



Respite Partnership Collaborative (RPC) Innovation Project Evaluation Final Report

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Executive Summary

The Mental Health Services Act (MHSA)—funded by Proposition 63—supports five unique components: (1) Community Services and Supports, (2) Prevention and Early Intervention, (3) Workforce Education and Training, (4) Capital Facilities and Technology, and (5) Innovative Programs. In September 2010, the Sacramento County Division of Behavioral Health Services (DBHS) initiated a community planning process to develop Sacramento’s first Innovation Project. DBHS convened an Innovation Workgroup that developed the Innovation Plan and the Respite Partnership Collaborative (RPC) Innovation Project.

Through a competitive selection process, Sacramento County DBHS awarded Sierra Health Foundation: Center for Health Program Management (the Center) a contract to administer the RPC Innovation Project. The RPC Innovation Project is a public-private partnership of the Sacramento County DBHS and the Center. The Center uses MHSA Innovation funding to support the RPC, whose members are from the community at large. RPC members make recommendations for respite service grants to community organizations. The RPC’s goal is to increase local mental health respite service options to offer alternatives to hospitalization for community members experiencing a crisis in Sacramento County.

American Institutes for Research (AIR) conducted an evaluation of the RPC Innovation Project from April 2013 through March 2016. Evaluation objectives were to assess the extent to which the RPC Innovation Project achieved the following:

1. Promoted successful collaboration between public and private organizations (i.e., DBHS and the Center) in Sacramento County
2. Demonstrated a community-driven process
3. Improved the quality and outcomes of respite services in Sacramento County

This report presents findings from evaluation activities, which included stakeholder interviews, RPC member surveys, and document reviews. This report emphasizes data collected in the third year of the evaluation after June 2015. The report begins with a brief history of the RPC Innovation Project. Next we describe evaluation objectives and methods for conducting the evaluation. Finally, we present findings, organized by evaluation objective.

Public-Private Partnership

The RPC Innovation Project created a new public-private partnership between DBHS and the Center. The partnership succeeded in launching and maintaining the RPC Innovation Project and supporting RPC members in a community-driven process. The partners shared a vision for improving mental health services in the community. They also learned how their unique skills in engagement and mental health services could benefit the project.

However, the partnership faced several challenges. The partners had separate expectations for their own and the other’s roles and responsibilities on the project. At times, the partners wanted to pursue different approaches for working with RPC members on a community-driven process. Communications, especially to new staff and leaders, also presented challenges to the

partnership. Nevertheless, DBHS and the Center’s partnership, which lasted 5 years, successfully supported the RPC’s primary activity of providing grant funding for new and expanded respite services in the community.

We identified two lessons for creating and maintaining a public-private partnership. First, new partnerships need a clearly articulated, shared understanding of project vision, goals, roles, processes, and vocabulary as early as possible. This may help to prevent misunderstandings by bringing inconsistent expectations and interpretations to the surface. Second, partnerships should build in formal opportunities for reflection on the partnership so partners can provide input to one another on a regular basis.

Community-Driven Process

With substantial support from the partners, the RPC Innovation Project incorporated a community-driven process. RPC members defined “community-driven process” as members being included in the process, generating ideas and identifying priorities, leading and making decisions, and working on behalf of the community.

The primary strength of the community-driven process was that it allowed RPC members to release requests for proposals and to fund 11 respite programs over 3 years. The process brought together stakeholders representing diverse perspectives who worked collaboratively on maintaining the RPC and on funding decisions. The community-driven process offered RPC members the opportunity to lead and to network with one another.

Some reported that the project could have been more community-driven. Because RPC members were accustomed to focusing on the refinement of structures and processes, they may not have expected and were not always prepared to determine priorities and strategies. Another challenge was limited participation by some key stakeholders. According to current RPC members’ survey responses, members considered hospital system and law enforcement representatives to be missing or absent voices. Although these stakeholders did participate in the RPC Innovation Project (for example, by attending community meetings), hospital system and law enforcement representatives did not maintain RPC membership over the entire project term. They were unable to commit to attendance and membership policies, and the RPC members chose not to change policies (e.g., allow shared membership) in response to these stakeholders’ request. Finally, the RPC Innovation Project faced waning engagement from RPC members over time.

Other communities seeking to establish a community-driven process should define the process up front. The definition can act as a framework for establishing structures, roles, responsibilities, and procedures. Communities may consider revisiting structures and procedures periodically. To prevent waning engagement, communities should seek different skillsets at project onset (e.g., skills in outreach) versus project conclusion (e.g., skills in grant management).

Respite Services Provided by RPC Grantees

The RPC Innovation Project funded 11 programs that offered new or expanded respite services to diverse populations in Sacramento County. Although the services differed from program to program, we identified four cross-cutting dimensions. These dimensions not only defined respite programs for Sacramento County, they also helped us to assess service quality when

interviewing clients and program staff. Collectively, the programs offered clients (a) a mental and physical break from stressors, (b) a safe place to engage in respite services, (c) a place to not be alone, and (c) a place to look forward beyond the respite program.

Grantee staff and clients reported high satisfaction with services. Clients we interviewed also reported leaving respite with skills for managing crisis situations and with improvements in their mental health state. Further, staff and clients indicated that the respite services offered an alternative to using the emergency room in times of crisis.

Grantees discussed implementation strategies that they viewed as critical to delivering quality respite services and improving client outcomes based on their experiences with the RPC Innovation Project. Key strategies that grantees described were as follows:

1. Determine appropriate, clearly defined respite services that respond to community needs
2. Develop plans, models, and policies that are flexible and realistic
3. Hire and train staff who are compassionate, culturally competent, and open to learning new skills
4. Build partnerships to establish community buy-in, engage clients and foster collaboration to address diverse community needs
5. Develop data collection methods to track client outcomes
6. Identify and pursue various means to sustain respite services such as additional grant funding, donations, and fundraisers.

1. Introduction

This report begins with a brief history of the Respite Partnership Collaborative (RPC) Innovation Project. Next we describe evaluation objectives and methods. Finally, we present findings about the public-private partnership, community-driven process, and respite services.

Mental Health Services Act

The Mental Health Services Act (MHSA)—funded by Proposition 63—was enacted in California in November 2004. Its purpose and intent is to accomplish the following:¹

- Define serious mental illness among children, adults, and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.
- Reduce the long-term adverse impact on individuals, families, and state and local budgets resulting from untreated serious mental illness.
- Expand the kinds of successful, innovative service programs for children, adults, and seniors that began in California, including culturally and linguistically competent approaches for underserved populations.
- Provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure.
- Ensure that all funds are expended in the most cost effective manner and that services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

MHSA funding supports five unique components: (1) Community Services and Supports, (2) Prevention and Early Intervention, (3) Workforce Education and Training, (4) Capital Facilities and Technology, and (5) Innovative Programs. Counties must select one or more of the following Innovative Program purposes² to focus on for “learning and change”:

- Increase access to underserved groups.
- Increase the quality of services, including creating better outcomes.
- Promote interagency collaboration.
- Increase access to services.³

¹ Mental Health Services Act as Revised September 2013, Section 3. Purpose and Intent. Retrieved from http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/MHSA_AsRevisedSept2013_ForPosting_120613.pdf

² California Department of Health Care Services. Enclosure 1: MHSA proposed guidelines for the innovation component of the county’s three-year program and expenditure plan. 2009 Jan 30 [cited 2016 May 26]. Retrieved from http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice09-02_Enclosure_1.pdf

³ Mental Health Services Act as Revised September 2013, Section 9. Part 3.2 Innovative Programs. Retrieved from http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/MHSA_AsRevisedSept2013_ForPosting_120613.pdf

History of Sacramento’s Innovation Project

The Innovation Plan, approved by Sacramento County’s MHSAs Steering Committee, supported an Innovation Project focused on crisis and alternatives to hospitalization. Crisis had been a “recurring community concern” throughout the MHSAs Community planning processes.⁴ During the economic downturn and recession in 2009, Sacramento County experienced an erosion of available community-based mental health services at all levels, including reductions to crisis response service capacity.

In September 2010, the Sacramento County Division of Behavioral Health Services (DBHS) initiated a community planning process to develop Sacramento’s first Innovation Project. DBHS convened an Innovation Workgroup of 20 community members who met four times in early 2011. DBHS invited the public to attend all meetings; the public also had an opportunity to provide comment at the end of each meeting. The Innovation Workgroup reviewed data about mental health crises in Sacramento County (e.g., suicide rates, homelessness, and hospitalizations). It developed and refined program strategies based on data, information from the MHSAs planning process, and community input. The strategies eventually became the Innovation Plan.

The Innovation Plan presented the RPC Innovation Project, and its purposes were as follows:

“...to test whether a community-driven process, that includes decision-making and program design, will promote stronger interagency and community collaboration. Additionally, the County seeks to learn whether this community-driven collaborative approach can lead to new partnerships that can maximize existing resources to establish a continuum of respite services that will reduce mental health crisis...”

The secondary purpose of this Innovation Project is to determine whether this community-driven collaborative leads to an increase in the quality of services being delivered, including achieving better outcomes...

In implementing a range of respite options designed by community partners, DBHS will test whether a process unlike the traditional government process now in place will facilitate a different outcome, be more expedient, improve relationships in the community, and create greater trust between the community and the County. It will also test whether adopting a model that gives community members program choice will improve the quality of services and produce better outcomes.”⁴

Through a competitive selection process, Sacramento County DBHS awarded Sierra Health Foundation: Center for Health Program Management (the Center) a contract to administer the RPC Innovation Project. The RPC Innovation Project was a public-private partnership of the Sacramento County DBHS and the Center. The Center used MHSAs Innovation funding to support the RPC, whose members were from the community at large. RPC members made recommendations for respite service grants to community organizations. The RPC’s goal was to

⁴ County of Sacramento. (2011). Mental Health Services Act: Innovation component of the three-year program and expenditure plan. Retrieved from http://www.sierrahealth.org/assets/Sacramento_County_INN_Plan_FFS.pdf

increase local mental health respite service options to offer alternatives to hospitalization for community members experiencing a crisis in Sacramento County.

RPC Innovation Project Evaluation

RPC, DBHS, and the Center selected American Institutes for Research (AIR) to conduct an independent evaluation of the RPC Innovation Project, based on a competitive request for proposal (RFP) process. Two RPC member representatives, two DBHS representatives, and two Center representatives reviewed applications.

The main evaluation objectives were to assess the extent to which the RPC Innovation Project

1. promoted successful collaboration between public and private organizations (i.e., between DBHS and the Center) in Sacramento County,
2. demonstrated a community-driven process. and
3. improved the quality and outcomes of respite services in Sacramento County.

We previously released interim findings about the RPC Innovation Project structure and processes.^{5,6} The purpose of this final report is to present findings from all evaluation activities over the entire evaluation period (June 2013 through March 2016) with a concentration on data collected after June 2015.

Methods

We collected data from key informant interviews, RPC member surveys, and document reviews.

Interviews. We conducted 86 key informant interviews about the RPC Innovation Project and respite services between November 2013 and March 2016. Key informants represented the RPC, the Center, DBHS, and grantee organizations (Exhibit 1). We interviewed some individuals multiple times over the course of the evaluation. We wanted to learn about stakeholders' early expectations, experiences with implementation at the midpoint of the project, and reflections on lessons learned in the last year of the RPC Innovation Project.

Exhibit 1. Key Informant Interviews

Stakeholder group	Number of interviews
RPC members	<ul style="list-style-type: none">• Two interviews with two past RPC members• Fourteen interviews with 11 current RPC members
The Center	<ul style="list-style-type: none">• Seven interviews with four people representing the Center
DBHS	<ul style="list-style-type: none">• Seven interviews with four people representing DBHS

⁵ Wang, G., Koester, L., Farrar, B., Manson, K., Gilmore, D., Lumby, E., . . . Mathew, R. (2014, November). *Respite Partnership Collaborative (RPC) Innovation Project evaluation: Report 1*. Retrieved from http://www.shfcenter.org/assets/RPC/RPC_Evaluation_Report_1.pdf

⁶ Wang, G., Koester, L., Gilmore, D., Lumby, E., Farrar, B., Poon, A., . . . Fernando, R. (2015, August). *Respite Partnership Collaborative (RPC) Innovation Project evaluation: Report 2*. Retrieved from http://www.shfcenter.org/assets/RPC/RPC_Evaluation_Report_2_Revised.pdf

Stakeholder group	Number of interviews
Facilitator	<ul style="list-style-type: none"> • One interview with one facilitator
Round 1 Grantees	<ul style="list-style-type: none"> • Eight interviews with four staff and three clients from Abiding Hope Respite House • Seven interviews with three staff and three clients from Capital Adoptive Families Alliance • One interview with one staff from Del Oro Caregiver Resource Center • Six interviews with two staff and three clients from Lu-Mien Community Services
Round 2 Grantees	<ul style="list-style-type: none"> • Five interviews with four staff and two clients from St. John’s Program for Real Change • Eight interviews with four staff and two clients from TLCS, Inc.
Round 3 Grantees	<ul style="list-style-type: none"> • Seven interviews with three staff and four clients from A Church for All • Five interviews with three staff and three clients from Gender Health Center • Two interviews with two staff from Sacramento LGBT Community Center • Six interviews with three staff and three clients from Wind Youth Services

Note: The status of RPC members (i.e., past or current membership) reflects their status at the time of the interview. Some individuals were interviewed multiple times over the course of the evaluation.

All interviews were 30 to 60 minutes, in person or by phone. For telephone interviews conducted with Round 1 and Round 2 grantees in October 2015, we carried out a rapid analysis by writing and systematically coding interview summaries. The team audio-recorded, transcribed, and used NVivo to thematically code all other interviews. The team also analyzed detailed notes developed during interviews and consulted audio recordings for accuracy.

RPC Survey

AIR conducted three RPC surveys that asked about the structure and processes of the RPC Innovation Project.

AIR fielded the first RPC survey from November to December 2013, sending it electronically and via paper to 38 participants representing past RPC members, current RPC members, DBHS, the Center, and the RPC facilitator. Of the 31 participants who completed the survey, 21 were current RPC members.

AIR fielded the second survey from October to November 2014, sending it electronically to 41 participants representing past RPC members and current RPC members. Out of the 23 participants who completed the survey, 16 were current RPC members. The second survey included the same topics as the first survey.

AIR fielded the third survey from October to November 2015, sending it electronically to 17 current RPC members. This survey expanded upon previous topics to include questions about the consensus decision making process and interaction with grantees. Fourteen current RPC members completed the survey.

Survey respondents were permitted to skip any items they preferred not to answer. AIR used Excel to calculate descriptive statistics (e.g., means, frequencies) based on available data.

Document Review

AIR reviewed and summarized meeting notes provided by the Center from RPC meetings, RPC Planning Committee meetings, and Standing Committee meetings. In addition, grantee organizations and the Center provided AIR with documents about the following:

- grantees' respite program structure (e.g., grant applications),
- grantees' processes (e.g., data collection tools),
- progress toward achieving their respite program goals,
- scopes of work,
- site visit reports, and
- outcomes reports.

2. Public-Private Partnership

Summary

An evaluation objective was to assess the extent to which the RPC Innovation Project promoted successful collaboration between public and private organizations (i.e., between DBHS and the Center) in Sacramento County. In brief, the public-private partnership successfully launched and maintained the RPC Innovation Project over 5 years. The two partners shared a vision to improve services, and they learned the value of each other's unique contributions. Challenges arose because of different expectations and approaches for the partnership itself and the work overseeing the RPC.

Introduction

DBHS and the Center formed the public-private partnership in 2011 after a request for qualification and competitive bidding process. DBHS believed this new partnership would facilitate distribution of funds to the community and provide new funding opportunities to sustain respite services. The Innovation Plan served as a framework for the RPC Innovation Project by outlining each partner's responsibilities within the public-private partnership. However, it did not include how the two partners would or should work together to fulfill responsibilities. Below, we describe findings from document reviews and our interviews with representatives from DBHS, the Center, and past/current RPC members. In this section, we describe the strengths and challenges faced by the partnership, followed by lessons learned.

Strengths of the Partnership

RPC Innovation Project Launch and Completion

DBHS and the Center successfully launched their partnership and completed the multimillion dollar RPC Innovation Project. Both the partnership and the RPC Innovation Project lasted 5 years. The public-private partnership supported community members to engage in a community-driven process (described in next section). As a result, community members selected local organizations to receive funding to implement respite services (described in section 5). Clients received needed respite services as a downstream effect of the public-private partnership.

Shared Vision

Successful partnerships require shared vision among partners.^{7,8,9,10} In the RPC Innovation Project, the Center and DBHS held a common overarching vision of improving mental health services. Although partners sometimes held different opinions on how to achieve this vision, partners' strong commitment to the vision enabled them to persevere through project challenges.¹¹ An RPC member stated:

I think their underlying values are the same ... the vision and the goals of the RPC. I think that helps the collaboration be effective ... despite if there's a disagreement, ... their underlying values still aligned.

Unique Contributions

Partners must see the unique contribution the other makes to the partnership and understand similarities and differences.¹² In the RPC Innovation Project, partners' unique characteristics that contributed to project success were community engagement and expertise in mental health.

Community Engagement. The Center's experience in working with community groups and grant making resulted in deep engagement among RPC members and grantees. The Center built close relationships with and among RPC members by spending time with members, offering support with the community-driven process (see page 15), and treating RPC members with high regard. As a result, members viewed their participation as having value. This helped RPC members to honor their commitments to the RPC, despite time challenges. One interviewee stated:

On a regular basis, volunteers need to be reminded that their participation is valued, respected, appreciated, and their opinions matter, and their voice counts a lot, [which gives] them some empowerment or emotional incentive for ongoing participation.

The Center also used its experience providing technical assistance as a grant maker to community organizations to anticipate program needs. One interviewee gave an example:

⁷ Corrigan, M. B., Hambene, J., Hudnut, W. III, Levitt, R. L., Stainback, J., Ward, R., . . . Witenstein, N. (2005). *Ten principles for successful public/private partnerships*. Retrieved from Urban Land Institute website http://uli.org/wp-content/uploads/2005/01/TP_Partnerships.pdf

⁸ Crosby, B. C., & Bryson, J. M. (2010). Integrative leadership and the creation and maintenance of cross-sector collaborations. *The Leadership Quarterly*, 21(2), 211–230.

⁹ Jacobson, C., & Choi, S. O. (2008). Success factors: Public works and public-private partnerships. *International Journal of Public Sector Management*, 21(6), 637–657.

¹⁰ Woulfe, J., Oliver, J. R., Zahner, S. J., & Siemering, K. Q. (2010). Multisector partnerships in population health improvement. *Preventing Chronic Disease*, 7(6), A119. Retrieved from http://www.cdc.gov/pcd/issues/2010/nov/10_0104.htm

¹¹ Wang, G., et al. (2015, August). *Respite Partnership Collaborative (RPC) Innovation Project evaluation: Report 2*. Retrieved from http://www.shfcenter.org/assets/RPC/RPC_Evaluation_Report_2_Revised.pdf

¹² See footnotes 8 and 10.

They've been incredibly helpful ... offering their expertise to like, "Oh, hey, this looks to be a really good instrument to use. Or maybe you want to rethink your data collection method.

Mental Health Expertise. Participants emphasized DBHS's subject matter expertise and mental health services systems knowledge. Interviewees indicated that DBHS helped them become better educated on the organization's mission, the MHSA, the role of the MHSA Steering Committee, and available funding. One interviewee stated:

The county has tremendous knowledge about mental health in terms of their team. ... [It] has been very, very helpful when we have that mental health expertise or can access it.

Challenges to the Partnership

DBHS and the Center partnered with one another to learn and create synergies between their two differing skillsets. However, there were hindrances to a smooth partnership, which included the following:

- different expectations and desires for each partner's role,
- different approaches to promoting and sustaining grantees,
- lack of commitment to partner communication, and
- changes in leadership and staffing.

Expectations and Desires for Each Partner's Role

Effective partnerships require each partner to have clearly defined, mutually understood roles that each organization heeds.^{13,14} The Innovation Plan defined roles, but partners had differing interpretations of how to fulfill these roles.¹⁵

One partner expected an equal partnership with opportunities to "express our own values to the work." The other partner envisioned a contractual relationship, sharing the following:

You may think when you talk about partners, it implies an equality ... we truly feel like we have a partnership in implementation. There are times when the county's going to have to make hard decisions, and the contractor is going to have to follow those decisions and implement them, and I think that that's been challenging at times.

The partners' relationship became more contractual over time and mirrored that of other DBHS contracts. While a contractual relationship may have clarified roles, some stated that it left less

¹³ See footnote 10.

¹⁴ Head, B. W. (2008). Assessing network-based collaborations. *Public Management Review*, 10(6), 733–749

¹⁵ Wang, G., et al. (2015, August). *Respite Partnership Collaborative (RPC) Innovation Project evaluation: Report 2*. Retrieved from http://www.shfcenter.org/assets/RPC/RPC_Evaluation_Report_2_Revised.pdf.

room for contributing fully or for exploring innovative means for maintaining a public-private partnership. An interviewee shared:

What I heard was it's a partnership and I actually operated that way for a while. Now, I have changed my mindset to, "I work for them," which doesn't mean I don't express my opinions or ideas, but I have to just accept to some degree that ultimately, I don't have a say.

Approaches to Promoting and Sustaining Grantees

First, partners had different views about public communications about grantees. In other work, the Center had success with various communication approaches (e.g., press releases, publications) to increase project visibility and to disseminate project information. But, DBHS, who has a large system of care and whose publicly-funded expenditures are under more scrutiny, was reluctant to engage in some activities. One interviewee stated:

I think there's a hesitation to lift up one grantee over other grantees, say, [why] not respite groups or other mental health grantees?

Second, partners held different expectations about grantee funding sustainability. DBHS expected the Center to leverage connections in the philanthropic world to identify potential funding sources, but the Center was not aware of this expectation at project onset and later determined it was unable to support grantees through its own endowment. However, as described later in this report, all grantees will receive MHSA funds after RPC funding ends. Addressing these discrepancies sooner in the project may have improved understanding between the partners, allowing them to adjust their expectations and proceed accordingly.

Commitment to Partner Communication

Although partners acknowledged the usefulness of partner check-in meetings, a challenge to the public-private partnership was prioritization and scheduling of the check-in meetings. One interviewee discussed the partnership-focused meetings' importance for "*talking about the way things could be*" and to explain ideas. Meetings were hard to schedule and therefore occurred infrequently. Dedicated time to reflect on partnership processes, process evolution, expectations, and new ideas could have improved the relationship.

Staffing and Leadership

Changes in RPC Innovation Project staffing and leadership presented barriers to the public-private partnership. As the RPC Innovation Project established an innovative public-private partnership, previous projects offered few precedents for how the two organizations should establish and maintain a partnership. Each new staff member needed to be introduced to the unique aspects of the project, such as the community-driven process and consensus-based decision making. One interviewee reflected that, in hindsight, the process could be improved, and stated:

Every time a new person came on, I would have had a group discussion so that person got grounded in the collective thinking.

In addition, leadership changes required partners to accommodate new leaders' visions and priorities for the RPC Innovation Project. The program was also under scrutiny each time a new leader took the helm. One interviewee stated:

If somebody comes on late into the game and they don't understand the whole context, they may start asking a lot of questions and then everybody tries to respond appropriately.

Lessons Learned

The challenges experienced by partners indicate that the project met one of its primary goals—innovation. Bringing together two organizations of differing cultures, strengths, and expertise produced friction at times, but friction offers opportunities to learn. One interviewee shared:

Probably the same successes are the challenges. The challenge is, again, with the partnership, two very strong agencies coming together and trying to figure this out.

The strengths and challenges experienced by the RPC Innovation Project partners help to inform lessons for other communities seeking to develop a public-private partnership. Interviewees emphasized the need for the following activities.

Lay the Groundwork

A kick-off meeting can help to establish partnership parameters. The meeting agenda must address coming to consensus on vision, goals, goal prioritization, unique partner contributions, role definitions, role activities, the internal processes of each organization, common vocabulary and terms, and a plan for maintaining the partnership. One interviewee stated:

[it's important to] be sure that they are aware that when you're crossing two different systems, the foundation world and government, that they are different cultures in and of themselves and ... maybe creating an opportunity to discuss some of that or maybe taking a little bit more time in the partner work upfront to flesh that out ... to be sure that we are using language that means the same thing to both organizations, and if not, then talking it through until we get a common understanding.

Decisions must also be documented formally to ensure mutual understanding, to inform new leaders or staff who join the project, and to maintain the project's vision and course. One interviewee summed up the necessary components as follows:

We're not working in collaboration; we're working in partnership. What that means to people has to be very clear in order for it to move forward in a healthy way. I also think it would be really important to have that documented. Here, our guiding document is the scope of work, which is a page and a half. There will be evaluation, there will be communication, there will be grant making, period, and it says nothing about there will be ways in which we work together as partners.

There needs to be a document, a charter, some memorandum of understanding that clearly states the roles. ... And then in that document, the expectations for communication and so on can be laid out, and then there is a place where there is some mutual accountability. Each can hold the other accountable for meeting the expectations laid out in the agreement.

Establish Partnership Processes and Feedback Loops

The groundwork described above provides a strong foundation for the partnership. However, partnerships also need regular check-in meetings as the project unfolds and the partners begin to work with one another. Frequent, regularly scheduled meetings dedicated to partnership maintenance are critical for alleviating frustrations that may arise as partners begin to work together.

3. Community-Driven Process

Summary

One evaluation objective was to assess the extent to which the RPC Innovation Project demonstrated a community-driven process. Most RPC members reported the RPC Innovation Project as community-driven, which they defined as members being included, leading, and working for the community. The process resulted in three rounds of funding, which supported new and expanded respite services in the community. The process included diverse members and produced a collaborative environment that gave members opportunities to network. The RPC Innovation Project became more community-driven over time as RPC members had more opportunities to lead. Challenges to becoming more community-driven included work patterns that prevented RPC members from setting strategic priorities, missing voices throughout the project period, and waning member engagement over time.

Introduction

The Innovation Plan first used the term “community-driven process” before the launch of the RPC Innovation Project. However, the Innovation Plan did not define the term, nor did it lay out how to implement a community-driven process. Through interviews and surveys, we studied this process and how it was applied in the RPC Innovation Project. This section describes how RPC members, DBHS, and the Center interpreted “community-driven process,” strengths of the community-driven process, challenges to the community-driven process, and lessons learned.

Community-Driven Process Definitions and Activities

Current RPC members defined “community-driven process” as the members being included in the process, generating ideas and identifying priorities, leading and making decisions, and working on behalf of the community (Exhibit 2).

Exhibit 2. Selected Responses to the Question, “What Does Community-Driven Mean to You?” Shared by Current RPC Members in the 2014 and 2015 RPC Surveys

Being included in process	Generating ideas and identifying priorities	Leading and making decisions	Working on behalf of community
<ul style="list-style-type: none"> • “The ENTIRE community is informed and engaged in the process.” (2015) • “It means that community members have open access to and lots of input within the process.” (2015) • “Inclusion of all stakeholders from the consumer to transportation provider, and all in between.” (2014) • “Community members are a part of the process.” (2014) 	<ul style="list-style-type: none"> • “That the work is generated by and led by the community that will be impacted by the work.” (2015) • “The community identifies the priorities and then provides oversight to ensure that priorities are being met.” (2014) • “As many representatives from various constituencies impacted by mental health programs are given an opportunity to voice opinions about brainstorming, designing, and implementing respite care programs and their funding.” (2014) 	<ul style="list-style-type: none"> • “Multiple stakeholders are brought to the table and have an equal voice in decision making” (2015) • “Community-driven for me means that the community (RPC) is determining the direction of and making the decisions” (2015) • “Community members take care of the process, with ownership, stewardship, approaches” (2015) • “The community is in the driver’s seat.” (2014) 	<ul style="list-style-type: none"> • “That we fight to meet the needs of community members and not our own.” (2014) • “Community collaboration and advocacy on behalf of their stakeholders with the government agency to improve and innovate appropriate process to achieve the desired outcomes. It is also a great learning experience to learn from positive gains or unplanned expectations.” (2014)

In 2014 and 2015, current RPC members responding to the RPC survey indicated that attending full RPC meetings, developing options about funding priorities, and making decisions in response to options were activities that are a very important part of a community-driven process.

Although more than 80% of current RPC members who responded to the 2014 and 2015 survey agreed that the RPC Innovation Project was community-driven, some also felt that the RPC Innovation Project became more community-driven over time. One interviewee stated:

We are more of a community-driven collaborative than we have been, say, in Year 2 or so. ... We have a process in which the RPC voice is planning the RPC meetings and also the direction of the RPC, and that wasn't the case in our first year. It took some time for us, in our developmental stages, to get to that point. ... The chairs are facilitating meetings, and when they're facilitating the RPC decision making as well ... I think that brings us more to the community-driven place.

Strengths of the Community-Driven Process

We identified several strengths of the RPC Innovation Project’s community-driven process. The process:

- supported release of grant funding for new respite services in the community,
- included a diverse membership representing many stakeholder perspectives,
- offered leadership opportunities for RPC members,
- created a collaborative environment, and
- allowed RPC members and organizations to network and build relationships.

Grant Funding for Respite Services

The RPC Innovation Project’s community-driven process was successful in building a structure and implementing processes for supporting grant funding for new respite services in the community. Between 2012 and 2016, the Center, DBHS, and the RPC members collaborated on developing and releasing three RFPs. As RPC members learned about respite services, they incorporated findings about the dimensions of respite that emerged from the first and second rounds of grantees into the subsequent RFP in 2014. Further, RPC members selected three rounds of grantee recipients, distributed \$5.2 million to 10 grantees, and monitored contracts.

In addition to making recommendations about awards, RPC members also recommended terminating contracts early. They made this recommendation for one grantee in Round 2 and a second grantee in Round 3 because of inadequate grantee response to concerns.

To reach these recommendations, the RPC members prepared for and attended Planning Committee, Standing Committee, and full RPC meetings. Although there is some debate about whether the process could have been more community-driven, the active community member participants of the RPC Innovation projects were successful in setting priorities for and getting funds out into the community.

Diverse Membership

A strength of the community-driven process was the RPC’s diverse membership (Exhibit 3). The RPC Innovation Project, by design, included individuals representing many different stakeholder perspectives. Across all project years, the RPC Innovation Project included representatives from healthcare, community organizations, government, and cultural communities. Per DBHS’s practice of valuing the voice of consumers and family members with lived experience, half of the Innovation Project seats were designated for these stakeholders.

Exhibit 3. Primary Stakeholder Perspectives Represented in the RPC Innovation Project, 2013–2015

Perspectives	2013 n = 21	2014 n = 16	2015 n = 14
Health professional	3 (14%)	3 (19%)	1 (7%)
Government staff or nonprofit organization staff	6 (29%)	3 (19%)	6 (43%)
Individual with lived mental health experience or family member of an individual with lived mental health experience	10 (48%)	8 (50%)	5 (35%)
Other (e.g., cultural, faith-based, child welfare/foster care)	2 (10%)	2 (13%)	2 (14%)

Note: Data collected through RPC survey in November to December 2013, October to November 2014, and November to December 2015.

Leadership Opportunities for RPC Members

The RPC Innovation Project succeeded in becoming more community-driven over time by increasing opportunities for RPC members to lead, influence, and collaborate on funding decisions. For example, the RPC transitioned to self-facilitation, and RPC members elected cochairs to work with the Center and DBHS to plan meetings. One interviewee shared:

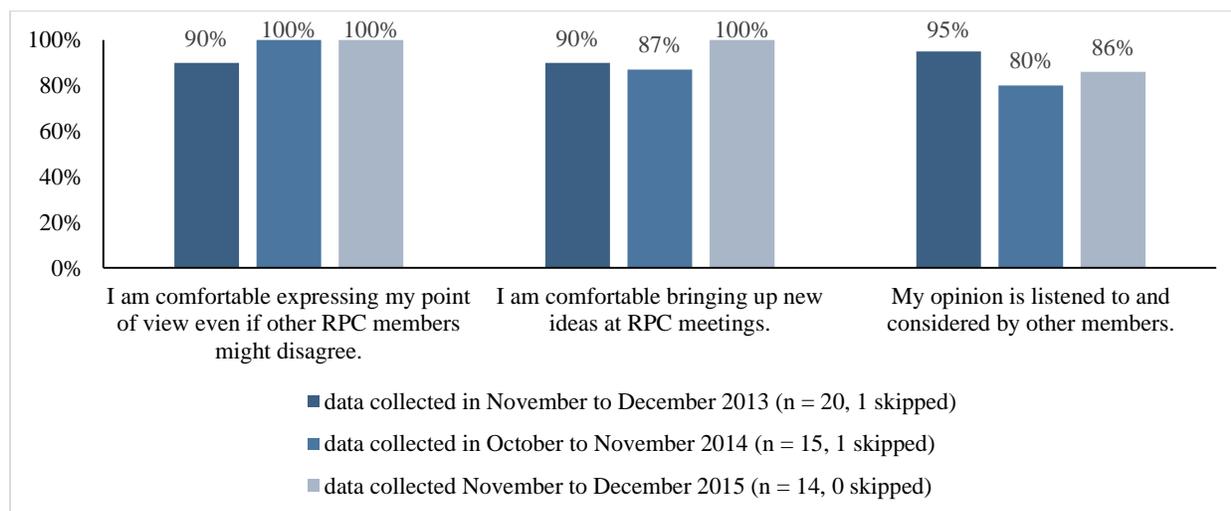
It's just been tremendous growth in having the chairs facilitate the meetings. I think the meetings are always strong with them whether it's a small group or a large group, but to have peers truly facilitating the meeting has made a big difference in the energy of the group, of people's buy-in ... and ownership.

Over the course of the RPC Innovation Project, perceived leadership of the RPC shifted from the partners (the Center and DBHS) to RPC members. Most current RPC members who responded to the 2013 survey reported that the Center and DBHS provide leadership together, but in 2014, most survey respondents perceived RPC members to lead alongside the partners. By the 2015 RPC survey, more current RPC members indicated that RPC members, including cochairs, provided leadership compared with partners.

Collaborative Environment

The RPC Innovation Project also succeeded in creating and maintaining an open and respectful arena for collaboration. Reports of openness and respect in the RPC Innovation Project were consistently high across three survey periods (Exhibit 4).

Exhibit 4. Percentage of Current RPC Members Who Agree or Strongly Agree With Survey Items About Openness and Respect in the RPC Innovation Project



Opportunities to Network and Build Relationships

The RPC Innovation Project's community-driven process gave RPC partners, members, and grantees opportunities to build their professional network. From 2013 to 2015, about 90% of respondents to the RPC surveys reported that developing professional networks with key organizations was a benefit of being part of the RPC Innovation Project.

Further, a referral network developed as people learned about the different services in the community offered by RPC members' and grantees' organizations. One RPC member said:

Being a part of a collaborative where we decide about funding also gives you the opportunity to learn about what organization is out there that can provide the services. It was an opportunity for me not just to learn about how the funding is distributed but also ... resources out there that we can tell our community about. ... [It] makes it easier for you to refer people to that organization.

By interacting regularly through meetings, RPC members built positive personal relationships, even friendships. One RPC member shared:

I hope that the friendships and the collaborations that we've made within the RPC itself, I hope that we're able to sustain those things amongst ourselves.

Finally, the RPC Innovation Project's Grantee Learning Community Meetings gave grantees a venue to share recommended implementation practices and strategies to overcome implementation challenges. One interviewee valued:

working together at the learning community meetings and having the opportunity to get to know the other folks who are delivering programs and working together ... whether it was ... ask[ing] each other questions or... how do you go about this or what about this? ... Referrals, of course, [were] also really important, that we can't be working in silos.

Challenges to the Community-Driven Process

Three structural and process factors presented challenges to the community-driven process. First, there were no policies or procedures in place that stated RPC members rather than partners should set priorities. Second, the membership attendance policy created obstacles to including some key community stakeholders. Third, waning engagement over the life of the project acted as a barrier to a community-driven process.

Structure and Processes

Setting priorities. When the RPC Innovation Project first launched, Ad Hoc, Standing, Planning, and full RPC Committees spent considerable time establishing a starting structure and processes.¹⁶ As the RPC's direction and needs evolved, RPC members took care to refine structures and processes appropriately. All devoted numerous hours to the details of membership, attendance, consensus decision-making policies, and grant-making procedures.

Although important, RPC members' focus on procedural details meant that they were less involved in identifying and defining the RPC Innovation Project's strategy and direction. This function largely fell to the Planning Committee (i.e., the Center, DBHS, and cochairs as of fall 2013). As a result, RPC members may not have expected to set priorities and were not always

¹⁶ Wang, G., et al. (2014, November). *Respite Partnership Collaborative (RPC) Innovation Project evaluation: Report 1*. Retrieved from http://www.shfcenter.org/assets/RPC/RPC_Evaluation_Report_1.pdf

equipped to do so. One interviewee described the RPC members' response when asked to identify priorities:

There's crickets because they haven't been in the driver seat, ... and if we said ... "We won't do anything until you guys say so," that might encourage folks to maybe be more part of that process. ... To drive the agenda and drive what's being discussed within the meeting, I think would look probably different than what it does now if [that] had taken place from the very beginning and [they] have been trained to know how to develop agendas from meetings and be a part of that.

Barriers to stakeholder involvement. Membership and attendance policies, requiring members to maintain an 80% attendance rate within a 6-month period, were not conducive to hospital system and law enforcement stakeholder participation in the RPC. These stakeholders did not commit to the membership and attendance requirements, and the RPC decided not to accommodate stakeholders' requests for shared seats and comembership. The RPC invited hospital system and law enforcement representatives to meetings to share their perspectives as nonvoting members. Yet, these stakeholders were identified as the most important missing voices in 2013, 2014, and 2015 RPC surveys.

Waning Engagement

Declines in membership and engagement over time hindered the community-driven process. One RPC member shared:

You had a handful of people that really participated and that made the decisions. ... I believe that as membership ... trickled and participation dwindled, then you end up with less viewpoints, less stakeholders. ... I think that you lose the bigger community.

We identified two reasons for declining engagement: time requirements and the natural phases of the project.

Time requirements. The RPC Innovation Project's time requirements prevented some members from active involvement in the community-driven process over an entire membership year.

When standing committees were in place, RPC members prepared for and attended standing committee meetings and other RPC obligations (e.g., full RPC meetings, grantee learning events). Some RPC members felt overwhelmed by the time commitment to meet standing committee demands. One RPC member shared:

[You need to have] realistic opportunities for the community to be involved without it burning them out really quickly through the process, and not wanting to be a part of it because they feel like it's just so much that they can't manage it. ... It's a huge commitment to be a part of something like this, and have homework in between, and still do your full-time job, and manage whatever family or social life you may have outside of the collaborative.

Even without standing committees (dissolved in 2015), some RPC members continued to find the meeting schedule to be challenging, as commitments cut into normal work hours. Other RPC members found it difficult to balance RPC participation with other competing priorities and life events (e.g., pregnancies or bereavement).

Project phases. Waning engagement was also related to the RPC Innovation Project’s phases, from building the collaborative, developing RFPs, selecting grantees, and distributing the money to managing grants. Several interviewees discussed how “exciting” it was to be at the beginning of a project that offered funding for new, needed community services. But RPC members were less clear about their role and purpose by project end. One interviewee said:

When pushing out \$5 million, it's a very concrete role for the RPC. ... The outcomes are less visible and tangible now.

Engagement may have declined among some members over time because funding prospects for their organizations were also declining. When some RPC members did not see benefits to their organizations, they decided not to participate any longer. One RPC member shared:

[When] there's new money out in the community, sometimes groups are eager to participate in something to see, “Hey, is this something that might be a good fit for our organization?”

Lessons Learned

These strengths and challenges help to inform lessons for other communities seeking to develop a community-driven process.

Define Community-Driven Process From the Start

A definition can act as a framework for establishing structures and processes that will support a community-driven process. For example, if the definition states that community members should lead project planning, then a structure that supports community member priority setting can be established from the start.

Stakeholders must also determine whether a process can be fully and wholly community-driven, especially within the context of public funds. For example, community member decisions to start or to end funding must be consistent with governmental rules and regulations for contracts and political context.

Decide Whether and How Often to Revisit Structures and Processes

Although a starting structure allows participants to move quickly into their work, participants may become accustomed to established structures. Periodically reflecting on existing structures and processes may give participants the opportunity to assess whether they have the roles they desire and whether they are fulfilling the roles to the best of their abilities. However, revising structures and processes has trade-offs. The time-consuming exercise can detract from key tasks. For example, time that the RPC members spent on developing structures and processes was time not spent deliberating more strategic decisions about mental health respite services.

Specify Roles and Responsibilities for Each Entity

With a definition of community-driven in mind, participants can determine clear criteria for membership and voting rights. Further, participants can better identify who sets agendas, leads meetings, comes up with options, presents options, makes recommendations, makes final decisions, manages budgets, describes detailed processes and procedures, and supports the project overall. It may be helpful to articulate roles and responsibilities for community member volunteers, paid staff, public funders, and private funders. For each role, another consideration is making sure that participants have the resources and trainings they need to fulfill their responsibilities.

Establish Strategies for Building and Sustaining Engagement

As projects move from start-up to maintenance phases, the strategy to attract and keep members may need to evolve. The kinds of members and skills (e.g., skills in setting the vision, stakeholder engagement, governance) to attract for a fast-paced, initiation phase may not be the same members and skills (e.g., skills in communication, grant management, sustainability) to include during maintenance phases.

4. Respite Services Provided by RPC Grantees

Summary

An evaluation objective was to assess the extent to which the RPC Innovation Project improved the quality and outcomes of respite services in Sacramento County. RPC Innovation Funding enabled 10 grantees to provide new or expanded respite services in the community. Although grantees' services were different, we identified four common dimensions of respite that cut across programs. These dimensions define respite for this community and set the standards for quality for future efforts. According to interviewees, clients were satisfied with the respite services as a whole, and services helped clients to improve skills and decrease use of more intensive services. Finally, we identified several implementation factors that contributed to quality and outcomes.

Introduction

The RPC Innovation Project released three rounds of grant funding between 2013 and 2015 and funded community-based organizations that served MHSAs Innovation Plan populations (Exhibit 5). Under the umbrella of MHSAs Innovation Plan populations, grantees also served subpopulations including but not limited to lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI) youth and adults; homeless youth and adults; and transition-age youth (ages 18–24) coming out of foster care.

Exhibit 5. Organizations Funded by the RPC Innovation Project and Populations Served

MHSA Innovation Plan Populations	Organization
Children with complex mental health needs in crisis/parents need a break	Capital Adoptive Families Alliance
Specialized cultural or ethnic populations	United Lu-Mien Community Services, Inc.
Adults/older adults in crisis	Del Oro Caregiver Resource Center Turning Point Community Programs TLCS
Adults/adults in crisis who have dependent children	Saint John's Program for Real Change
Teens/transition age youth in crisis	Children's Receiving Home Sacramento LGBT Community Center Wind Youth Services
Unserved/underserved cultural populations	A Church for All Gender Health Center Sacramento LGBT Community Center

This section summarizes findings from document reviews and interviews with grantee staff and clients. We report the definition of respite and quality, outcomes (as discussed and reported by grantee staff and clients), and key elements for implementing and sustaining services to provide quality respite care and to help improve client outcomes.

Definition of Respite and Quality

Several grantees described how the RPC Innovation Project respite programs provide services that no other organizations offer. An interviewee stated:

I don't know if there was anything called respite in Sacramento County before this. ... They [the RPC] looked to fill in different needs in the community that may not have been on people's radar throughout the community and maybe just in a specific community. It set up an array of different services, instead of pigeon-holing one type of service.

Further, the grantees provide an array of respite services that differ across organizations (e.g., 24/7 care for adults in crisis, summer camps for families with children experiencing mental health crisis). Four cross-cutting dimensions of respite help to define respite and to explain the quality of services provided (Exhibit 6). We describe each dimension, illustrate how grantees implemented respite in accordance with these dimensions, and share grantee staff and client perspectives on each dimension.

Exhibit 6. Dimensions of Mental Health Respite Described by Grantee Staff and Clients



Mental and Physical Break

A period of time that provides physical distance or decreased exposure to emotional or physical stressors.

Most grantees provided clients with time and physical space away from stressors (e.g., stigma and discrimination; environmental stressors, particularly for homeless clients) in a warm and welcoming environment. During interviews, many staff and clients spoke favorably about the atmosphere provided by grantee organizations and how it differed from more traditional service providers.

Grantees offered many options to provide different clients with a physical and emotional break. While some offered several hours of respite, others provided longer term out-of-home respite for up to 14 days. A few grantees offered a menu of in-home and out-of-home care options so that caregivers could take a break from caring for loved ones. These options included supervised activities for children, hourly in-home respite, 24-hour in-home respite, adult daycare respite, and institutional respite.

Respite services also gave a mental and physical break to those in a “constant state of crisis,” such as the homeless youth and LGBTQI populations, to escape daily acts of aggression and hostility. A staff member shared:

Respite is crucial for these young folks because not only can they get a break from the elements, they get a break from police harassment, discrimination, violence from other folks outside. ... It is truly [a] ... life-sustaining break when they come into our drop-in center and can exist in a safer space.

Some grantees offered the opportunity for clients to get the physical and mental break they needed in a way that worked best for them. TLCS, Inc., and A Church for All clients could choose to be alone in a quiet space, reach out to staff or other clients, or use the phone or computer to connect with loved ones or other services. Many clients appreciated this flexibility and described it as a positive aspect of their respite experience.

Safe Place

A safe place is defined as “an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together.”¹⁷

Grantee staff and clients described respite as a physically and emotionally safe place. Homeless clients, in particular, used respite to rest and seek refuge from harsh conditions. In addition to offering a safe place for clients to come in and rest, grantees functioned to help keep out physical threats. One staff member shared:

We're the only door that is locked. ... There's people who have gone through horrible things like rape or assault or anything, and it's just knowing the fact that the door is locked and no one is going to come in without the staff knowing, it's just a lot of peace of mind.

In practice, grantees used two approaches to create and maintain emotionally safe places for clients. First, some included peer respite models. For example, many youth at the Sacramento LGBT Community Center and Wind Youth Services were wary of law enforcement, adults, or other authority figures. In response, the Sacramento LGBT Community Center ran a peer-based

¹⁷ Williams, R. (1999). Cultural safety—what does it mean for our work practice? *Australian and New Zealand Journal of Public Health* 23(2), 213–214.

model, in which groups of youth ages 13 to 17 and ages 17 to 23 participated in open discussions and support.

Second, grantees established ground rules related to such behaviors as respect and inclusion to help create safe places, which they communicated to clients in various ways. Clients faced consequences if they did not follow these ground rules. A staff member explained:

If there is any sort of language that is, in any way, shape, or form, prejudiced, hateful, disrespectful in any regard we shut it down. We let them know immediately. We go through it, this is a safe place and you cannot speak like that out here. If that is how you feel, you are more than welcome to take it outside and take it on but in this drop-in center, absolutely not, there will be no hate speech. We are on it. We will not tolerate it. Absolutely not.

Not Alone

The realization that others face similar challenges to yours and do not judge those challenges, your reactions to them, or means of coping.

Grantees cultivated a sense of community among consumers by providing spaces where they could form relationships with others who share similar experiences. For example, a Capital Adoptive Families Alliance parent said:

because the group itself ... creates an atmosphere that does give relief, it does give some down time, because you know that you're around a group of people that are in the same boat that you're in. ... I don't worry if my child ... has an anxiety attack around these people, because they're not going to freak out.

Grantees formed support systems that extended beyond respite hours. Beyond forming emotional systems of support, A Church for All encouraged their homeless clients to form communities for physical safety:

[We] encourage them to develop community, and support each other, and empower each other ... and that then helps them to stay safe in the evenings, overnight when they're out on the streets. They then report back and forth to us about the condition of folks and, and if we have concerns about people, they help us find people...we've developed a model where we think about peer support and empowerment in less than ideal settings where people have to survive.

Grantees also developed trusting and supportive relationships with clients. One staff member said that it can help clients “feel connected to the world. They have a bond some place with someone who can do something.” Staff helped with providing phones or computers to connect with loved ones or to find additional support services. As a result of these trusting and supportive relationships, clients confided in staff members. A client shared this experience:

Even [the counselor] was here with me and we talked, and there were two staff members. It was painful to let him know what was going on. And the incredible thing that really, really impacted me, which was so cool, is that I was able to tell him, like an intimate man, like a friendship type of thing. ... Just to have those people in my life is incredible. It's a huge growth for me. So that means I'm growing leaps and bounds and realizing that I am doing the deal instead of rocking back in a fetal position.

Looking Forward

Being in a better emotional state and being able to look forward after receiving respite services.

Grantees provided clients the opportunity to leave refreshed and ready to take the next steps. Staff and clients emphasized the restorative nature of respite services, describing respite as helping clients to “get back on [their] feet” and “move forward with [their] journey.” Staff and clients discussed services that helped them look forward (Exhibit 7).

Exhibit 7. Services Delivered by Peers and Professionals to Help Clients Look Forward, by Grantee

Grantee	Examples of Services Delivered by Peers and Professionals
A Church for All	<ul style="list-style-type: none"> • Counseling • Support from staff to access phone and Internet to connect with other community organizations and/or social services (e.g., Sacramento County's Alcohol and Drug program)
Capital Adoptive Families Alliance	<ul style="list-style-type: none"> • Recreational therapy for children with complex mental needs • Support groups
Del Oro Caregiver Resource Center	<ul style="list-style-type: none"> • Development of individualized respite plans
Gender Health Center	<ul style="list-style-type: none"> • Counseling • Referral to internal hormone clinic, navigation and enrollment services, legal services, etc.
Iu-Mien Community Services	<ul style="list-style-type: none"> • Introduction of mental health concepts and how to cope with mental health challenges
LBGT Center	<ul style="list-style-type: none"> • Support groups
Saint John's Program for Real Change	<ul style="list-style-type: none"> • Counseling • Goal-setting • Professional development services (e.g., resume review)
TLCS, Inc.	<ul style="list-style-type: none"> • Counseling
Turning Point Community Programs	<ul style="list-style-type: none"> • Solution-focused brief therapy and dialectical behavioral therapy
Wind Youth Services	<ul style="list-style-type: none"> • Counseling • Navigation services provided by Youth Advocates • Provision of clothing and hygiene products for job interviews

Some grantees helped with transportation to off-site agencies. TLCS, Inc., offered taxi or bus service. Saint John’s Program for Real Change, Wind Youth Services, and A Church for All gave bus passes to attend appointments, get medications, and connect clients to other community organizations. These included mental health agencies and service providers, adoption agencies, board and care facilities, medical clinics, domestic violence organizations, and education and vocational training programs. As a Wind Youth Services client described:

I think the most convenient thing about Wind is that I could call the Drop-in Center ... or I can email my [youth advocate] and I'm like, I need you to print these things and I need you to have this set up for me. ... So by the time I get [to the respite center] I can come get these things and give me a bus pass so I can leave and go achieve these things.

Round 3 grantees helped clients get identification (e.g., birth certificates) to access community services. One grantee stored identification documents at their facility and provided copies to clients due to the high rate of identification theft among the homeless population.

Client-Related Outcomes, as Discussed by Grantee Staff and Clients

The next section presents grantees’ perspectives on respite program outcomes. These outcomes come from progress reports and client and staff interviews; findings are not intended to be generalizable to all respite services or clients. Clients and staff reported on several categories of client-related outcomes.

Satisfaction With Services

A Church for All, Saint John’s Program for Real Change, and Turning Point Community Programs asked clients about satisfaction with respite services via surveys and reported client satisfaction rates of more than 80%.

Clients in particular discussed positive experiences with respite staff, such as feeling respected, cared for, and accepted without judgment as compared to staff at other organizations where they received mental health–related services. One client said:

I feel like the staff are very respectful. They're not condescending or they don't belittle you or ridicule [you]. I've been in places where the staff would just make a situation ... escalate just by their attitude towards the patients and by their personal judgment for those people with borderline personality disorder or any mental health disorder. Here, I haven't come across that yet. I feel supported from everyone.

Improved Skills

Other staff and clients discussed how clients left respite services with improved communication and coping skills. For example, United Iu-Mien Community Services staff reported seeing clients engage in more open discussion about mental health with peers, helping to reduce stigma in the Iu-Mien community. Staff at Wind Youth reported observing youth using the de-escalation

techniques taught in the workshops at the drop-in center to help prevent “flare-ups” among their peers. A staff member shared:

I've also noticed that when tempers flare, other youth will step in and help others de-escalate. They will step in and separate the parties, they will step in and say you don't want to do this right now. ... They have that ability, and it's amazing because maybe they have a hard time applying it to themselves.

Capital Adoptive Families Alliance, United Iu-Mien Community Services, Sacramento LGBT Community Center, and Turning Point Community Programs assessed coping skills, and all reported improvements in clients’ ability to cope. Several clients reported that they could better handle “trigger” situations in the community after leaving respite. One staff member described teaching and reinforcing positive coping techniques:

I will ask them OK how do you handle that ... how do you cope with that, what makes you feel better in order to manage whatever that is, depression, or anxiety. ... And so if they have some really good coping mechanisms, I will give them feedback, you know, well that's very wise you've learned how to do that, I want you to feel good about yourself with that. ... And if they don't I will start suggesting some to them so we can work on it together, so that they are better equipped when they leave there that they can handle a crisis.

Mental Health

Capital Adoptive Family Alliance, Del Oro Caregiver Resource Center, Gender Health Center, Sacramento LGBT Community Center, and Wind Youth Services sought to understand improvements in clients’ overall mental health after respite. A majority of surveyed clients reported improved depressive symptoms, a reduced state of crisis, and feeling emotionally safe.

Emergency Department Visits

It was not feasible to study the causal effects of respite services on emergency department visits or psychiatric hospitalizations due to the variation in size, foci, and sophistication in tracking systems among grantees. Nevertheless, grantees felt very strongly that they were decreasing client use of hospital systems. Some clients from Iu-Mien Community Services, Gender Health Center, A Church for All, and Turning Point Community Programs reported that they would have called 911 or gone to the emergency room (ER) without respite. One client said:

It's an ER alternative for people who could never go to an ER because they do not feel safe or feel they could be taken care of.

Key Factors for Implementing and Sustaining Respite Services

Grantees discussed implementation strategies that they viewed as critical to delivering quality respite services and improving client outcomes based on their experiences with the RPC Innovation Project. Key strategies that grantees described were:

1. Determine appropriate respite services that respond to community needs and that are clearly defined for staff and clients.
2. Develop plans, models, and policies that are flexible and realistic.
3. Hire and train staff that are compassionate, culturally competent, and open to learning new skills.
4. Build partnerships to establish community buy-in, engage clients and foster collaboration to address diverse community needs.
5. Improve data collection to track client outcomes.
6. Identify different means to sustain respite services such as additional grant funding, donations, and fundraisers.

Determine Appropriate Respite Services That Respond to Community Needs and That Are Clearly Defined for Staff and Clients

Determining appropriate respite services included the need to develop a clear understanding of crisis and respite as well as to respond to the needs of the community being served.

Develop clear definitions of respite and crisis. Grantees held their own interpretations of respite and crisis, and uncertainty about term definitions affected program implementation. Unclear definitions resulted in screening complications and inappropriate referrals from partner organizations. One grantee discussed the need in the first year to think through what defines a mental health crisis, which clients could best be served by the program, and which clients could be better served by other organizations for non-mental health issues. Grantees believed communication and outreach to partner organizations—on how grantees defined crisis and respite and in turn which clients they served—was essential to appropriate referrals.

Respond to community needs. The grantees' mandate was to provide services to unduplicated clients experiencing a mental health crisis. But many grantees found a need to extend respite services to clients facing chronic mental health issues rather than acute crises. Most grantees supported this need by offering clients repeat services, extending a needed stay, or shortening the time before a client was allowed back. One staff member said:

We were anticipating more of a traditional crisis intervention model, ... and it turned out that was not what the program required. That's not what our community was asking for.

Grantees including Gender Health, A Church for All, and Wind Youth from Round 3, as well as TLCS and Turning Point from Round 2 provided services to homeless people experiencing a mental health crisis. They implemented two different approaches. The first approach prioritized mental health crises and tried to “balance” providing services to homeless persons. One staff member stated:

We balance all the time talking to people that are homeless. A term we use is if this is a mental health crisis or if it's a logistical housing issue crisis, and sometimes it's both. If it's just a logistical issue, they just want a place to stay, and that's not what a mental health crisis center is for. That's one of the biggest challenges we deal with—the homeless population that wants shelter.

The second approach prioritized serving homeless populations with the belief that being homeless is, in and of itself, a mental health crisis. These organizations described respite as a life-sustaining break from not only the outside elements but also from harassment, discrimination, and violence their clients face on the street.

Homelessness is a mental health crisis. The high levels of trauma, abuse, and violence that our young folks are subjected to while outside absolutely either creates a mental health condition, or exacerbates an existing one.

Develop Plans, Models, and Policies That Are Flexible and Realistic

Each grantee faced challenges in developing and implementing the service plans proposed in their initial grant applications. One grantee discussed the need to develop a realistic implementation plan that included the right amount of staff time needed to execute the program and provide staff salaries comparable with other organizations to prevent high staff turnover. A staff member shared:

Being very realistic about what you need, in terms of infrastructure and personnel, is essential. I would say that any time you apply for grant funding, it's so easy to underestimate that piece of it. ... Sometimes we forget our staff are the service in some ways.

Another grantee recommended a flexible service model tailored to the client population. As grantees further identified client needs, they needed to modify services. For example, one grantee needed to adjust how much time clients were permitted to stay at the facility. Another grantee needed to increase access to practical resources such as a taxi service.

Developing bylaws and procedures, including how to welcome clients and how to de-escalate situations, was important for grantees. For example, Wind Youth and Gender Health each identified themselves as “low-barrier” or “unconditionally supportive ... in welcoming clients.” They did not prevent clients from accessing services based on past conduct or situations. Staff view violent outbursts, verbal assaults, or physical violence as mental health issues at their core. Therefore, clients involved in violence may access services after meeting with staff members. One grantee staff person commented:

When you are offering respite services, you have to have that consistency [in services] if you're going to build any trust and rapport with the people that are coming in. Sitting down and writing out, what are your procedures, what are your rules, what are your policies? When this (an infraction) comes up, how are we going to respond in a consistent way? ... We can't expect clients to abide by rules if they are not clearly communicated.

Hire and Train Staff Who Are Compassionate, Culturally Competent, and Open to Learning New Skills

All grantees acknowledged the importance of their staff. Finding staff with the appropriate personality and skills to deliver respite services, in some cases under challenging circumstances, was crucial to delivering quality respite care. One organization discussed hiring professionals trained in complex mental health issues; two other organizations described finding staff who may not have mental health experience but who are compassionate and have the ability to deliver consistent care to clients.

Cultural competency. Grantees were committed to ensuring that staff reflect the populations they serve. Peer-based models helped to ensure a culturally competent staff because staff often share similar cultural characteristics as clients (e.g., being the same ethnicity; speaking the same language; identifying as LGBTQI; or having been homeless, a teenage mother, in the foster care system, or a caregiver to a child with a lived mental health experience). One staff member said:

We knew our community was being severely under-served and experiencing aggression, microaggression, and hostility. I mean, we know this from our lived experience.

Grantees also discussed building strong client relationships and fostering trust to provide culturally competent services. A staff member stated:

One lesson we learned is that it's important to build good relationship with the clients that you serve, in order to provide culturally appropriate services to them. Without that trust, you can't really engage in conversation with specific populations because if they don't know who you are, they usually don't tell you what's bothering them, especially if the subject is mental health.

Staff trainings. Grantees expressed the need to “continually assess the healthiness” of staff and provide support and trainings to effectively deliver services to clients. One staff member stated:

The other lesson is keeping up with training for staff and volunteers, which is really important. Mental health training such as cultural competence training, detecting what people need, assistance, what mental health issues they think they might have or what they need, to understand that in a way that you can find the right resource for them.

Trainings included harm reduction, de-escalation techniques, suicide assessment and prevention, dealing with grief and loss, motivational interviewing, CPR, and first aid. TLCS, Inc., provided 3 weeks of training to new staff members, whereas Wind Youth provided an all-day Mental Health 101 to all new employees and a monthly training thereafter. A Wind Youth staff member shared:

We've had training in mental health so we've become more aware of what different types of mental health crisis look like, and just being able to better assist each other and have back up support on the drop-in center floor as staff members has been great.

Build Partnerships to Establish Community Buy-In, Engage Clients, and Foster Collaboration to Address Diverse Community Needs

The first year implementing the grant was an essential time for grantees to build relationships and to exchange ideas with neighbors, partner organizations, and clients. Outreach efforts informed the community at large of their services and helped build referral networks with other agencies. Establishing community support involved multiple phone calls, face-to-face meetings, and presentations with hospitals, community members, organizations, and government services such as the fire department. For example, TLCS, Inc., hosted an open house, held a news conference, created a weekly newsletter, and participated in more than 100 outreach events and meetings. Saint John’s Program for Real Change strengthened existing partnerships and conducted outreach by word of mouth and flyers at drug courts and mental health courts.

Many grantees conducted community outreach to better inform neighbors and partner organizations about their services to mitigate concerns. Nevertheless, neighboring businesses concerned by client behaviors presented challenges to three grantees. A staff member expressed:

It’s just been hard to exist here, and do our jobs well, when the police and the city and our neighbors really feel strongly about us leaving.

Further, grantees discussed how the RPC Innovation Project provided an opportunity for grantees to collaborate on referrals, staff trainings, and sharing of protocols, procedures, and data tracking. Grantees took advantage of networking opportunities created by the RPC Learning Communities to learn about each other’s services, client population, as well as best practices. Many grantees worked together to form a continuum of care for their clients. For example, one interviewee discussed that they might refer a client with more intense needs from their 6-hour respite program to TLCS’s 23-hour respite program.

Develop data collection methods to track client outcomes

Many grantees sought to assess clients entering and exiting their respite programs. In doing so, they needed to improve their data collection to understand client outcomes and the impact of respite in the community better. Two key themes emerged.

Accuracy and completeness. Although a few organizations administered surveys to assess outcomes such as coping skills and overall mental health state, challenges included comprehension of survey questions, refusal to complete survey questions, or clients leaving prior to survey administration. One staff member stated that many youth from the foster care system resisted completing surveys:

[Paper surveys are] something that was new to them. Past youth program coordinators never forced them to do any type of data tracking. ... On housing status, about 1% reported that they were from a foster environment, but 43% refused to answer the question.

Infrastructure. Most grantees did not have formal data collection processes in place to measure emergency department visits, psychiatric hospitalizations, and institutionalization. A few grantees with a more robust data collection infrastructure were interested in, or were in the process of,

determining how they might measure such outcomes. For example, Wind Youth used RPC funding for a new data collection system. The staff member hoped the new system would provide:

housing, mental health connections, physical health, how many youth are involved in Medi-Cal, how many youth are connected to their PCPs, transported to doctor visits, we do a lot of that work and it's not properly captured. Preventing emergency room visits honestly, because the peer counselor program is something specific that we're going to focus on with the implementation of this data collection, and so I would like to see that. I would like to just have solid demographics that I can take at any moment.

Identify Different Means to Sustain Respite Services Such as Additional Grant Funding, Donations, and Fundraisers

Sustainability of innovation projects is not a guarantee. Welfare and Institutions Code Section 5830 allows counties to transition successful innovation projects to another category of MHSA funding as appropriate. This project's timing was fortunate as it aligned with a period of MHSA expansion by DBHS. Each of the 11 respite programs came before the MHSA Steering Committee for consideration of sustainability based on meeting or exceeding RPC performance measures, as indicated by progress reports that were approved by the RPC. DBHS conducted a MHSA component analysis for each respite program to determine whether it aligned with either the MHSA Community Services and Supports or Prevention and Early Intervention components and to identify any necessary programmatic shifts. With support from the MHSA Steering Committee, each of the 11 respite programs transitioned to sustainable Community Services and Supports or Prevention and Early Intervention funding and service contracts directly with DBHS.

This opportunity was helpful for smaller organizations, such as A Church for All, Capital Adoptive Families Alliance, and Gender Health Center. The RPC's seed funding for these small-scale organizations opened the door to other funding sources that required organizations to meet certain criteria.

All grantee staff also described plans to apply for other grant funding. For example, Gender Health Center is pursuing a California Reducing Disparities Project grant under California's Office of Health Equity.

Securing funds through donations and fundraisers was a common strategy among grantees. Nonmonetary donations were a new sustainability strategy for Round 3 grantees in particular. For example, LGBT Community Center noted success with food donations. They want to pursue a formal food donation program and use the additional funds to extend respite program hours or expand the program in other ways.

5. Conclusion

The RPC Innovation Project set out to test how a novel public-private partnership and a community-driven process would influence respite services in Sacramento County. Through interviews, surveys, and document reviews, we found the following.

The public-private partnership between DBHS and the Center successfully launched and maintained the RPC Innovation Project. The partners shared a vision to improve mental health services and learned about each other's unique contributions and culture. Partners faced challenges related to incongruent expectations and approaches for the RPC Innovation Project. Despite challenges, the partnership lasted 5 years and supported RPC members in their community-driven process.

With substantial partner support, the RPC Innovation Project included a community-driven process. This process gave RPC members from the community opportunities to solicit, review, and fund proposals each year for 3 years. The diverse members representing many stakeholder perspectives felt the community-driven process was collaborative and offered important networking opportunities. By increasing RPC member opportunities to lead, the process became more community-driven over time. But, even by project end, some felt the project was not fully community-driven. Challenges to the community-driven process were the extent to which RPC members were willing and able to lead, the absence of key voices, and waning engagement. Despite these challenges, RPC members' participation in the community-driven process resulted in funding for 11 new or expanded respite programs.

The grantees' respite programs delivered a range of services; for example, some offered drop-in programs and others offered overnight programs. They also served diverse clients, from caregivers to youth and adults at risk for experiencing crises. Despite differences in services and clients, four common dimensions across programs set the standard for respite program quality in the future. Staff and clients reported that satisfaction with services was high, and respite helped to improve skills and mental health while decreasing hospital system use. Grantees shared six lessons learned for how best to implement high-quality services that improve clients' outcomes. The lessons addressed determining appropriate respite services that address community needs; developing flexible plans; hiring and training staff; building partnerships across the community; improving data collection; and identifying different means to sustain respite services.

6. Appendices

Appendix A. Year 1 Report: Executive Summary

The Mental Health Services Act (MHSA)—funded by Proposition 63—was enacted in California in November 2004. MHSA funding supports five unique components: (1) Community Services and Supports, (2) Prevention and Early Intervention, (3) Workforce Education and Training, (4) Capital Facilities and Technology, and (5) Innovative Programs. Innovative programs contribute to learning by testing new approaches to inform current and future practices.

In September 2010, the Sacramento County Division of Behavioral Health Services (DBHS) initiated a community planning process to develop Sacramento County’s first Innovation Project. Through community input, the Respite Partnership Collaborative (RPC) Innovation Project was created with the goal to create alternatives to hospitalization by increasing local mental health respite service options for community members experiencing a mental health crisis in Sacramento County. The project seeks to: (1) create learning opportunities on how the project is developed and administered, (2) integrate community feedback into program development and implementation, and (3) expedite the release of funds of respite services to community organizations. The RPC Innovation Project is administered by the Sierra Health Foundation: The Center for Health Program Management (the Center).

As part of the Innovation Project, an evaluation contract was awarded to American Institutes for Research (AIR) to evaluate the 5-year RPC Innovation Project. The main evaluation objectives are to assess the extent to which the RPC Innovation Project does the following:

1. Promotes successful collaboration between public and private entities (i.e., DBHS and the Center) in Sacramento County.
2. Demonstrates a community-driven process.
3. Improves the quality and outcomes of respite services in Sacramento County.

The purpose of this annual report is to present early findings from evaluation activities conducted from June 2013 through June 2014. Evaluation methods employed include interviews, surveys, and document review, all of which are detailed in Chapter 2.

Main findings about the RPC Innovation Project include:

1. Structures and processes need to be clearly defined and implemented in order to establish a new community-driven group process and enable the group’s grant making.
2. Considerable time is required to establish structures and processes, and to decide on how best to engage members continually. Time is required for administrative responsibilities as well as serving on committees and attending multiple monthly meetings.
3. Public and private entities may have different approaches to achieving specific activities or goals. Effort is required in presenting and resolving conflicting strategies and familiarizing each other with own priorities, resources, and approaches.

As seen from the following, diverse RPC members were engaged, though it is unclear the extent to which the RPC Innovation Project was a community-driven process:

1. Intentional recruitment and accommodating members regardless of background or experience can achieve considerable diversity, including a mix of lay and professional members.
2. Members need to devote many hours to the RPC Innovation Project's processes and deliberations on a monthly basis. Time commitment requirements can be seen as a problem and can help explain members' minimal role on nonmeeting-related activities, including getting organizations to develop and submit proposals for funding. In addition, time commitment requirements may be a reason why hospitals and law enforcement were not successfully engaged as key stakeholder groups.
3. The Center and DBHS are perceived as co-leading the RPC Innovation Project and having more influence than members. Due to this, it remains unclear the extent to which the RPC Innovation Project demonstrates a community-driven process.

The RPC Innovation Project resulted in new respite services in Sacramento County:

1. The RPC Innovation Project successfully funded organizations to provide mental health respite services to varying populations.
2. Cross-cutting dimensions of respite are consistent across organizations that received funding through the RPC Innovation Project. All the respite services help clients take a mental or physical break, give clients a safe physical and emotional space to spend time, support clients in not feeling alone, and prepare clients to look forward beyond the time in respite.
3. Grantees have varying capabilities to study outcomes of their services. Immediate outcomes include utilization of respite services, and all grantees reported tracking utilization. Another immediate outcome is client satisfaction. This report offers client and staff perspectives on satisfaction based on AIR's interviews. Long-term outcomes include emergency department (ED) visits, psychiatric hospitalizations, and institutionalization; these were more difficult for grantees to capture.

Appendix B. Year 2 Report: Executive Summary

The Mental Health Services Act (MHSA)—funded by Proposition 63—supports five unique components: (1) Community Services and Supports, (2) Prevention and Early Intervention, (3) Workforce Education and Training, (4) Capital Facilities and Technology, and (5) Innovative Programs. In September 2010, the Sacramento County Division of Behavioral Health Services (DBHS) initiated a community planning process to develop Sacramento’s first Innovation Project. DBHS convened an Innovation Workgroup that developed the Innovation Plan and the Respite Partnership Collaborative (RPC) Innovation Project.

American Institutes for Research (AIR) is conducting an evaluation of the RPC Innovation Project. Evaluation objectives are to assess the extent to which the RPC Innovation Project does the following:

1. Promote successful collaboration between public and private organizations (i.e., DBHS and the Sierra Health Foundation: The Center for Health Program Management [the Center]) in Sacramento County
2. Demonstrate a community-driven process
3. Improve the quality and outcomes of respite services in Sacramento County

To address the evaluation objectives, the evaluation includes interviews, an RPC survey, a community survey, and a document review.

This report presents findings from evaluation activities conducted from June 2014 to April 2015 to DBHS, RPC members, and the Center.

RPC Structures and Processes

The RPC Innovation Project structures and processes have evolved since project inception. Now, the RPC Innovation Project includes in the Planning Committee two RPC co-chairs, whom most current RPC members viewed as providing leadership. In addition, the RPC Innovation Project moved away from standing committees and absorbed the work of the Communications Committee, Membership and Governance Committee, and Sustainability, Public Policy and Collaboration Committee into the full membership. Although the RPC Innovation Project used to include a professional facilitator, RPC members now facilitate their own meetings. The RPC reflected on its previous requests for proposals (RFPs) and the proposals it received in response. The RPC refined its RFP and definition of respite over the course of the project and held bidders’ conferences to increase the number of bidders who submit strong applications. Finally, the RPC monitored grantee progress on goals and made funding decisions based on goal achievement.

Public-Private Partnership

Areas that help to develop public-private partnerships include shared vision and goals, unique contributions and culture, and roles. In the RPC Innovation Project, both the Center and DBHS held a common overarching vision of improving mental health services. However, RPC Innovation Project partners experienced a challenge in how they prioritized goals, and they held different viewpoints on how actively the Center should participate and support RPC members.

At the RPC Innovation Project onset, partners were excited about the partnership and the unique contributions each partner would bring. As the RPC Innovation Project unfolded, the partners maintained their enthusiasm while learning to navigate the differences in organizational culture, process, and terminology. Partners also differed in their interpretations of how to fulfill roles laid out in the Innovation Plan. At times, partners were not clear what activities were within the scope and who was responsible for each activity.

Areas that help to maintain public–private partnerships include leadership and partnership processes. Leadership consistency in the RPC Innovation Project helped to establish goals, roles, and other activities more firmly. In contrast, changes in leadership required all partners to accommodate new ways for leaders to view and prioritize the RPC Innovation Project. Although the process of providing feedback enables partnerships to grow and evolve, RPC Innovation Project partners experienced challenges with dedicating time and developing formal activities like partnership reflection meetings to maintain the partnership.

Community Participation in the RPC Innovation Project

RPC members view the RPC Innovation Project as being collaborative, and this perception has changed only a little over time. However, RPC membership has waned over the course of the last 2.5 years, and time commitment to be part of the RPC Innovation Project was increasingly problematic in 2014 when compared to 2013. A large proportion of current RPC members also were never involved in key activities such as serving as a spokesperson, recruitment, or setting meeting agendas. Nevertheless, most RPC members felt that they, DBHS, and the Center all had a lot of influence.

RPC members' definitions of community-driven process indicate that the process involves being included in generating ideas and identifying priorities, leading and making decisions, and working on behalf of the community. In a survey, more than 90% of current RPC member respondents agreed that the RPC Innovation Project is community-driven.

Based on the community survey, more than 75% of community survey respondents had heard of the RPC Innovation Project. Among those who had heard of the RPC, most felt the RPC helped them to learn about mental health respite services and was responsible for improving services and outcomes.

Respite Services Provided by RPC Grantees

Interviews with the Round 2 grantees TLCS, Inc., and Saint John's Program for Real Change showed that respite services provided clients with time and physical space away from their current situations. These programs offer clients a mental and physical break with the flexibility to customize their respite experience to best meet their needs. During interviews, these grantees focused on physical safety. Grantees offer security by meeting clients' immediate, basic needs and providing a secure environment free of physical threats. Round 2 grantees also discussed "friendship" and "trust" in staff. Clients said they previously feared sharing their experiences, but now talked with staff about their feelings. Although TLCS, Inc. and Saint John's Program for Real Change offer a place for clients to gather, the focus is less on bringing communities together than it is on providing individuals opportunities to talk through their life experiences,

current needs, and next steps with staff. Interviewees described helping clients to feel more rejuvenated to focus on their individual goals.

Interviewees addressed key issues and lessons learned in implementing respite services at their organization. Themes that emerged from the interviews included training staff, determining client services, and networking and outreach. Both Saint John's Program for Real Change and TLCS, Inc., described the need to train staff extensively before delivering respite services to clients. Training topics included mental health 101, motivational interviewing, harm reduction, suicide assessment, trauma-informed care, working knowledge of community resources, and cardiopulmonary resuscitation (CPR) and first aid. Round 2 grantees emphasized the importance of strategizing how to implement services as their clients have a "great range of needs." Strategies were put in place at the beginning of and throughout the program on how to assess clients for respite services, what services to offer, and the amount of staff time needed to accomplish established goals. Finally, Round 2 grantees worked to establish networks. These outreach efforts informed the community at large of their services and built the trust needed for agencies to refer clients to them.

Regarding outcomes monitoring, Round 2 grantees provided utilization data on the number of people served. Saint John's Program for Real Change and TLCS, Inc., administered client satisfaction surveys, but data collection could be challenging because clients left unexpectedly and did not always understand what was being asked of them. Although both grantees have data collection systems in place, they do not currently have formal processes to measure long-term outcomes related to emergency department (ED) visits, psychiatric hospitalizations, and institutionalization.

Sustainability strategies described during interviews with Round 2 grantees included seeking additional grant funding, looking for funding and collaborative opportunities with hospitals, and trimming costs.

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