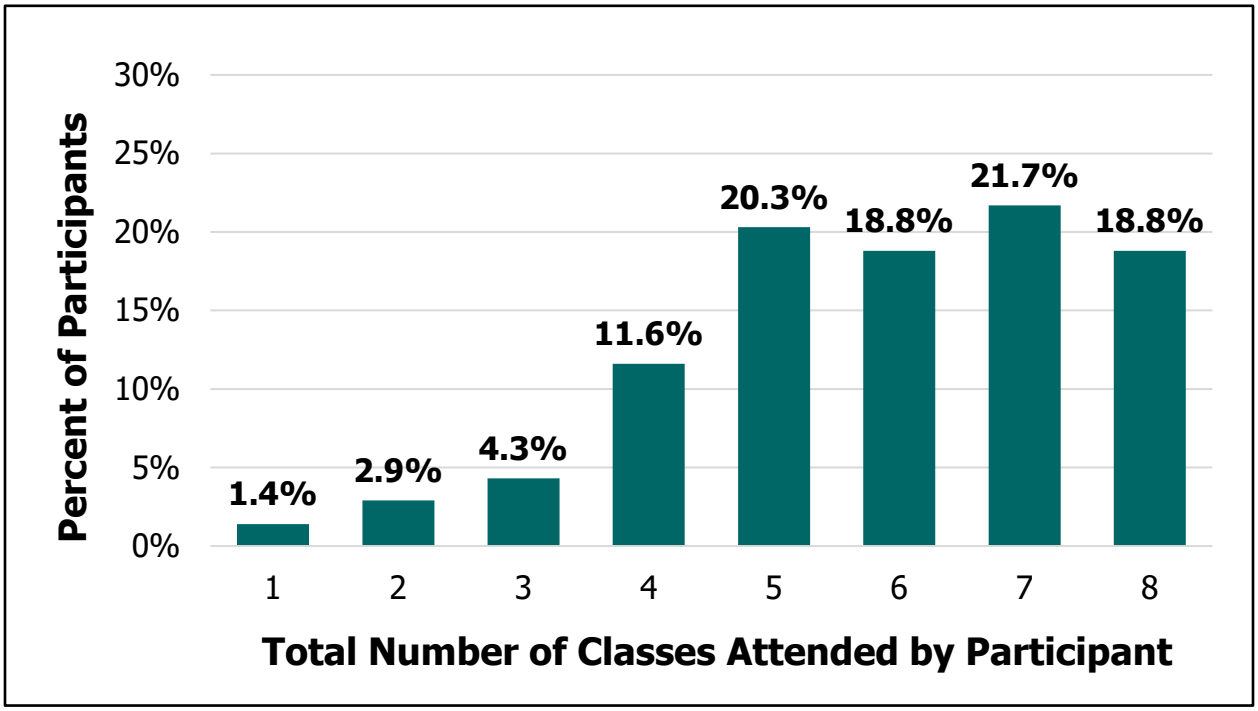


Table 10: SM class attendance (n = 69)

	MEAN (SD)	MEDIAN (Q1, Q3)
Number of classes attended [a]	5.8 (1.7)	6 (5, 7)

[a] Class attendance is measured in whole numbers, so both mean and median are reported.

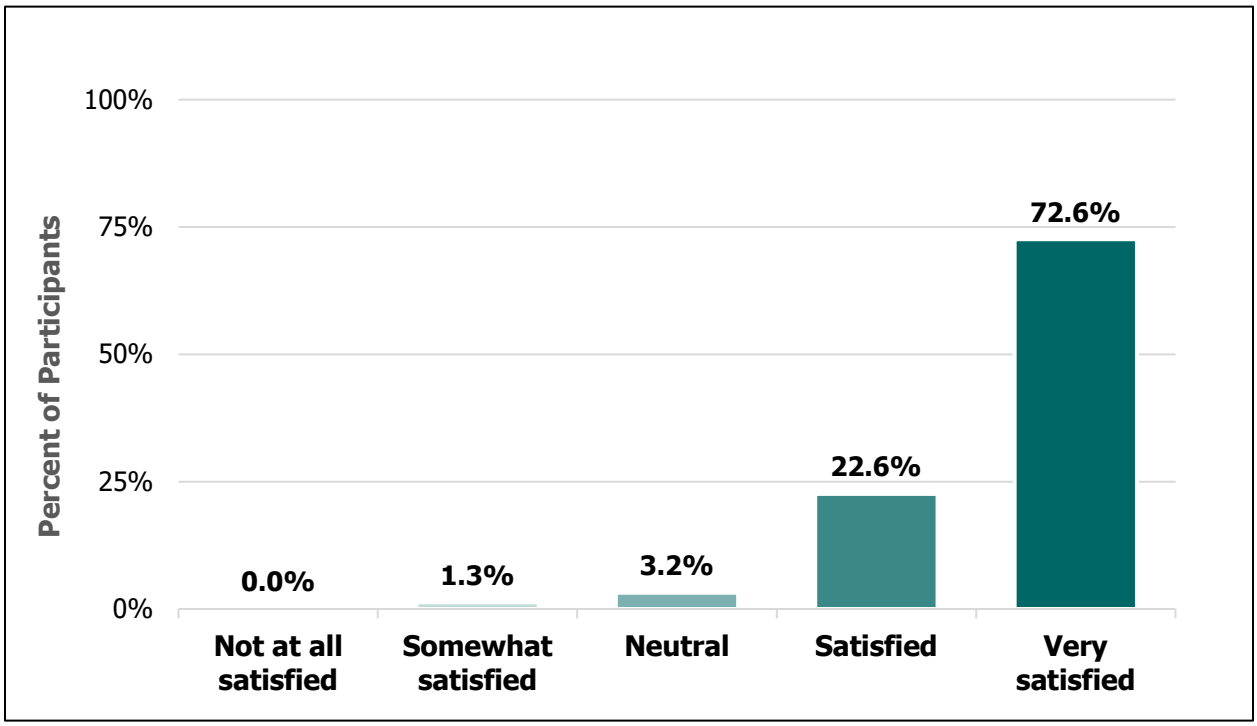
PARTICIPANT SATISFACTION

KEY POINTS

Nearly all participants were satisfied or very satisfied with the MOMS SM course.

Participants who attended at least one MOMS SM class were asked about their level of satisfaction with the MOMS SM course at Endpoint; response choices ranged from "Not at all satisfied" to "Very satisfied". Nearly all participants reported that they were satisfied or very satisfied with the MOMS SM course (96%).

Figure 4: Satisfaction with the MOMS SM course at Endpoint (n = 62)



Outcomes

MENTAL HEALTH AND WELLBEING

KEY POINTS

Participants demonstrated significant improvements on measures of depression between Baseline and Endpoint and sustained improvements at Follow-Up.

Perceived stress decreased significantly between Baseline and Follow-Up.

Participants' anxiety symptoms decreased significantly between Baseline and Endpoint and remained significantly lower at Follow-Up compared to Baseline.

At Baseline, about 60% of participants reported having experienced a traumatic event. Traumatic stress symptoms were significantly lower at Follow-Up compared to Baseline.

Depressive Symptoms

Depressive symptoms were measured at Screening, Baseline, Endpoint, and Follow-Up using the Center for Epidemiological Studies Depression Scale (CES-D). The CES-D is a 20-question instrument that asks respondents to identify how often they may have felt certain ways in the past week. Responses range from "Rarely or none of the time (Less than 1 day)" to "Most or all of the time (5 – 7 days)." Scores range from 0 – 60, with higher scores indicating greater depressive symptoms.

A Note on Screening and Baseline Scores

The Baseline Assessment was typically administered before a participant's first MOMS SM class, however, participants experienced engagement with NYC DHS MOMS staff before completing the Baseline Assessment. We examined whether there was a change in CES-D scores between Screening and Baseline for the analytic sample. CES-D scores at Baseline were significantly lower than at Screening.

Table 11: CES-D scores, Screening to Baseline (n=62[a])

	SCREENING Median (Q1, Q3)	BASELINE Median (Q1, Q3)	SIG.
CES-D	25 (19, 35)	22 (15, 32)	***

*p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

[a] Median Baseline CES-D was slightly higher among the 57 individuals who also completed either

Linear Change

To examine the change in participant depressive symptoms, we compared CES-D scores at Baseline to scores at Endpoint and Follow-Up. In all comparisons, CES-D scores at Endpoint or Follow-Up were found to be significantly lower than those at Baseline, suggesting a decrease in depressive symptoms after the course that was sustained after three months.

Table 12: CES-D scores, Baseline to Endpoint & Follow-Up

	BASELINE Median (Q1, Q3)	ENDPOINT Median (Q1, Q3)	FOLLOW-UP Median (Q1, Q3)	SIG.
CES-D (n=52)	24 (17, 32.5)	19 (12, 29)	–	**
CES-D (n=49)	25 (17, 34)	–	20 (10, 29)	***

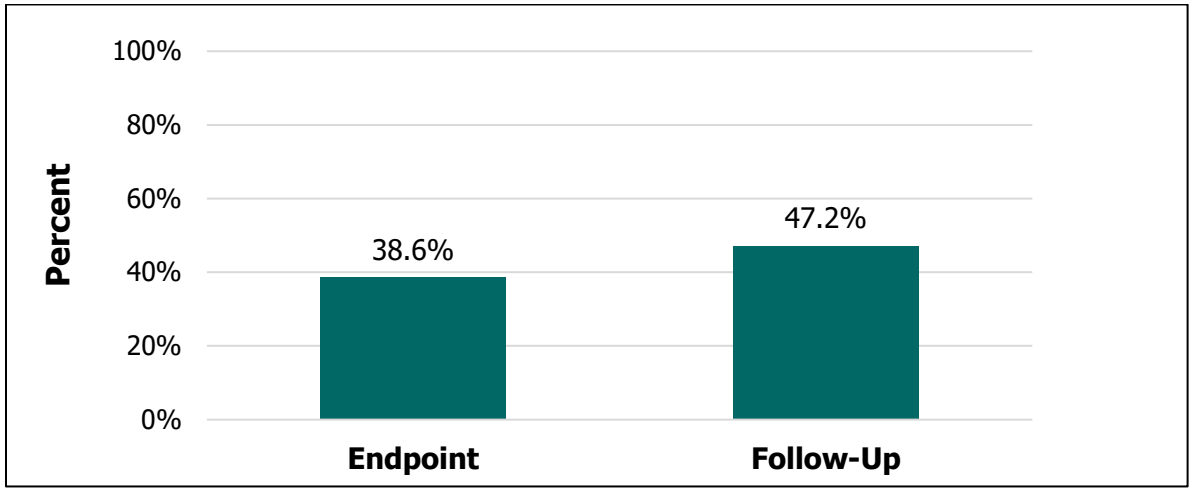
* p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

Dichotomous Change

An additional way to analyze change in depression symptoms is to dichotomize or create two categories of depression symptoms. We examined two categories using the commonly used threshold of 16 (at risk for clinical depression); one category includes CES-D scores below 16 and the other category includes CES-D scores of 16 or higher. By dichotomizing the CES-D score at the threshold of 16 we can get an estimate of how many participants reduced their depressive symptoms below the threshold of at risk for clinical depression. Examination of the proportion of participants in this category is another way to understand a decrease in depressive symptoms; we examined the proportion of participants in the category of CES-D score <16 at Endpoint and Follow-Up.

As an eligibility criterion for MOMS SM, participants must have been at or above the threshold CES-D score of 16 at the time of screening. At Endpoint, nearly 40% of participants were below the threshold for risk for clinical depression; at Follow-Up, the proportion of participants was about 47%.

Figure 5: Percent of participants with CES-D score < 16, Endpoint & Follow-Up



Depression Severity

In addition to the CES-D measure, depression severity (indicative of possible major depressive episode) was measured at Baseline, Endpoint and Follow-Up using the Patient Health Questionnaire-9 (PHQ-9). The PHQ-9 is a 10-question instrument that asks respondents to identify how often they have been bothered by problems in the last two weeks. Responses range from "Not at all" to "Nearly every day". A total score is calculated by summing 9 questions; scores range from 0 – 27, with higher scores indicating greater depression severity.

There was a significant decrease in PHQ-9 scores from Baseline to Endpoint and Follow-Up, suggesting a reduction in depression severity and likelihood of major depression after the course and the reduction was sustained after three months.

Table 13: PHQ-9 scores, Baseline to Endpoint & Follow-Up

	BASELINE Median (Q1, Q3)	ENDPOINT Median (Q1, Q3)	FOLLOW-UP Median (Q1, Q3)	SIG.
PHQ-9 (n=54)	9.5 (4, 13)	7 (2, 11)	–	*
PHQ-9 (n=47)	9 (4, 13)	–	4 (1, 9)	***

* p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

Perceived Stress

Stress was measured at Baseline, Endpoint, and Follow-Up using the Perceived Stress Scale 4 (PSS-4), a four-item questionnaire that measures "the degree to which situations in one's life are appraised

as stressful". The questions ask how often the respondent felt or thought a certain way during the past month on a five-point scale; responses range from "Never" to "Very Often". The total score is the sum of response values for all four questions. Scores range from 0 – 16, with higher scores indicating greater perceived stress.

PSS-4 decreased significantly between Baseline and Follow-Up, suggesting a reduction in perceived stress between the start of the course and three months after participation.

Table 14: PSS-4 scores, Baseline to Endpoint & Follow-Up

	BASELINE Mean (SD)	ENDPOINT Mean (SD)	FOLLOW-UP Mean (SD)	SIG.
PSS-4 (n=59)	7.7 (2.9)	7.3 (2.9)	–	–
PSS-4 (n=50)	7.7 (3.1)	–	6.8 (2.8)	*

* p<.05, ** p< .01, *** p<.001; paired t-test

Anxiety Symptoms

Anxiety was measured at Baseline, Endpoint, and Follow-Up using the Generalized Anxiety Disorder 7-item scale (GAD-7), a 7-item questionnaire that asks about how often the respondent has been bothered by certain problems over the past two weeks. Responses range from "Not at all" to "Nearly every day". The total score is the sum of response values for the seven questions. Scores range from 0 – 21, with higher scores indicating greater severity of anxiety.

There was a significant decrease in GAD-7 scores from Baseline to Endpoint and Follow-Up, suggesting an overall decrease in generalized anxiety symptoms immediately after the course that was sustained after three months.

Table 15: GAD-7 scores, Baseline to Endpoint & Follow-Up

	BASELINE Median (Q1, Q3)	ENDPOINT Median (Q1, Q3)	FOLLOW-UP Median (Q1, Q3)	SIG.
GAD-7 (n=54)	6 (2, 12)	4.5 (2, 8)	–	**
GAD-7 (n=49)	6 (2, 12)	–	3 (0, 7)	***

* p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

Traumatic Stress Symptoms

The prevalence of experiencing a traumatic event was assessed at Baseline using a question from the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), which defines a traumatic event as "unusually or especially frightening, horrible, or traumatic." Post-traumatic stress symptoms were measured at Baseline, Endpoint, and Follow-Up using the PTSD Checklist for DSM-5 (PCL-5), which was administered regardless of whether a participant endorsed having experienced a traumatic event. Participants were asked to indicate how often they were bothered by a certain problem in the last month; responses range from "Not at all" to "Extremely" bothered. Total scores were calculated by summing responses to all questions and range from 0 – 80, with higher scores indicating greater post-traumatic stress symptoms. At Baseline, about 60% of participants endorsed having experienced a traumatic event.

A significant decrease in PCL-5 scores was seen from Baseline to Follow-Up, suggesting a reduction in traumatic stress symptoms between the start of the course and three months after participation.

Table 16: Participants who reported having previously experienced a traumatic event, assessed at Baseline (n=64)

Endorsed having experienced a traumatic event	n (%)
Yes	38 (59.4%)
No	26 (40.6%)

Table 17: PCL-5 scores, Baseline to Endpoint & Follow-Up

	BASELINE Median (Q1, Q3)	ENDPOINT Median (Q1, Q3)	FOLLOW-UP Median (Q1, Q3)	SIG.
PCL-5 (n=47)	22 (11, 40)	20 (10, 39)	–	–
PCL-5 (n=42)	23.5 (13, 40)	–	18 (8, 35)	*

* p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

Emotion Regulation

Emotion regulation was measured at Baseline, Endpoint, and Follow-Up using the Difficulties in Emotion Regulation Scale – Short Form (DERS-SF). *Emotion regulation* refers to the ability to identify, understand, and accept emotional experiences, and to modulate emotional responses based on a situation. The DERS-SF is an 18-item questionnaire that asks how often, or what percentage of the time, certain statements apply to the respondent; responses range from "Almost never (0 – 10%)" to "Almost always (91 – 100%). Total scores were calculated by summing responses to all questions and range from 18 – 90, with higher scores indicating greater difficulties with emotion regulation.

No difference in DERS-SF total scores was detected between Baseline and Endpoint or Baseline and Follow-Up.

Table 18: DERS-SF total scores, Baseline to Endpoint & Follow-Up

	BASELINE Median (Q1, Q3)	ENDPOINT Median (Q1, Q3)	FOLLOW-UP Median (Q1, Q3)	SIG.
DERS-SF (n=53)	37 (28, 47)	33 (26, 43)	–	–
DERS-SF (n=45)	36 (28, 46)	–	34 (27, 41)	–

* p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

Self-Efficacy

General self-efficacy, which describes one's belief in their ability to succeed in different situations and at tasks and goals, was measured at Baseline, Endpoint and Follow-Up using the New General Self-Efficacy Scale (NGSES). The NGSES asks respondents to indicate how strongly they agreed with certain statements; responses range from "Strongly disagree" to "Strongly agree." Scores range from 1 – 5, with higher scores indicating greater self-efficacy.

No significant difference in NGSES scores was detected between Baseline and Endpoint or Baseline and Follow-Up.

Table 19: NGSES scores, Baseline to Endpoint & Follow-Up

	BASELINE Median (Q1, Q3)	ENDPOINT Median (Q1, Q3)	FOLLOW-UP Median (Q1, Q3)	SIG.
NGSES (n=54)	4 (3.4, 4.5)	4 (3.8, 4.5)	–	–
NGSES (n=43)	3.9 (3.3, 4.5)	–	4 (3.8, 4.8)	–

* p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

SOCIAL SUPPORT

KEY POINTS

Participants' perceived social support increased significantly between Baseline and Endpoint across all types of support measured and overall. At Follow-Up, scores remained significantly higher than at Baseline.

Participants reported significantly greater instrumental support — support to meet concrete and tangible needs — at Endpoint and Follow-Up compared to Baseline.

Perceived Social Support

Social support was measured at Baseline, Endpoint, and Follow-Up using the Medical Outcomes Study Social Support Survey (MOS-SSS), a 19-item questionnaire that measures overall functional social support and four social support subscales[24]. The four subscales are:

- Emotional/Informational Support
- Tangible Support
- Affectionate Support
- Positive Social Interaction

The questions ask about often certain forms of support are available to the respondent; responses range from "None of the time" to "All of the time". Scores for this scale and subscales were calculated according to guidance from the publisher and range from 0 – 100 [25], with higher scores indicating greater availability of support.

Example questions from each subscale are given below.

Table 20: MOS-SSS subscales

MOS-SSS SUBSCALES	EXAMPLE ITEMS
Emotional / Informational Support	Someone you can count on to listen to you when you need to talk
Tangible Support	Someone to help you if you were confined to bed
Affectionate Support	Someone who shows you love and affection
Positive Social Interaction	Someone to have a good time with

[24] Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social Science & Medicine*, 32(6), 705–714.

[25] Per guidance from the publisher, MOS-SSS scores were calculated by taking the average of the items in each scale and then transforming the values to a 0 – 100 scale using a formula (provided by the publisher). The transformed scores can then be compared to other studies if desired.

There was a significant increase in MOS-SSS overall scores and scores for all subscales from Baseline to Endpoint and Follow-Up, suggesting that participants perceived greater social support after the course and three months after participation.

Table 21: MOS-SSS scores, Baseline to Endpoint

	BASELINE Median (Q1, Q3)	ENDPOINT Median (Q1, Q3)	SIG.
Emotional / Informational Support (n=56)	40.6 (21.9, 62.5)	70.3 (50.0, 100)	***
Tangible Support (n=57)	31.3 (0, 68.8)	56.3 (25.0, 100)	***
Affectionate Support (n=58)	66.7 (41.7, 100)	87.5 (58.3, 100)	***
Positive Social Interaction (n=57)	50 (41.7, 75)	75 (50, 100)	***
Overall Social Support (n=52)	46.7 (28.9, 67.1)	70.4 (50.7, 89.5)	***

* p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

Table 22: MOS-SSS scores, Baseline to Follow-Up

	BASELINE Median (Q1, Q3)	FOLLOW-UP Median (Q1, Q3)	SIG.
Emotional / Informational Support (n=51)	34.4 (21.9, 50)	65.6 (50, 78.1)	***
Tangible Support (n=51)	31.3 (0, 56.3)	68.8 (25, 100)	***
Affectionate Support (n=50)	66.7 (41.7, 100)	75 (58.3, 100)	***
Positive Social Interaction (n=49)	50 (33.3, 66.7)	75 (50, 83.3)	**
Overall Social Support (n=46)	40.8 (26.3, 60.5)	71.1 (50, 81.6)	***

* p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

Perceived Instrumental Support

Instrumental support — social support that helps to meet concrete and tangible needs — was measured at Baseline, Endpoint, and Follow-Up using four questions from the research literature.[26] Respondents were asked whether certain forms of help were available "from others if such support was needed"; response choices ranged from "Never true" to "True all of the time". The total score is the average of response values for all four questions. Scores range from 0 – 5, with higher scores indicating greater instrumental support.

There was a significant increase in scores measuring instrumental support from Baseline to Endpoint and Follow-Up, suggesting that participants felt that forms of concrete and tangible support were more available to them after the course and three months after participation.

Table 23: Instrumental social support scores, Baseline to Endpoint & Follow-Up

	BASELINE Median (Q1, Q3)	ENDPOINT Median (Q1, Q3)	FOLLOW-UP Median (Q1, Q3)	SIG.
Instrumental support (n=57)	1.3 (0.5, 2.0)	1.8 (1.3, 2.8)	–	*
Instrumental support (n=50)	1.3 (0.5, 1.8)	–	1.8 (1.3, 2.8)	**

* p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

[26] Jackson, A. P., Brooks-Gunn, J., Huang, C. C., & Glassman, M. (2000). Single mothers in low-wage jobs: Financial strain, parenting, and preschoolers' outcomes. *Child Development*, *71*(5), 1409–1423.

PARENTING CONFIDENCE AND SELF-ESTEEM

KEY POINTS

Measures of parenting confidence and self-esteem did not differ significantly between Baseline and Follow-Up.

Parenting confidence and self-esteem were measured at Baseline and Follow-Up using the Parenting Sense of Competence Scale (PSOC). Participants were asked to indicate their level of agreement or disagreement (on a 6-point scale) with statements regarding their attitudes towards parenting. The PSOC includes two subscales that measure parenting satisfaction and efficacy. Scores were calculated by summing the responses for the scale or subscale. Total scores range from 17-102 and subscales scores range from 9 – 54 for satisfaction and 7 – 42 for efficacy, with higher scores indicating a greater sense of parenting confidence and self-esteem, satisfaction, or efficacy.

No difference in PSOC scores was detected between Baseline and Follow-Up.

Table 24: PSOC scores, Baseline to Follow-Up

	BASELINE Median (Q1, Q3)	FOLLOW-UP Median (Q1, Q3)	SIG.
PSOC total score (n=50)	75.5 (66, 82)	76 (67, 82)	–
PSOC satisfaction (n=50)	37 (31, 41)	37 (32, 43)	–
PSOC efficacy (n=51)	33 (28, 36)	33 (27, 37)	–

* p<.05, ** p<.01, *** p<.001; Wilcoxon signed-rank test

ECONOMIC SECURITY AND MOBILITY

KEY POINTS

The percentage of participants who reported a high level of financial stress decreased significantly between Baseline and Follow-Up, although the increase in self-reported employment was not statistically significant.

At Endpoint and Follow-Up, fewer participants reported trouble paying for clothes and shoes compared to Baseline. The proportion reporting trouble paying for hygiene products also decreased significantly from Baseline to Follow-Up.

Employment

Participants were asked whether they were currently working for pay at Baseline, Endpoint and Follow-Up. While the number of and percentage of participants working for pay was greater at Endpoint and Follow-Up than Baseline, a difference in proportions was not detected in analysis.

Table 25: Participants working for pay, Baseline to Endpoint & Follow-Up

	BASELINE n (%)	ENDPOINT n (%)	FOLLOW-UP n (%)	SIG.
Working for pay (n=59)	9 (15.3%)	15 (25.4%)	–	–
Working for pay (n=51)	8 (15.7%)	–	14 (27.5%)	–

* p<.05, ** p< .01, *** p<.001; McNemar's test

Financial stress

Financial stress was measured at Baseline, Endpoint, and Follow-Up using the question "How much stress or worry do you feel about your personal finances?" Response choices were "None", "Very little", "Some", "A fair amount", and "A lot". For analysis, responses were grouped into two categories:

- "None", "Very little", and "Some" responses were combined as *low to moderate financial stress*.
- "A fair amount" and "A lot" responses were combined as *high financial stress*.

The proportion of participants reporting a high level of financial stress was significantly lower at Follow-Up compared to Baseline.

Table 26: Financial stress, Baseline to Endpoint (n = 59)

	BASELINE n (%)	ENDPOINT n (%)	SIG.
Low to moderate financial stress	18 (30.5%)	21 (35.6%)	–
High financial stress	41 (69.5%)	38 (64.4%)	

* p<.05, ** p< .01, *** p<.001; McNemar's test

Table 27: Financial stress, Baseline to Follow-Up (n = 52)

	BASELINE n (%)	FOLLOW-UP n (%)	SIG.
Low to moderate financial stress	13 (25.0%)	25 (48.1%)	**
High financial stress	39 (75.0%)	27 (51.9%)	

* p<.05, ** p< .01, *** p<.001; McNemar's test

Basic Need

Ability to meet basic needs was assessed at Baseline, Endpoint, and Follow-Up. Participants were asked about how much trouble they experienced paying for several categories of material goods: food and formula; clothes and shoes; cleaning and hygiene supplies like shampoo, toothpaste, pads, tampons, and toilet paper ("hygiene products"); and diapers, if applicable. Response choices were "No trouble", "Some trouble", and "Lots of trouble". For analysis, responses "Lots of trouble" and "Some trouble" were combined into a single category.

The proportion of participants who reported trouble paying for clothes or shoes was significantly lower at Endpoint and Follow-Up than at Baseline, and the proportion who reported trouble paying for hygiene supplies was significantly lower at Follow-Up than at Baseline. No significant difference in proportions was detected for other basic needs.

Table 28: Self-reported trouble paying for basic needs, Baseline to Endpoint

	BASELINE n (%)	ENDPOINT n (%)	SIG.
Trouble paying for diapers (n=30)			
Lots of Trouble or Some Trouble	23 (76.8%)	20 (66.7%)	–
No trouble	7 (23.3%)	10 (33.3%)	

	BASELINE n (%)	**ENDPOINT n (%)**	SIG.
Trouble paying for food or formula (n=58)			
Lots of Trouble or Some Trouble	19 (32.7%)	22 (37.9%)	–
No trouble	39 (67.2%)	36 (62.1%)	
Trouble paying for clothes and shoes (n=58)			
Lots of Trouble or Some Trouble	50 (86.2%)	38 (65.5%)	**
No trouble	8 (13.8%)	20 (34.5%)	
Trouble paying for hygiene supplies (n=58)			
Lots of Trouble or Some Trouble	40 (69.0%)	33 (56.9%)	–
No trouble	18 (31.0%)	25 (43.1%)	

* p<.05, ** p<.01, *** p<.001; McNemar's test

Table 29: Self-reported trouble paying for basic needs, Baseline to Follow-Up

	BASELINE n (%)	**ENDPOINT n (%)**	SIG.
Trouble paying for diapers (n=27)			
Lots of Trouble or Some Trouble	24 (88.9%)	18 (66.7%)	–
No trouble	3 (11.1%)	9 (33.3%)	
Trouble paying for food or formula (n=51)			
Lots of Trouble or Some Trouble	20 (39.2%)	14 (27.5%)	–
No trouble	31 (60.8%)	37 (72.6%)	
Trouble paying for clothes and shoes (n=51)			
Lots of Trouble or Some Trouble	45 (88.2%)	32 (62.8%)	***

	BASELINE n (%)	**ENDPOINT n (%)**	SIG.
No trouble	6 (11.8%)	19 (37.3%)	
Trouble paying for hygiene supplies (n=51)			
Lots of Trouble or Some Trouble	37 (72.6%)	23 (45.1%)	**
No trouble	14 (27.5%)	28 (54.9%)	

* p<.05, ** p<.01, *** p<.001; McNemar's test

Conclusion

DISCUSSION

DHS and Elevate partnered to establish NYC DHS MOMS to strengthen supports for mental health in Tier 2 shelters for families with children. The NYC DHS MOMS Pilot — the first replication of the MOMS Partnership model within a shelter setting — was implemented in two BronxWorks family shelters. After a period of contracting and planning beginning in early 2020, pilot service delivery began September 2021 and continued through November 2022. Over the course of the pilot, 80 BronxWorks clients participated in MOMS SM; BronxWorks continues to offer NYC DHS MOMS programming beyond the pilot stage.

Design and Implementation

Several features of the implementation and service environment shaped the course of the pilot and adaptation of the MOMS model. The presence of MSW/LMSW employees in the BronxWorks shelters, including those in the CCC role established in 2016 as part of the ThriveNYC initiative, were a significant asset in allowing NYC DHS MOMS to draw from existing staff capacity and resources; with the exception of the MOMS CMHA role, the core MOMS staff was comprised of existing employees at BronxWorks and DHS. While staffing shortages and turnover present a challenge in the landscape of homeless services, flexibility among BronxWorks and DHS staff involved in the pilot — who stepped in to carry out responsibilities as needed or acted in multiple roles — allowed for MOMS staff roles to filled continuously without disruption to service delivery.

The successful integration of the new MOMS CMHA role within the shelter staff required particular attention and consideration. Early in the pilot, concerns arose about the overlap or conflict of the MOMS CMHA's responsibilities with that of other shelter staff. The involvement of BronxWorks leadership in helping to coordinate work across staff, as well as renewed efforts to thoroughly onboard MOMS CMHAs to the shelter workplace, helped to reduce these concerns and improve the integration of the MOMS CMHA role. Additionally, given the residential nature of the shelter environment, MOMS CMHAs were highly accessible to participants throughout their working hours. This necessitated that the team develop strategies to support MOMS CMHAs in maintaining appropriate boundaries with former participants; for example, communicating with participants early in the MOMS SM session about expectations for communication and contact after their participation.

Service delivery was able to occur in-person without significant disruption related to Covid-19. On those occasions when in-person meetings were determined to be a high risk, MOMS staff successfully facilitated remote classes according to guidance and training on the virtual delivery of MOMS SM.

Evaluation Findings

This study assessed outcomes for NYC DHS MOMS Pilot participants through a pre-post evaluation of self-reported measures. Overall, BronxWorks clients were very engaged with the pilot and MOMS SM course, with high levels of enrollment and attendance throughout the period of service delivery; participants overwhelmingly reported high levels of satisfaction with the program.

These findings are supported by the personal observations and experiences of MOMS staff throughout the course of the pilot.

Participants experienced improvements in several key indicators of mental health: measures of depression and anxiety decreased significantly after MOMS SM participation, and these reductions were sustained three months after program completion. Measures of perceived stress and traumatic stress symptoms also showed improvement between program start and the time of Follow-Up. The evaluation found significant and sustained improvements in social and instrumental support for pilot participants. Participants also experienced a reduction in trouble paying for certain basic needs over the course of participation and the period three months after completion.

This evaluation did not detect change in certain measures, including self-efficacy, emotional regulation, and parenting confidence and efficacy. The sample size for this study was small, and some analyses may have been limited by insufficient statistical power to detect a change. For those findings which were significant, there may also be explanations for the changes identified outside of NYC DHS MOMS, including the support of preexisting resources and services at BronxWorks, other factors in participants' environments, or the alleviation of depression symptoms with time.

Overall, the evaluation findings indicate that participation in MOMS SM was associated with several key outcomes for which the pilot aimed, particularly improvements in participant mental health and social support. These results are encouraging. Mental health challenges are pervasive among mothers and caregivers experiencing homelessness, and low social connectedness for parenting women living in shelter exacerbates the psychological burden of housing insecurity and homelessness.[27] In addition to the well-being of mothers, these factors pose a risk for the current and future well-being of their children; improvements in mothers' mental health are a critical outcome not only for participants, but also for their families. This is true of social support, too, which has been found to buffer against the effects of stress and material hardship on both mothers and their children.[28]

NEXT STEPS

The NYC DHS MOMS Pilot demonstrated the successful implementation of the MOMS program within two BronxWorks shelters and suggested positive outcomes for participating clients. Building on this work, DHS and Elevate are planning for a second phase of pilot implementation and evaluation to test the expansion of NYC DHS MOMS to additional provider sites. With continued support from the Robin Hood Foundation FUEL, this next pilot will explore the feasibility and effectiveness of implementation in new provider settings as well as the factors which contribute to the success of implementation and to participant outcomes.

For the purpose of the small-scale pilot, MOMS SM was offered only in English. To date, initial efforts to adapt the MOMS SM course for Spanish-language participants have taken place, including the pilot delivery of a 1:1 Spanish translation of the MOMS SM curriculum in western Massachusetts. In planning for the future of MOMS Partnership programming in NYC, Elevate is currently preparing to launch a process of further linguistic and cultural adaptation of the MOMS

[27] Marçal, K. E. (2021). Perceived instrumental support as a mediator between maternal mental health and housing insecurity. *Journal of Child and Family Studies*, *30*, 3070–3079.

[28] Marçal, K. E. (2022). Pathways from food and housing insecurity to adolescent behavior problems: The mediating role of parenting stress. *Journal of Youth and Adolescence*, *51*(4), 614–627.

SM curriculum followed by pilot implementation and evaluation at BronxWorks, estimated to take place over the course of 2 years.

The initial NYC DHS MOMS Pilot offered valuable insights into the unique considerations for integrating the MOMS CMHA position within the shelter setting and the functions of the MOMS CMHA role in service delivery for the DHS client community. Drawing on this experience and from lessons generated in other MOMS service settings, Elevate intends to undertake a process of revisiting and refining our understanding of the MOMS CMHA position. This planned work will include the revision of current implementation tools and practices to best describe, hire, and train for the MOMS CMHA role. In addition, Elevate is exploring opportunities to further investigate the ways in which the MOMS CMHA's co-facilitation of MOMS SM contributes to participants' experiences and outcomes.

Finally, Elevate intends to synthesize information from the NYC DHS MOMS Pilot and other MOMS Partnership replication sites to identify key takeaways for refining the MOMS Partnership model. Elevate's goal is to further our understanding of the individuals for whom and the contexts in which the MOMS model is most successful, as well as the core ingredients of the model that are most strongly associated with positive outcomes. Elevate anticipates that this cross-site analysis will inform the following targets for continuous improvement:

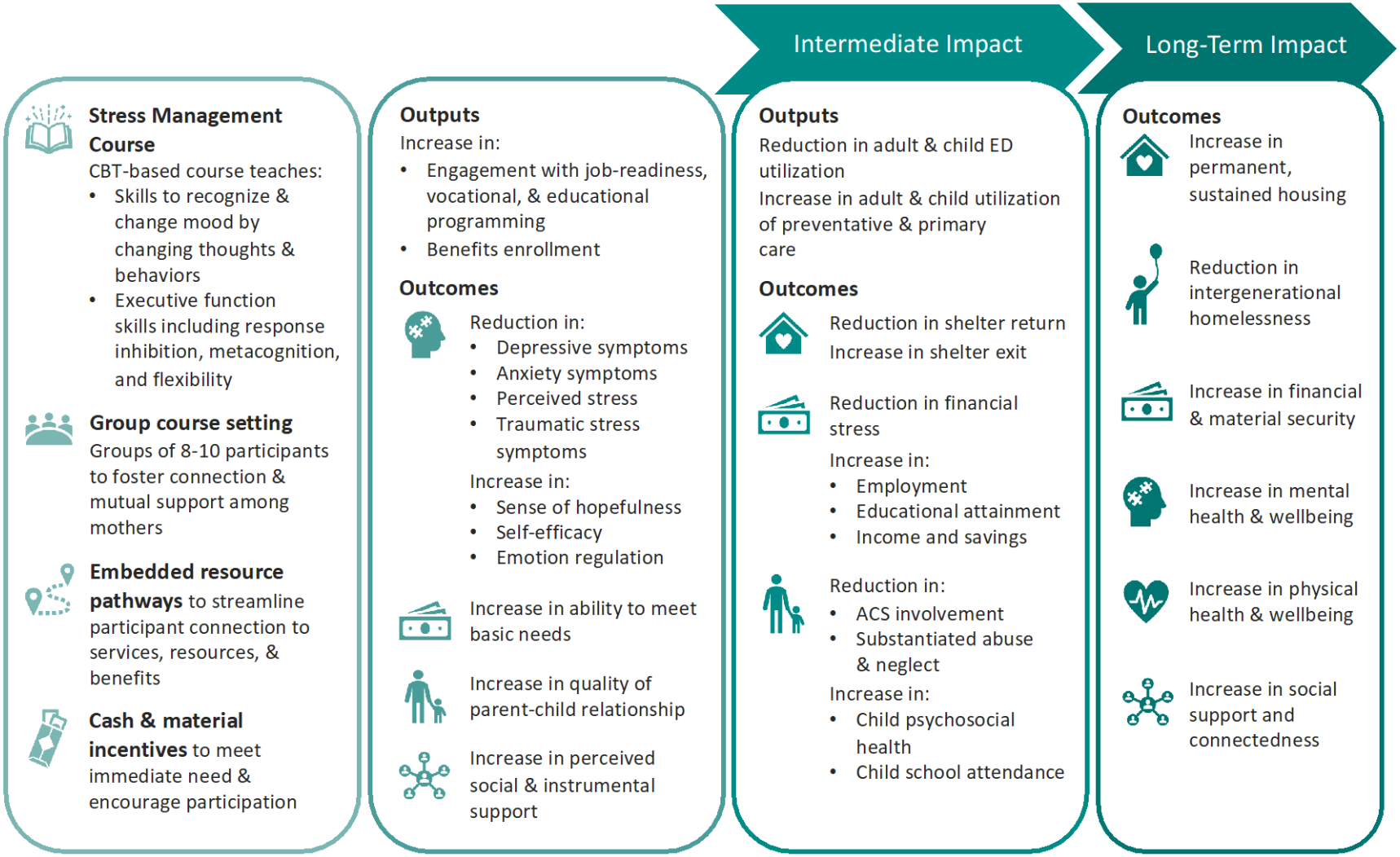
- Revisions to the MOMS Partnership Theory of Change;
- Guidance on the appropriateness of flexibility and adaptations in MOMS implementation while maintaining model fidelity;
- Determination of thresholds for the measurement of key outcomes; and
- Identification of future sites and client communities best suited for the MOMS Partnership.

These learnings are essential to Elevate's work championing accessible, effective programming for maternal and family well-being, and to the pursuit of our mission to advance mental health as a pathway to social and economic mobility.

Index of Tables and Figures

Appendix

APPENDIX A: THEORY OF CHANGE



APPENDIX B: INCENTIVE SCHEDULE

BronxWorks clients could receive the following incentives for engagement with the NYC DHS MOMS Pilot.

ACTIVITY	INCENTIVE
Eligibility Screening	$25 cash gift card
Baseline Assessment	$50 cash gift card
Class Attendance (Classes 2 – 7)	$20 cash gift card per class
Endpoint Assessment	$50 cash gift card
Follow-Up Assessment	$50 cash gift card