BEHAVIORAL HEALTH AND RECOVERY SERVICES
A Mental Health, Alcohol and Drug Service Organization

Madelyn Schlaepfer, Ph.D.
Behavioral Health Director

800 Scenic Drive, Modesto, CA 95350

July 22, 2016

Mental Health Services Oversight & Accountability Commission
1325 J. Street, Suite 1700
Sacramento, CA 95814

Dear Colleagues:

Please find attached Final Learning Reports for two (2) Stanislaus County Mental Health Services Act (MHSA) Innovation Projects that were completed in FY 15-16. They are being submitted separately and were not included in the FY 16-17 Annual Update because of time and logistical constraints.

Working from the BHRS Vision and Mission, MHSA General Standards, input from stakeholders, and in accordance with state guidelines, these projects were developed in FY 2013-14. As three (3) year demonstration projects, they were fully and successfully implemented by two (2) organizations: Turning Point Community Programs and the Center for Collective Wisdom. Each Innovation project ended on June 30, 2016.

We understand that counties must provide the Mental Health Services Oversight and Accountability Commission with a Final Report upon completion of these projects and that the Final Report may be included in the county's Annual Update or its Three-Year Plan, whichever is due during the year the project is completed. The county does not have to provide, but may submit, a separate report.

An acknowledgement that you have received this document is appreciated.

If you have any questions, please do not hesitate to contact me, or Dan Rosas, MHSA Manager, at (209) 525-6225.

Sincerely,

Madelyn Schlaepfer, Ph.D.
Behavioral Health Director

cc: Dan Rosas

Enclosure

StanUp for Wellness!

Support Mental & Emotional Health

Stanislaus County
Behavioral Health and Recovery Services

Mental Health Services Act
Innovation Final Reports FY 2015-16
June 2016

Stanislaus County
Striving to be the Best
Behavioral Health and Recovery Services

Mental Health Services Act
Proposition 63
California

WELLNESS • RECOVERY • RESILIENCE

TABLE OF CONTENTS

Stanislaus County Behavioral Health and Recovery Services (BHRS)
MHSA Planning Office
800 Scenic Drive
Modesto, CA 95350
Phone: (209) 525-6247 Fax: (209) 558-4323

INNOVATION OVERVIEW

Innovation is one of five components of Proposition 63, the Mental Health Services Act (MHSA), passed by California voters in 2004. It provides funds and evaluates new approaches in mental health. The projects contribute to learning about and addressing unmet need rather than having a primary focus on providing services.

Innovation projects are developed to target a mental health adaptive dilemma, or a challenge that cannot be resolved through habitual or known responses. The result we hope to achieve is the development of new best practices in mental health in Stanislaus County.

Innovation funding is unique and intended for projects that focus on and demonstrate one of the following primary purposes:

a) Increase access to mental health services to underserved groups;
b) Increase the quality of mental health services, including measurable outcomes
c) Promote interagency and community collaboration related to mental health services, supports, or outcomes;
d) Increase access to mental health services

In addition, Innovation projects are expected to contribute to learning in the following ways:

a) Introduce a new mental health practice/approach that has never been done before
b) Make a change to an existing mental health practice/approach, including an adaptation for a new setting or community
c) Introduce a new application to the mental health system of a promising, community driven practice/approach or a practice/approach that's been successful in a non-mental health context or setting

Innovation projects are developed through input from community planning processes and are reflective of the unmet need identified by inclusive and diverse stakeholder input. Innovation funding makes it possible to try out new approaches, gather data, define and measure the success of the new approach or practice without taking funds away from other necessary services.

Round 1 of Innovation Funding

Since January 2010, Stanislaus County has conducted community planning for Innovation funding that resulted in the development of 17 new projects to date. The first round of planning resulted in one project with learning goals related to stakeholder and agency partner participation in understanding public funding processes and how these community partners may contribute to decision-making.

The project was entitled "Evolving a Community-Owned Behavioral Health System of Supports and Services". Concluding in FY 2012-13, the final report was submitted to the MHSOAC in June 2013.

Round 2 of Innovation Funding

Stanislaus County's second round of Innovation planning began with the BHRS Leadership Team's intention to bring project ideas in behavioral health unique to efforts in the county's commitment to community capacity building, increasing protective factors, and advancing of non-stigmatizing early intervention approaches. On October 26, 2010, the Stanislaus County Board of Supervisors authorized the first Request for Proposals (RFP) process for the Innovation learning projects. It resulted in the selection and funding of nine (9) new projects operated by six (6) unique community based organizations and one county agency for two or three years.

Six final reports were submitted to the MHSOAC in June 2014. The organizations and their projects were as follows:

- Center for Human Services/Building Support Systems for Troubled Children
- Center for Human Services/Civility School Learning Project
- Center for Human Services/Revolution Project
- Stanislaus County Health Services Agency/Integration Innovations
- Sierra Vista Child and Family Services/Connecting Youth to Community Supports
- Tuolumne River Trust/Promoting Community Wellness through Nature

Three additional projects from round two were completed in FY 2014-15.

The organizations and their projects were as follows:

- National Alliance for Mental Illness (NAMI)/Beth and Joanna Friends in Recovery
- West Modesto King Kennedy Neighborhood Collaborative/Families in the Park
- Peer Recovery Art Project/Arts for Freedom

Round 3 of Innovation Funding

A third round of Innovation planning was conducted in FY 2012-13 and resulted in two (2) new projects:

- Stanislaus County Wisdom Transformation Initiative/Center for Collective Wisdom
- Garden Gate Innovative Respite Project/Turning Point Community Programs

The projects were approved in June 2013 and began implementation in FY 2013-14. The final learning reports for these projects can be found on the following pages of this document.

Final reports for these and all Stanislaus County Innovation projects that have ended may be viewed on-line by going to www.stanislausmhsa.com

Round 4 of Innovation Funding

On July 18, 2014, community stakeholders approved a priorities funding plan that included a third RFP process for Innovation. Proposers were asked to select a mental health adaptive dilemma consistent with stakeholders' priorities. The Innovative approach had to include prevention strategies that are known to address similar adaptive dilemmas in other fields such as health.

The prioritized adaptive dilemmas were as follows:

1. Improving parental competency and social support for fathers
2. Improving the well-being of children, Transition Age Youth (TAY), and Transition Age Young Adults (TAYA)
3. Treatment options for people struggling with both substance abuse and mental illness
4. Connecting people receiving services to community based support
5. Honoring and identifying more holistic approaches to well-being
6. Connecting and linking underserved and diverse communities with resources

On September 30, 2014, in conjunction with the county's General Services Agency, the Stanislaus County Board of Supervisors authorized BHRS to issue a Request for Proposals (RFP) for the Innovation learning projects. The RFP was issued on October 3, 2014, and an Evaluation Committee reviewed and scored five submitted proposals.

On December 2, 2014, the GSA issued a Notice of Intended Award to the following two (2) community-based organizations:

- Center for Human Services/Father Involvement Project
- Sierra Vista Child and Family Services/Quiet Time Project

In addition, the BHRS Juvenile Justice program requested to expand its services through a Youth Peer Navigator Innovation project to serve children, Transition Age Youth (TAY), and Transition Age Young Adults (TAYA). The expansion request was reviewed by the Evaluation Committee and recommended for approval by the BHRS Senior Leadership team.

On February 10, 2015, the Stanislaus County Board of Supervisors approved two year agreements with the community-based organizations and BHRS Juvenile Justice contingent on their approval from the MHSOAC. On June 25, 2015, the MHSOAC approved the three projects at its monthly meeting.

Round 5 of Innovation Funding

The next round of funding resulted in the development of two new Innovation projects.

On February 27, 2015, community stakeholders endorsed moving forward with a Full Service Partnership (FSP) Co-Occurring Disorders Innovation project with a focus on adults who have both serious mental illness and co-occurring substance use disorder. The three year project was approved by the Stanislaus County Board of Supervisors on June 2, 2016 and by the MHSOAC on August 27, 2016.

On October 23, 2015, stakeholders endorsed a BHRS funding recommendation for a three year Suicide Prevention Project aimed at decreasing the alarming number of suicides in Stanislaus County. The project was approved by the Stanislaus County Board of Supervisors on March 15, 2016, and the MHSOAC on April 28, 2016.

TAB 2

CULTIVATING CULTURES OF COLLECTIVE WISDOM

Assessing the Impact and Lessons Learned from The Wisdom Transformation Initiative

June 2016

John G. Ott, J.D. • Rose A. Pinard, Ph.D.
Center for Collective Wisdom • c4cw.org

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Over the last decade, the Stanislaus County Behavioral Health and Recovery Services Department (BHRS) has confronted an increasingly complex and volatile fiscal and policy reality. Between 2006 and 2012, department revenues declined by 18%, from $83 million to $68 million, and the number of staff by 35%, from 516 to 338. These overall reductions in funding and staff happened despite the new funding the department received through the Mental Health Services Act (MHSA).

In this same period, the number of people served by the department declined from 11,000 to 10,000, even as the number of people in the county struggling with behavioral health issues was increasing significantly, caused in part by veterans returning home from Iraq and Afghanistan as well as the fallout from the recession.

Senior leaders began to understand this reality as an *adaptive dilemma,* defined as a challenge that cannot be resolved, or a longing that cannot be realized, through habitual or known responses. After several years of rapidly declining revenues and increasing need, senior leaders became convinced that they could not simply manage their way out of the challenges confronting the department using only the short-term strategies they had relied on in the past.

They committed to undertake a more comprehensive and proactive response: a transformation process, an ongoing process of rethinking the role of the department, and increasing the capacity of staff to learn and adapt together in ways that would improve results even with diminishing budgets.

As designed by John Ott and Rose Pinard, the principals of the Center for Collective Wisdom (C4CW), four commitments defined this transformation effort: a commitment to results; a commitment to community capacity-building; a commitment to fiscal sustainability; and a commitment to leadership development. Taken together, these four commitments and related practices were called the Wisdom Transformation framework.

With support from Ott and Pinard, senior leaders began laying the foundation for this transformation process, exploring the implications of each of the four commitments for their respective programs and areas of responsibility, and then introducing the framework to managers and coordinators in 2012. Then, in 2013, stakeholders approved an Innovation Project, entitled the Wisdom Transformation Initiative (WTI), to deepen and extend this transformation process into some of the largest community-based partners working with BHRS.

THE IMPACT OF WTI

Over 700 participants from four organizations participated in WTI. From July 2013 through December 2015, C4CW worked intensively with each participating organization through custom-designed and tailored processes grounded in the Wisdom Transformation framework, with a particular focus on the commitment to leadership development.

This project first explored learning questions related to the *impact* of organizations adopting the Wisdom Transformation framework. More specifically, the project assessed whether the adoption of the Wisdom Transformation framework could help participating organizations increase their capacity to:

- Learn to adapt better to the policy and fiscal volatility within the behavioral health system;
- Create a stronger and more positive internal environment for staff and others connected to the organization so they can better support the people they serve; and
- Cultivate more effective collaboration among each other and with BHRS.

The data offer a resounding *yes* to these questions about impact. First, every organization successfully resolved one or more adaptive dilemmas through the Wisdom Transformation process. Examples include:

- Redesigning programs for better impact;
- Making significant progress on team productivity goals;
- Making a shift to embodying a commitment to community to improve impact;
- Developing plans for long-term sustainability; and
- Improving staff recruitment, training, and retention practices.

Moreover, every organization reported and demonstrated ongoing capacity to effectively address new adaptive dilemmas, including:

- Increased capacity to use data to improve program and organizational impact; and
- Increased capacity to use the process of Wisdom Dialogues[1] to address adaptive dilemmas.

Second, every organization also reported more positive internal working environments for staff and others connected to the organization. Data documented improved staff morale, strengthened relationships among staff and others, and a significantly improved capacity to cultivate safe spaces for meaningful conversations among people who had different perspectives.

Third, every organization reported and demonstrated improved capacity to effectively collaborate with each other, BHRS, and communities connected to people receiving services. This was a principal focus of the Innovation project, and the data document numerous examples of improved collaboration among organizations, and between organizations and BHRS.

Beyond these immediate impacts, the project also inquired into whether adopting the framework would help organizations improve outcomes for people suffering from or at risk of mental illness. While the timeframe for this project was too brief to create or document sustained impact on outcomes for people receiving services, the data that did emerge are promising.

Essential to realizing the potential for improved results is the commitment and capacity of organizations to sustain their transformation processes beyond the project. In their final reports, every organization expressed a commitment to continue their particular WTI work beyond the initiative.[2] Different organizations have integrated aspects of the framework into their long-term strategic plans, and have developed staff surveys and other assessment instruments to assess their progress in embodying the framework over time. Moreover, leaders and program managers from several organizations are regularly teaching and modeling the commitments and practices of the framework to other staff, and staff members continue to regularly access online videos and other resources to deepen their understanding and ability to adapt the framework for their programs.

---

[1] A process developed by Ott and Pinard to help organizations embody the commitment to leadership when addressing adaptive dilemmas.

[2] Final Organization progress reports, December 2015.

LESSONS LEARNED ABOUT PROCESS

Beyond the question of *impact,* we also explored questions about what *processes* would help organizations successfully adopt the Wisdom Transformation framework. Specifically, we assessed:

- What processes would help community-based organizations—each with different missions, cultures, and histories—successfully adapt the Wisdom Transformation framework within their particular programs and services;

- What processes would help build effective intra-organizational learning communities among staff members, community leaders, family members, and people who receive services; and

- Whether cross-organizational learning communities are promising strategies for sustaining long-term transformation efforts.

We have learned a number of lessons about what helps organizations successfully adopt the framework, including the need for:

- Assessing readiness for undertaking an ongoing transformation process, given the current challenges confronting an organization;
- Regularly assessing the commitment within the organization to continue the process;
- Re-framing and translating the framework to fit each organization's unique culture;
- Engaging senior leaders first, and coaching them as allies, to help sustain the process; and
- Using technology and online resources to support the ongoing transformation.

Beyond these general lessons about helping organizations successfully adopt the framework, several additional lessons arose about how to strengthen *intra-organizational* learning communities, including lessons about data and data capacity, and lessons about process. In particular, as C4CW engaged with teams and programs within participating organizations, patterns became apparent about what can help groups embody the commitments and practices of the framework when tackling complex issues. Ultimately, C4CW created a process called Wisdom Dialogues to capture the learning about these patterns.

The question of *cross-organizational* communities yielded an unexpected result. The design for WTI projected that staff across the participating organizations would form learning communities over time, grounded in a shared commitment to results and the Wisdom Transformation framework. Once implementation began, however, and each organization began to move more deeply into its own transformation process, all of the organizational leaders expressed a strong preference for delving more deeply into their own intra-organizational transformation processes rather than investing time and resources in the cross-organizational work.

BUILDING ON THE PROGRESS OF WTI

WTI created significant positive impacts for participating organizations, and demonstrated a number of promising practices about how to help community-based organizations successfully adapt the framework within their particular programs and services. The organizations showed clear signs of healthier and more resilient cultures, cultures defined by the capacity to cultivate the conditions for collective wisdom. This progress is already paying dividends in improved services and supports for

people struggling with mental health issues, and preliminary data point to improved results over time.

So now what?

The cross-organizational work envisioned within WTI was premature. Organizations prioritized the time within this initiative to focus on their individual transformation processes. Having now made substantial progress on their individual transformation plans, however, leaders of the WTI organizations have proposed a new MHSA project, funded with Workforce Education and Training funds, to address cross-organizational and systemic adaptive dilemmas.

This potential MHSA project, endorsed by stakeholders and included in the proposed FY 2016-17 budget for BHRS, would:

- Address one or more systemic adaptive dilemmas through multi-stakeholder Wisdom Dialogues, focusing particularly on solutions that do not require additional revenue;
- Help selected BHRS and community leaders learn how to design and facilitate multi-stakeholder Wisdom Dialogues to address future adaptive dilemmas; and
- Help selected BHRS and community organization staff members learn how to develop and report data to support multi-stakeholder Wisdom Dialogues.

WTI participants have also recommended that BHRS leaders:

- Strengthen the capacity for mental and behavioral health organizations and providers to work together as a more coherent system; and
- Leverage the lessons of WTI to amplify the larger change agendas unfolding across the County.

Six years ago when BHRS was just beginning its journey of transformation, department leaders were virtually alone in their conviction that a new way was needed.

No longer.

In particular, the Focus on Prevention Initiative provides a unique opportunity for BHRS and its partners to leverage the learning of WTI. Launched by the Board of Supervisors in 2014, the Focus on Prevention Initiative reflects a growing awareness among leaders across the county that what has worked before is no longer enough. Inspired in part by the BHRS transformation process and WTI, this long-term effort has embraced much of the Wisdom Transformation framework, including the commitment to results, and essential aspects of the commitments to community capacity-building and leadership development.

From this perspective, WTI has already succeeded, influencing substantial innovation and learning not only within the behavioral health system, but in sectors and efforts across the county. No small achievement.

ACKNOWLEDGMENTS AND APPRECIATIONS

For all that has been, I say *thank you.*
For all that will be, I say *yes.*
— *Dag Hammarskjold*

For the Center for Collective Wisdom (C4CW), the journey of the Wisdom Transformation Initiative (WTI) began in June 2006, when John Ott facilitated a retreat for senior leaders in the Behavioral Health and Recovery Services Department (BHRS). Denise Hunt was Director then, and she was beginning to sense the scope of the adaptive dilemma confronting the behavioral health system, an array of challenges and changes that ultimately spawned the transformation process within BHRS and the Wisdom Transformation Initiative, this Innovation Project.

We could not have anticipated at the time how this movement would expand within Stanislaus County, or how our own lives would be inspired and transformed by the work we have been invited to support since then: the work with Prevention Services to embody a commitment to community capacity-building; the Alcohol and Other Drug stakeholder process to invite community partners to join with BHRS staff to resolve a substantial budget reduction; the work with Promotoras and the Family Resource Centers to build a movement of wellbeing grounded in community; the work with BHRS senior leaders and mid-level managers as the department launched its transformation process; this Wisdom Transformation Initiative; and now the Stanislaus County Focus on Prevention Initiative, with its profound commitment to effect results that matter for families, and an equally profound commitment to embody a value that *there is no other.*

We first want to thank the hundreds of participants who said *yes* to WTI at every stage of this initiative, from the first exploratory conversations in 2012 to the most recent meeting of WTI leaders earlier this year. We are so grateful for the work you do in the world, and for all that you have taught us. We hope that the insights shared in this document begin to reveal, at least in some small way, how we are now different, and see the world differently, because of you.

We are especially grateful to WTI organization leaders Cindy Duenas, Ron Gilbert, Cle Moore Bell, Carole Collins, Judy Kindle, and Jeff Anderson, for your vision, commitment, and steadfast stewardship of WTI.

We would like to offer appreciation for everyone who has guided and supported us within BHRS during this project, and especially Madelyn Schlaepfer, Ruben Imperial, Karen Hurley, and Dan Rosas for your leadership and counsel. We also offer our deep gratitude to the Mental Health Services Act stakeholders who entrusted us with this exploration. And to Denise Hunt: words cannot convey how grateful we are for the invitation you extended to us those many years ago.

In addition, we are blessed to work, play, and learn alongside our C4CW colleagues Trevor Olwig, Ken Ithiphol, Bert Grimm, and Becky Winslow. Thank you for all you have done for WTI.

For all that has been, we say *thank you.* And we cannot wait to discover what is wanting to happen next. For all that will be, we say *yes.*

—John Ott • Rose Pinard
June 2016

INTRODUCTION

Over the last decade, the Stanislaus County Behavioral Health and Recovery Services Department (BHRS) has confronted an increasingly complex and volatile reality. When we began working with BHRS in June 2006, the department's budget was over $83 million. The department employed 516 staff and provided behavioral health services to over 13,500 people. This was the first year of the Mental Health Services Act (MHSA).

Then the recession happened, and even with the infusion of Mental Health Services Act (MHSA) funding, the overall BHRS budget contracted over the next several years. By fiscal year 2011-12, the budget was $68 million, the number of staff was 338, and the number of people served was just over 10,000.

At the same time, the number of people in the county struggling with behavioral health issues was increasing significantly, caused in part by families and individuals struggling with the fallout from the recession, and veterans returning home from Iraq and Afghanistan.

While revenues and staffing have stabilized and even increased since 2012, the fiscal and policy reality has become even more complex and volatile. To cite just two contributing factors: the passage of the Affordable Care Act has significantly increased the number of people who are eligible for mental health services, while the dismantling of the California Department of Mental Health has created significant instability around state-level regulations.

In 2010, after several years of rapidly declining revenues and increasing need, the department's senior leaders concluded that they needed a more proactive response to the complexity they were confronting. They committed to undertake a transformation process, an ongoing process of rethinking the role of the department, and increasing the capacity of staff to learn and adapt together in ways that would improve results even with diminishing budgets.

A support guide written to help staff understand and embrace this transformation effort explained senior leaders' thinking this way:

> The purpose of this effort is to help us move away from short-term reactions to issues beyond our control, and toward a more proactive and sustainable way of doing our work. We know the word *transformation* can be ambiguous, and is often overused. We use the word purposefully, however, to indicate that this is not a short-term strategy, nor an effort that focuses only on the margins of our work. This is a long-term effort designed to strengthen the health and resiliency of the department's culture, and the wellbeing of our staff members, our partners, and ultimately the people we serve.[3]

As designed by John Ott and Rose Pinard, principals of the Center for Collective Wisdom (C4CW), four commitments initially defined this transformation effort: a commitment to results; a commitment to community capacity-building; a commitment to fiscal sustainability; and a commitment to leadership development. Taken together, these four commitments and related practices were called the Wisdom Transformation framework.

---

[3] John Ott and Rose Pinard. *Help Along the Way: A Guide to Support the Transformation of the BHRS Department.* 2012, pp. 1-2.

As part of this transformation effort, BHRS began its first Innovation Project in 2010. In this project—entitled Evolving a Community-Owned Behavioral Health System of Supports and Services—BHRS invited community stakeholders to join with department leaders to address a dramatic shortfall in the Alcohol and Other Drug (AOD) budget. A direct expression of the commitments to fiscal sustainability and community capacity-building, this project explored how to develop deeper shared ownership of the department's budget among community stakeholders—including people who receive services, family members, and community leaders—and how to engage stakeholders as partners in addressing the consequences of budget shortfalls.

This first Innovation Project, also designed and facilitated by Ott and Pinard, was a marked success. Community stakeholders and department leaders reached consensus on a set of recommendations for how to absorb the budget shortfall—recommendations that were ultimately approved by the Board of Supervisors. More importantly, the process revealed an array of community-based, faith-based, private sector, and other supports and services beyond those funded by BHRS. Stakeholders and BHRS leaders worked to better integrate and leverage these supports and services to mitigate the impact of the budget cuts. The project demonstrated how community partners and department leaders could discern and act together to responsibly steward the behavioral health system in the midst of profound challenges.

Given the success of the first Innovation Project, in 2012 BHRS initiated six half-day trainings for department managers and coordinators, helping them explore how to introduce the Wisdom Transformation framework into the day-to-day work of their programs. And then in 2013, MHSA stakeholders approved the current Innovation Project, entitled the Wisdom Transformation Initiative (WTI), to deepen and extend the transformation process into some of the largest community-based partners working with BHRS.

WHY THESE PARTNERS

The six original community-based organizations participating in this project included Aspiranet, Center for Human Services, Sierra Vista Child and Family Services, Telecare, Turning Point Community Programs, and West Modesto King Kennedy Neighborhood Collaborative. Together, these six organizations represent the largest non-profit and community-based contractors working with BHRS. They provide behavioral health support to many of the county's most vulnerable individuals and families, through family resource centers, neighborhood- and school-based service sites, multi-lingual services, and other community-based efforts.

Leaders from each organization had already demonstrated an abiding commitment to the Wisdom Transformation framework, participating in voluntary training sessions introducing some of the framework's core concepts and practices prior to the start of the Innovation Project. Most of the organizations had already begun to implement Results-Based Accountability (RBA) processes consistent with the commitment to results, particularly in those programs funded through the county's MHSA plans.

From July 2012 through June 2013, before the beginning of the Innovation Project, leaders from the six organizations participated in a voluntary learning collaborative to explore how to adapt the Wisdom Transformation framework to support their work in the county. These conversations revealed an array of challenges affecting community-based organizations that support people suffering from or at risk of mental illness.

With increasing demands for services and wildly fluctuating public funding levels, providers must learn how to better leverage community-based, non-clinical resources whenever possible. To effect such change requires staff and others to develop new skill sets. For example, leaders and managers must become better adept at designing and implementing processes to engage line staff, people who receive services, family members, community leaders, and others in learning conversations about how to improve outcomes and create new approaches to complex community realities. Such processes require very different skills than, for example, the skills required to ensure compliance with Medi-Cal regulations and other quality assurance issues.

Moreover, within the six partner organizations, as well as within BHRS, many senior leaders and managers were (and are) approaching retirement age, while many younger staff members are reporting higher levels of stress and lower morale. Learning how to effectively address these organizational realities is essential for community-based organizations to improve outcomes for the people they serve.

The more leaders from the six organizations engaged with each other, the more they discovered common interests and challenges, and the more committed they became to exploring how the Wisdom Transformation framework could help them improve emotional and behavioral health outcomes despite the fiscal challenges. Representatives from all six organizations helped to develop the initial proposal for the Innovation Project and were eager to engage in the process.[4]

THE LEARNING QUESTIONS

The primary purpose of the Innovation Project was to promote interagency and community collaboration. Consistent with Innovation guidelines, this project explored new approaches to collaboration and system transformation to strengthen:

- Organizational practices, processes, and procedures;
- Educational efforts for service providers, including nontraditional mental health practitioners;
- Outreach, capacity building, and community development; and
- Systems development.

Through this project, we explored learning questions related both to the *impact* of organizations adopting the Wisdom Transformation framework, and to the *process* of how to help organizations successfully adopt and apply the framework.

Specifically, we assessed whether and how the adoption of the Wisdom Transformation framework helped participating organizations increase their capacity to:

- Learn to adapt better to the policy and fiscal volatility within the behavioral health system;
- Create a stronger and more positive internal environment for staff and others connected to the organization so they can better support the people they serve; and
- Cultivate more effective collaboration among each other and with BHRS.

[4] Once the initiative began, however, two organizations—Aspiranet and Telecare—chose to withdraw from the initiative, and one other organization—Sierra Vista Child and Family Services—delayed their participation for 18 months. We discuss these developments in greater detail in Section 5.

We also inquired into whether adopting the framework would help organizations improve outcomes for people suffering from or at risk of mental illness. While the timeframe for this project was too brief to create or document sustained impact on outcomes for people receiving services, the data we have collected allows us to offer some beginning reflections about the potential for this lasting impact.

These were the *impacts* we sought to assess through the Innovation Project. In addition, we also explored questions about what *processes* would help organizations successfully adapt the Wisdom Transformation framework into their day-to-day operations and larger cultures. That is, we assessed:

- What processes would help community-based organizations—each with different missions, cultures, and histories—successfully adapt the Wisdom Transformation framework within their particular programs and services;
- What processes would help build effective intra-organizational learning communities among staff members, community leaders, family members, and people who receive services; and
- Whether cross-organizational learning communities and peer allies are promising strategies for sustaining long-term transformation efforts.

DATA SOURCES

In developing the reflections and analyses for this paper, we have relied on a wide array of data sources, including the following.

1. **Organizational learning and progress reports.** These semi-annual reports, completed by senior leaders with input from program staff and others, as appropriate, provided opportunities for each organization to offer reflections about their progress, the challenges they were encountering, and the lessons they were learning. The reports also encouraged feedback about the quality and amount of support they were receiving from C4CW. We used these reports to regularly assess and evolve the initiative as it was unfolding.

2. **Key informant interviews and focus groups.** Applied Survey Research conducted a first round of key informant interviews in June 2014. These interviews included 24 participants from three organizations. C4CW conducted more extensive key informant interviews during the fall of 2015. These interviews included sessions with representative groups of participants from each organization, and separate sessions with each organization's senior leaders. The focus of these interviews was on participants' experiences of the initiative and its impact on their work. C4CW conducted a total of 13 interviews with 64 participants.

3. **Impact assessment survey**. This anonymous online survey, conducted between November and December 2015, was completed by a representative sample of participants from each organization who consistently engaged in the initiative, including senior leaders and program staff. The survey assessed participants' perceptions about the degree to which the initiative impacted their organization and/or program's capacity in key outcome areas. A total of 57 respondents completed this survey.

4. **Self-assessment survey.** This pre- and post-survey instrument was administered online with 11 CHS and TPCP senior leaders who participated in the ally development process, including 1:1 coaching sessions. The purpose of the survey was to assess their perceived

capacity to embody the Leadership for Collective Wisdom framework. Pre-process surveys were conducted in early 2015. Post-process surveys were conducted in December 2015.

5. **Monthly work summaries**. All C4CW team members completed detailed summaries of work performed each month, including the type of work, the number of hours for each task and the total number of hours expended, the program or organization the work was for, and other details.

Beyond these common data sources, we reviewed data unique to each organization, including: specific products developed through their WTI work; summaries from various planning and implementation meetings and wisdom dialogues; feedback summaries from orientations and immersion trainings in the Wisdom Transformation and Leadership for Collective Wisdom frameworks; and others.

Another source of information for this report was our direct observations of each organization while working to support their WTI efforts. Over the course of the initiative, we developed and followed a protocol for regularly recording our observations as process notes for each organization. We regularly reviewed these process notes while working with the organizations, and again during the writing of this document.

Finally, we reviewed the preliminary findings of our data analysis with organizational leaders, inviting their feedback and reflections to help guide the completion of this final report.

A Brief Description of Each Section

Section 1 begins with a brief description of the Wisdom Transformation framework, and a more detailed exploration of the commitment to leadership, which became the starting place for our work with each of the participating organizations.

At the heart of the Wisdom Transformation framework's commitment to results is the discipline of using data to answer three related but distinct questions for any program or initiative:

- How much did we do?
- How well did we do it?
- Is anyone better off?[5]

We use these questions to organize our analysis of the data. Section 2 addresses the *'How much did we do?'* question, reviewing data documenting the number of organizations, programs, and people who participated in WTI, and some of the demographic characteristics of these participants. It also details the types and amount of support provided to participating organizations. Section 3 explores '*How well did we do it?'* by analyzing participant feedback offered over the course of the initiative about what aspects of the initiative worked well, and what could be improved.

The question '*Is anyone better off'* is ultimately about assessing the meaningful impact of any program or initiative. Section 4 analyzes and reflects on the data about the *impact* of WTI on participating

[5] These questions are part of the Results-Based Accountability framework developed by Mark Friedman. See, e.g., *Trying Hard is Not Good Enough.* Book Surge Publishing, 2009. BHRS has adopted this framework as the guiding orientation for its commitment to results.

organizations. Section 5 then delineates the lessons we learned about the *process* of helping organizations adopt the framework in service of improving their capacity to promote recovery and wellbeing for people struggling with mental and behavioral health issues. This section also details a number of the challenges we encountered over the two and a half years of working with the organizations, and describes the adaptations we made to address these challenges.

Finally, Section 6 outlines a series of recommendations for how BHRS can build upon the lessons of WTI to continue advancing the transformation of the department and its community partners.

A Final Note About Data

A major challenge for this report was how to present a coherent analysis of the overall initiative, while at the same time honoring the layers of experience and perspective within and across the four organizations. One way we addressed this challenge was to share extensive quotes from the multiple data sources, both to illustrate the major themes of the report, and to help readers appreciate this diversity of experience and perspective.

For readers who want a more direct experience of participants reflecting on their WTI experience, we have compiled several short video clips of excerpts from interviews conducted in the spring of 2014, about one year into the initiative.

The data collection strategies for this initiative did not originally include video testimonials, but we were able to leverage the videotaping of some early training events to include a series of interviews with a few WTI participants. We interviewed eight people from two organizations, and have included with their permission short excerpts from our conversations with four of the participants. Readers can access these video clips through the following links:

Christina Kenney: https://vimeopro.com/c4cw/wisdom-transformation-initiative-video-clip-1

Cindy Duenas: https://vimeopro.com/c4cw/wisdom-transformation-initiative-video-clip-2

Kate Trompetter: https://vimeopro.com/c4cw/wisdom-transformation-initiative-video-clip-3

Paul Corona: https://vimeopro.com/c4cw/wisdom-transformation-initiative-video-clip-4

These videos include powerful stories of personal and organizational transformation. In future efforts like the Wisdom Transformation Initiative, we recommend including funding to support a more systematic approach to video interviews, ideally including video interviews at the beginning, mid-point, and conclusion of the initiative.

SECTION 1: THE FRAMEWORK(S) AND OUR APPROACH

To understand the Wisdom Transformation Initiative, we must first briefly describe the Wisdom Transformation framework, and the commitment to leadership in particular.

THE WISDOM TRANSFORMATION FRAMEWORK

We detailed the original Wisdom Transformation framework in a support guide produced for BHRS staff in 2012.[6] Before we began WTI, we adjusted the language and created practices and illustrations that were more appropriate for non-profit and community-based organizations. We visually represented the four commitments of this revised framework as follows:

When we invited each organization to decide which commitment(s) they wanted to address first in their internal transformation process, all of them chose to focus on the commitment to leadership. Moreover, as we began working with their senior leadership teams and line staff, we quickly realized that we needed to simplify the conceptual framework to make it more immediately relevant to their work on the ground. That is, while all four commitments resonated with senior leaders and mid-level managers of BHRS, given their responsibility for overseeing a complex behavioral health system, this was not the case for leaders and staff of community-based organizations.

---

[6] John Ott and Rose Pinard. *Help Along the Way: A Guide to Support the Transformation of the BHRS Department.* 2012.

Our adaptation was to work with senior leaders and all other participants to master the commitment to leadership, integrating the content of the commitment to results within this first commitment. We then worked with the commitments to community and sustainability as appropriate for each program and group of participants we engaged. We discuss this adaptation in greater detail in Section 5.

FOUNDATIONAL CONCEPTS FOR THE COMMITMENT TO LEADERSHIP

The commitment to leadership rests on two foundational concepts: collective wisdom and the four dimensions of change.

Collective Wisdom

In our forthcoming book entitled *Leadership for Collective Wisdom,* we write:

> When human beings gather in groups, a depth of awareness and insight, a transcendent knowing, becomes available to us that, if accessed, can lead to profound action. We call this transcendent knowing *collective wisdom*.
>
> This knowing is not of the mind alone, nor is it of any individual alone. When this knowing and sense of right action emerges, it does so from deep within the individual participants, from within the collective awareness of the group, and from within the larger field that holds the group.[7]

This understanding of collective wisdom is the starting place for the commitment to leadership. Management theorist Margaret Wheatley explains this innate capacity of groups this way:

> [There is a] wisdom we possess [in groups] that is unavailable to us as individuals. The wisdom emerges as we get more and more connected with each other, as we move from conversation to conversation, carrying the ideas from one conversation to another, looking for patterns, suddenly surprised by an insight we all share.
>
> There's a good scientific explanation for this, because this is how all life works. As separate ideas or entities become connected to each other, life surprises us with emergence—the sudden appearance of a new capacity and intelligence. All living systems work in this way. We humans got confused and lost sight of this remarkable process by which individual actions, when connected, lead to much greater capacity. To those of us raised in a linear world with our minds shrunken by detailed analysis, the sudden appearance of collective wisdom always feels magical.[8]

Wheatley's last point may seem surprising: the reason the emergence of collective wisdom can feel magical—somehow extraordinary or even unreal—is because we have become so focused on the

---

[7] John Ott and Rose Pinard, manuscript of forthcoming book *Leadership for Collective Wisdom*. Cited with permission from the authors.

[8] Juanita Brown and David Isaacs, *The World Café: Shaping Our Futures through Conversations that Matter,* San Francisco: Berrett-Koehler Publishers, 2009, p. xii.

rational ("our minds shrunken by detailed analysis") that we have lost touch with other ways that bring forth new capacity and intelligence.

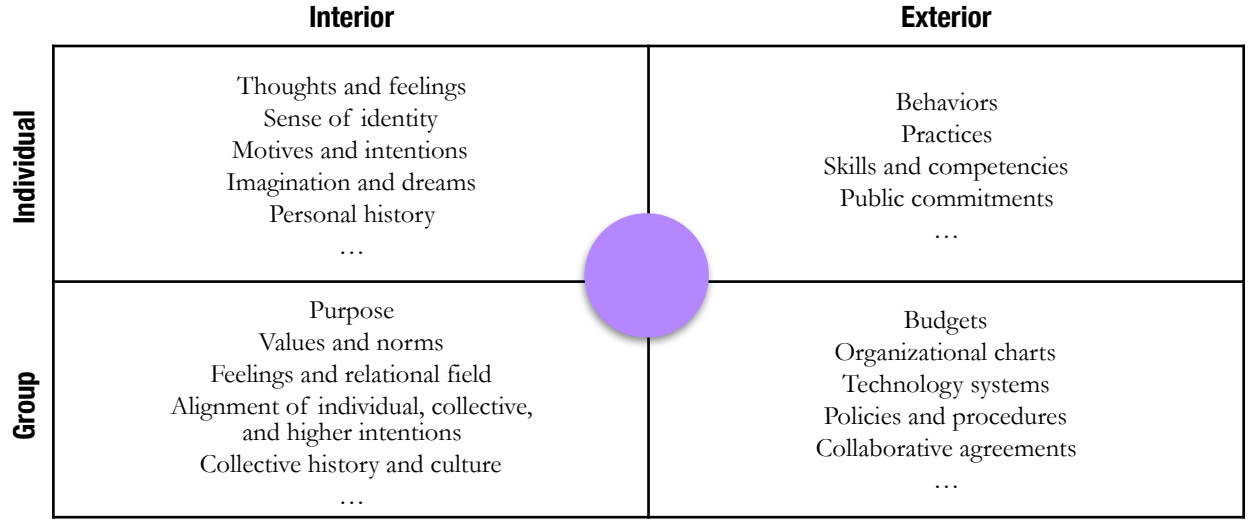
Sometimes conversations and writings about collective wisdom can, perhaps unintentionally, reinforce this perception of the extraordinary nature of the phenomenon, intimating that collective wisdom is only available to the initiated, to the chosen few who have attained an exalted level of consciousness or who faithfully adhere to a particular process or protocol.

The beginning premise of the commitment to leadership is that collective wisdom is a potentiality of *all* groups, not just so-called 'healthy' or 'enlightened' ones. This premise is not a declaration of naïve faith or a wistful prayer. It emerges from decades of experience with the phenomenon, through our work in non-profit organizations, in communities and community-based change efforts, in foundations, in small and large public sector systems, and in small and large-scale private sector organizations.

Moreover, as Wheatley writes, this is how new capacity and intelligence emerges in *all* of life, through new connections: from cell to cell, dendrite to dendrite, human to human, group to group. As extraordinary and mysterious as the experience of profound connection—and of collective wisdom emerging—may feel in the moment, collective wisdom as a phenomenon is natural, even potentially ordinary.

The Four Dimensions of Change

A second foundational concept for understanding the commitment to leadership is the four dimensions of change. Any complex human undertaking involves at least four dimensions of change: the individual and group *interior* dimensions of change, and the individual and group *exterior* dimensions of change.[9] The following diagram graphically represents these four dimensions:



[9] We developed this framework based on Ken Wilber's work on the evolution of consciousness. See, e.g., Ken Wilber, *A Brief History of Everything*, Boston: Shambhala, 1996.

The upper left quadrant represents the individual interior dimension of change, including an individual's thoughts, attitudes, feelings, dreams, sense of purpose, intentions, sense of identity, personal history, and all aspects of an individual's subconscious and unconscious mind. That is, the individual interior dimension of change includes all of those aspects of an individual's interior life that cannot be known by someone else unless the individual chooses to reveal them.

The lower left quadrant is the group interior dimension of change. This quadrant refers to the interior dimensions of a group's experience that are not visible. For example, what feelings or shared history are present within the group? Do people in the group feel safe speaking their truth, or do they feel afraid and anxious? What is the nature of the interaction between members' individual intentions and the group's collective intentions? Are there old wounds or betrayals that continue to undermine trust among members?

The upper right quadrant is the individual exterior dimension of change. This realm involves behaviors, practices, skills, competencies, and other aspects of an individual's life that can be observed by someone else.

The lower right quadrant is the group exterior dimension of change. In addition to group behaviors and skills (paralleling the individual exterior dimension of change), this realm includes the myriad external manifestations of group life: budgets, technology systems, strategic plans, policies and procedures, collaborative agreements, organizational reporting structures, job descriptions, and so forth.

Many organizations fail to achieve or sustain their desired impacts because, over time, they become so focused on the group exterior dimensions of change that they forget to continue engaging the other dimensions of change. An underlying premise of the four dimensions of change, supported by our experience and research, and that of many others, is that groups are more likely to experience collective wisdom arising to support their efforts when they engage all four dimensions of change. That is, when groups engage all four dimensions of change in a disciplined and sustained way, we open a portal for collective wisdom to arise and guide our efforts in the world.

Leadership for Collective Wisdom

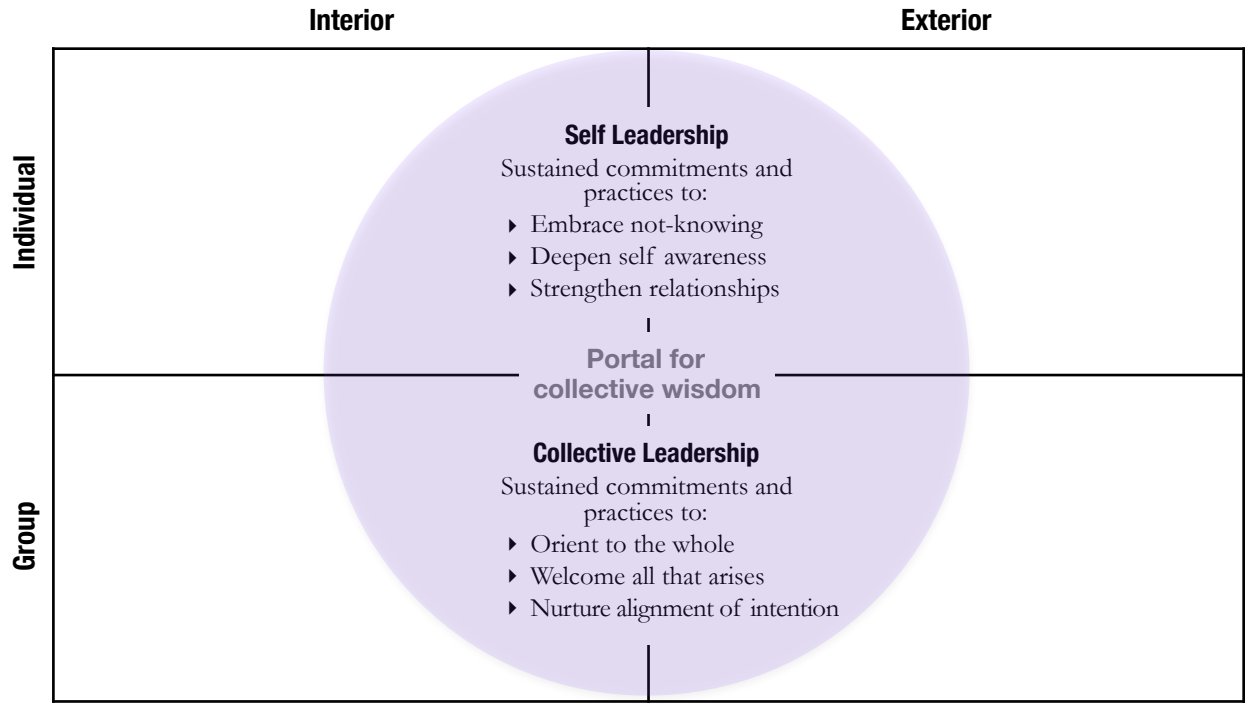
But how do we do this? How do we engage all four dimensions of change in a disciplined and sustained way to open a portal for collective wisdom to arise? One answer to this question is the Leadership for Collective Wisdom (LfCW) framework.

No group can simply decide to be wise, just as no gardener can decide to *make* a tomato. If a gardener longs for tomatoes, she must plant the seeds, and then carefully tend to the conditions that support their growth. She waters; she weeds; she protects; she waits. The better she is at sustaining the conditions that nurture tomatoes, the more likely she will be graced with an abundance of ripe, juicy fruit.

So it is with collective wisdom. The seeds of collective wisdom are always present whenever two or more of us gather, but to realize this potential, we must nurture the conditions that make it more likely for collective wisdom to arise among us. Engaging the four dimensions of change in a disciplined and sustained way is how we become gardeners of collective wisdom.

Cultivating the conditions that support the emergence of collective wisdom requires two aspects of leadership: *self* leadership and *collective* leadership. The Leadership for Collective Wisdom framework maps these different aspects of leadership to the four dimensions of change.

Self leadership involves commitments and practices in the individual interior and exterior dimensions of change, while *collective leadership* requires commitments and practices in the group dimensions of change:

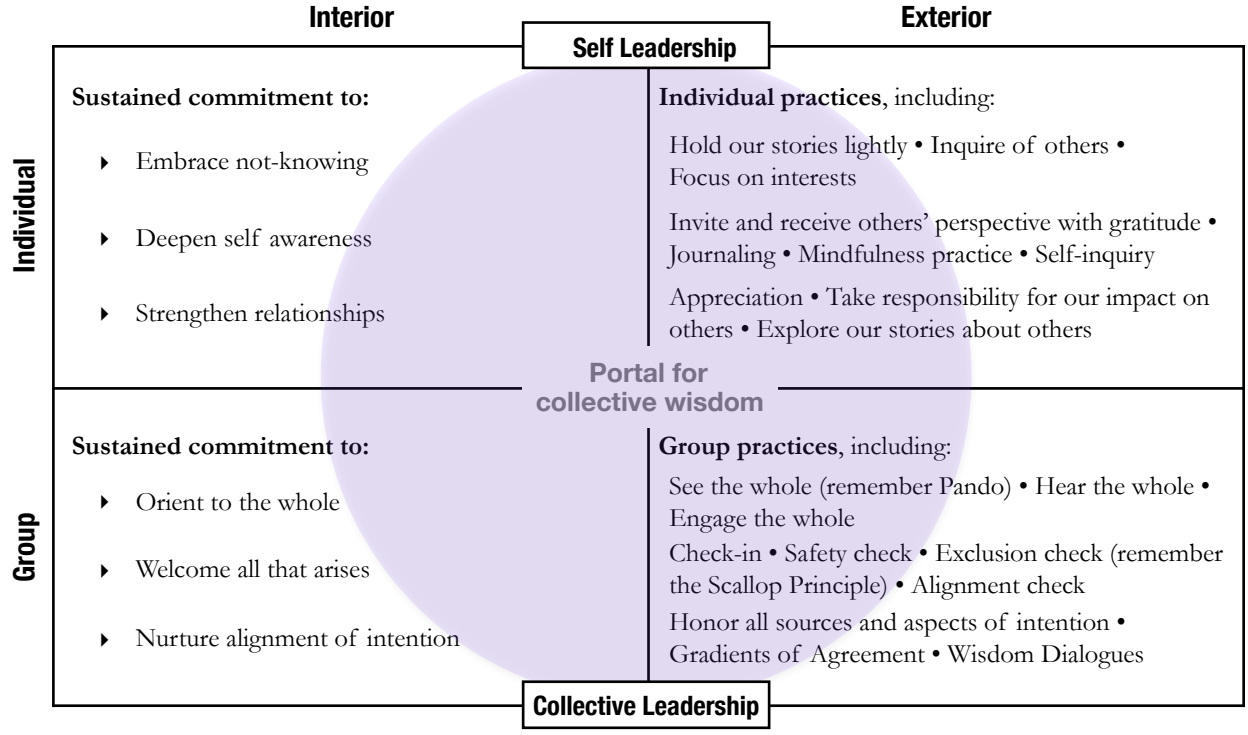


The framework includes both interior *commitments* we make to ourselves and to each other, and exterior *practices* to help us embody these commitments in the day-to-day work of our organizations and communities. In the diagram on the following page, we have mapped some of the practices that we have found most impactful in helping people embody the commitments of self- and collective leadership.

Much of our early work with WTI organizations was focused on teaching these commitments and beginning practices to senior leaders and others within the organization. That is, we helped staff and others learn how better to systematically engage the four dimensions of change through the commitments and practices of the Leadership for Collective Wisdom framework.

Although no organization or community can will itself to be wise, we can become better at cultivating the conditions that support collective wisdom, and more alert to signs that it is arising to support us. A first sign is an emergent *quality of knowing* that is beyond the mind, and beyond any one individual. Sometimes this quality of knowing manifests in a sudden and shared sense of what to do next, or a knowing that extends beyond words and amplifies a shared sense of connection and purpose.

A second sign is the emergence of spontaneous moments of *joy and generosity*, and a *sense of deeper connection*—to ourselves, to each other, and to a greater whole. A third sign is *positive, often surprising results*. Collective wisdom emerges by opening to it, not by trying to control or will it into being. The effects are often surprising because they are not predetermined; they arise through the openness of heart, deep curiosity, and intentional conversations that unfold within the group.[10]



WHY THE COMMITMENT TO LEADERSHIP

We define *leadership*, then, as the capacity to cultivate the conditions for collective wisdom in support of effective action. Any person, in any context, has the capacity to exercise leadership, to act in ways that support a group becoming more capable of effective action guided by collective wisdom. And any action that helps a group access collective wisdom in support of effective action is an act of leadership.

This understanding of leadership was a crucial starting place for WTI. Within hierarchical organizations, staff members can sometimes confuse leadership with authority. Authority is the right to make decisions and exercise control within a specified jurisdiction. For example, the BHRS director has authority to submit a proposed budget to the chief executive office (CEO) of the county, but not to formally enact it. That authority rests, by legislation, with the Board of Supervisors.

[10] Alan Briskin, Sheryl Erickson, John Ott, and Tom Callanan, *The Power of Collective Wisdom and the Trap of Collective Folly,* San Francisco: Berrett-Koehler Publishers, 2009, pp. 15-34.

Authority alone cannot ensure effective action. How often have we heard of a beautifully crafted strategic plan that ends up collecting dust, with nothing of consequence changing? A group of people can have the authority to develop a plan, but lack the capacity to transform that plan into meaningful action.

No one person, even someone with formal authority, can mandate that a group engages all four dimensions of change. Such work requires the sustained effort of all group members. A commitment to leadership in this context, therefore, is a commitment to create a *leader-ful* organization, an organization in which each person is invited, encouraged, and supported to exercise leadership in service of increasing the organization's effectiveness.

This is why the commitment to leadership is arguably the most important of the four transformation commitments, and why it made sense to us to use this commitment as the entry place for our work with all WTI organizations. When each person in a group or organization begins to accept both her opportunity and responsibility for leadership, the group as a whole becomes more able to adapt and innovate, and more able to realize its potential for collective wisdom in response to any challenge it confronts.

OUR APPROACH WITH THE ORGANIZATIONS

Given our focus on the commitment to leadership through the Leadership for Collective Wisdom framework, our work with each WTI organization was designed to engage both the interior and exterior dimensions of change. At the same time, while the Leadership for Collective Wisdom framework (and by extension the Wisdom Transformation framework) was a given, each organization's senior leadership team decided how their organization would integrate the framework into the organization's work, and what issue(s) the organization would address using the framework. That is, rather than dictating what an organization had to work on, we instead supported each organization to work on any issue or issues that mattered to its senior leaders and staff.

We initially framed this invitation using the concept of *adaptive dilemmas*. We define adaptive dilemmas as challenges that cannot be resolved, or longings that cannot be realized, through habitual or known responses. As part of the early planning process with each organization, we invited senior leadership teams to identify adaptive dilemmas that mattered enough for staff, volunteers, and others to invest significant time and energy to learn a new way of engaging each other—through the Leadership for Collective Wisdom framework—in service of discovering breakthrough responses that were vital for the organization's success. Each senior leadership team then developed a beginning plan for how to address their adaptive dilemma(s), including actions they would take and how they would assess progress over time.

These plans, and the processes to create them, were important starting places for each organization in WTI. This way of beginning the initiative made it clear that each organization would chart its own path, and was ultimately responsible for the progress it made through the initiative.

At the same time, the initial plans and adaptive dilemmas identified by the organizations were not the point. Our focus throughout WTI was to help participants across an organization embody a *new way of being,* and *new ways of engaging* each other, the larger whole of the organization, their partners, and BHRS, so that they could more reliably access collective wisdom in support of their ongoing work together. Some organizations remained focused for the entire initiative on the adaptive dilemmas first identified by their senior leaders. Others evolved their focus over the course of the

initiative, for a variety of reasons—e.g., as more people engaged with WTI and perceptions about what would have the highest leverage evolved, or as trust increased among participants and deeper conversations revealed different issues needing to be addressed, or as events unfolded that created a different urgency for the organization.

This way of working—helping each organization chart a process aligned with the capacity and commitments of people within the organization, and with the organization's larger culture—is an essential orientation for C4CW: essential because in every process we design, we invite people to engage at ever greater depths of the interior dimensions of change, even as they work to improve skills, practices, structures, and processes in the exterior dimensions. Such depth of work can never be mandated—participants and the organization as a whole must continue to say *yes* to this level of engagement, and must always be able to say *no* throughout the process.[11]

[11] As noted previously, two organizations that originally said *yes* to WTI decided to withdraw during the first year. We explore these developments more fully in Section 5. We helped each organization exit gracefully from the initiative, and leaders from both expressed interest in engaging again should there be a next iteration of WTI. For us, this marked a success for the initiative because the organizations discerned what was in their best interests and were supported to act accordingly.

SECTION 2: HOW MUCH DID WE DO?

In this section, we summarize data about the organizations and people who participated in WTI, including some of the demographic characteristics of these participants. We also detail the kinds and amount of support provided to participating organizations.

PARTICIPATING ORGANIZATIONS

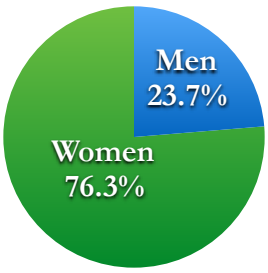
Four organizations participated in the WTI.

- **Center for Human Services** (CHS) was established as a local non-profit in 1970 to serve youth and families. Currently, CHS serves tens of thousands of children, individuals and families annually in Stanislaus County through six core program areas: Mental Health Services, Shelter Services, Youth Services, School-based Services, Substance Abuse Treatment, and Family Resource Centers.
- **Sierra Vista Child and Family Services** (SVCFS) has grown over the past four decades into one of the largest nonprofit agencies in the region, serving more than 22,000 children and families each year with nearly 300 dedicated employees, 21 programs, and providing services in every school district throughout Stanislaus and Merced Counties.
- **Turning Point Community Programs** (TPCP) is a state-wide organization with a unique vision about offering caring, hope, respect, and support on the path to recovery and mental health. Each year Turning Point serves close to 5,000 people who need mental health services in seven counties. Programs in Stanislaus County include The Empowerment Center; Garden of Eat'n; Integrated Services Agency; Garden Gate Respite Center; Warm Line; and Peer Navigators.
- **West Modesto King Kennedy Neighborhood Collaborative** (WMKKNC) is one of the leading community-based organizations addressing the health care concerns and needs of West Modesto residents in Stanislaus County. The WMKKNC has been in existence since 1993 with approximately 500 members and oversees the coordination and implementation of various state and locally funded programs and initiatives.[12]

NUMBER AND DEMOGRAPHICS OF PARTICIPANTS

In total, **704 unique individuals** participated in WTI across the four organizations. Participants included 167 men and 537 women.[13]

Figure 1: Gender distribution of WTI participants (N: 704)

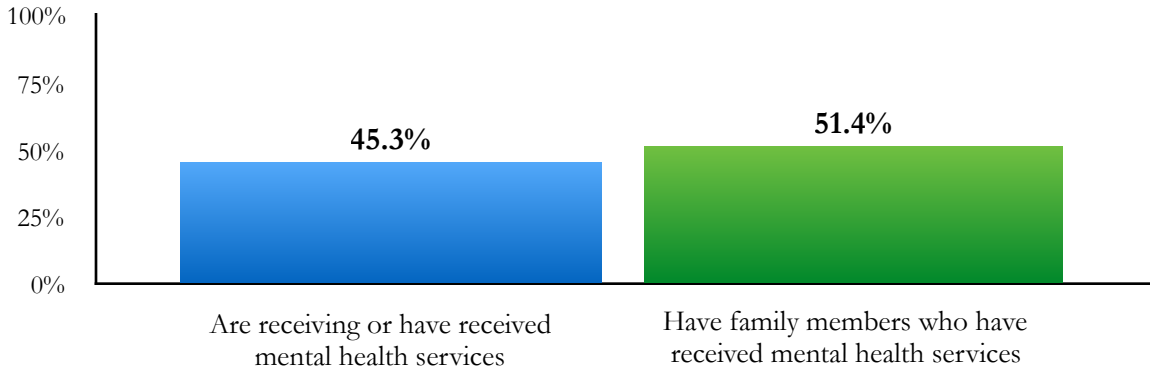


[12] Descriptions of participating organizations came from the organizations' websites.

[13] Data as reported by organizations in their progress reports.

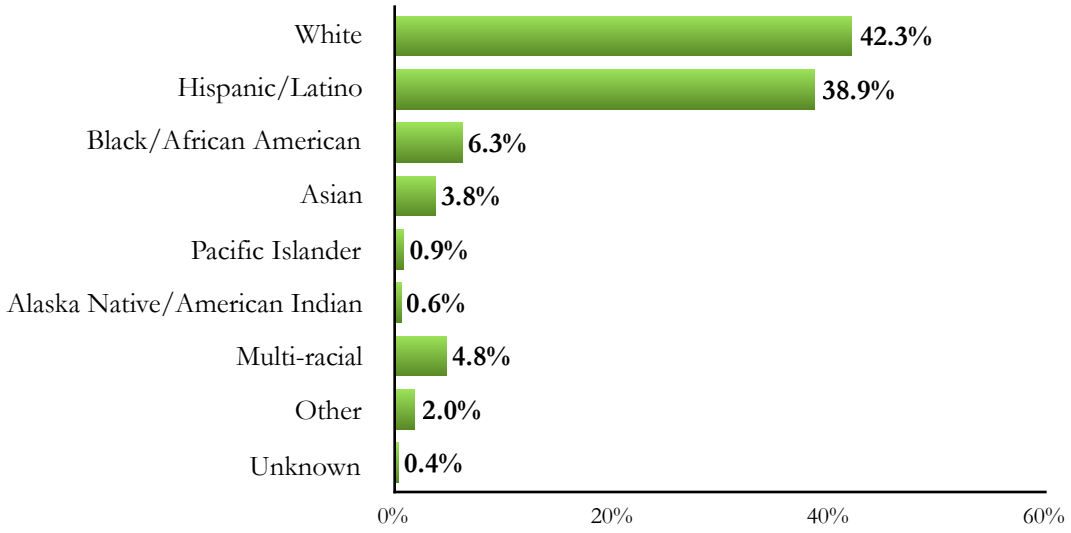
Of these 704 participants, 319 people (45.3%) were currently receiving or had received mental health services, and 362 (51.4%) were family members of people who were currently receiving or had received mental health services.[14]

Figure 2: Distribution of WTI participants by experience with mental health services (N: 704)



Participants reflected an array of races and ethnicities, including: 297 people (42.3%) who are white; 274 people (38.9%) who are Hispanic or Latino; and 44 people (6.3%) who are African American.[15]

Figure 3: Race/ethnic distribution of WTI participants (N: 704)



[14] Ibid.

[15] Ibid.

SUPPORT PROVIDED TO ORGANIZATIONS

At the beginning of the initiative, each organization developed a plan for adopting the Wisdom Transformation framework to improve the programs and services it provides for people suffering from or at risk of mental illness. Each plan delineated:

- The results the organization intended to achieve through the adoption of the framework, including progress on outcomes, program and service improvements, and others.
- How the organization would assess progress over the two years.
- What the organization would do to effect the results it sought, including how it would engage people who receive services, family members, and community leaders as well as staff members and others in its efforts, as appropriate.
- How the organization would tell the story of this initiative to staff, people who receive services, family members, and other stakeholders.

We periodically reviewed this plan with organization leaders and helped them adjust their plans as necessary to track how the initiative was evolving in each organization. In response to these plans and ongoing feedback from the organizations, C4CW created custom-designed support processes for each organization. These tailored support processes included:

- **Consultation support:** Each organization received significant hours of support from C4CW, with the total number for all organizations exceeding 3,300 hours.[16] Examples of how organizations used this time included immersions in the framework for specific audiences and/or the entire organization; group and 1:1 coaching; design and facilitation of Wisdom Dialogues[17] to address specific adaptive dilemmas; design and facilitation of strategic planning sessions to integrate the framework more deeply into the day-to-day operations of the organization.
- **Small grants:** Each organization received two $5,000 grants[18] to support its efforts, one in each of the first two years of the initiative. Organizations used these grants mostly to pay for expenses associated with trainings, strategic planning retreats, and extended Wisdom Dialogue sessions, including meeting costs, mileage, overtime, stipends, and other expenses. At least two organizations purchased technology to support online learning sessions.
- **Ally training:** Leadership teams from two of the participating organizations received intensive training, coaching, and support to become "in-house experts" on the Wisdom Transformation framework generally, and the Leadership for Collective Wisdom framework in particular.
- **Webinars:** Staff members and volunteers from one of the participating organizations, including people who have received services and family members, participated in a series of

[16] Analysis of C4CW monthly work summaries and related reports.

[17] See a detailed description of this process innovation in Section 5.

[18] One of the organizations received only one $5,000 grant because they started the project later than the others.

webinars in the second year of the project to reinforce the fundamentals of the framework and engage with emerging implementation questions.

- **Online resources:** C4CW created a website of training videos—c4cwwti.org—so that volunteers, staff, people receiving services, and partners of participating organizations can review and continue to reflect upon and teach the essential elements of the Leadership for Collective Wisdom framework.

Additionally, C4CW designed and facilitated periodic meetings of leaders from participating organizations to share emerging lessons and challenges, explore how to improve the project over time, and develop plans for sustaining the effort beyond the Innovation Project.

SECTION 3: HOW WELL DID WE DO IT?

Participants' feedback offered over the course of the initiative highlighted aspects of WTI that worked well, and other aspects that could be improved. This section summarizes this feedback.

Throughout this section, frequency counts (as indicated by "n") are specified for each key finding and are based on analyses of the multiple data sources used for this report. While the primary unit of analysis is individual organizations, progress was documented at one or more levels, depending upon the chosen scope of engagement for each organization. These levels included: leadership teams, individual programs and program staff, and individual staff members and volunteers.

A final preliminary note: Throughout this section, we use reflections and quotes from participating organizations to illustrate key findings and themes. To protect participants' confidentiality, however, we excluded any information that would explicitly reveal their identity.

WHAT WORKED WELL

Progress reports, key informant interviews, and survey data indicated that a number of dimensions of the initiative worked well, including the following.

1. The overall support provided by the Center for Collective Wisdom (C4CW). (n: all 4 participating organizations)
2. Wisdom dialogues and other collective engagement and discernment processes designed and facilitated by C4CW. (n: 4)
3. Engagement of staff and volunteers in trainings to learn the Leadership for Collective Wisdom framework. (n: 3)
4. The Leadership for Collective Wisdom framework and C4CW's orientation to leadership. (n: 2)
5. Flexibility to adapt the plan for implementing Wisdom Transformation processes. (n: 2)

The following sample quotes (noted in *italics*) illustrate these themes.

> *The support we continue to receive from C4CW is vital to helping us slow our pace and helping us to keep a healthy, effective focus, staying out of the firefighting mode which we desperately need when changes in programming can surface so abruptly.*[19] (Theme 1)

> *The 1:1 coaching was very specific, allowing me to be able [to] receive targeted knowledge about how a dynamic or process could be interpreted, consider all data, and work on application on a personal level which was very helpful about several key issues I was needing help with.*[20] (Theme 1)

> *The support … has been undeniably effective, timely, and very well designed to respond to specific needs, understand key processes and where management and staff may be experiencing areas that*

[19] Organization progress report, January 2014.

[20] Organization final report, December 2015.

could become more effective. Many consultations have resulted in re-examining more effective ways to communicate concerns, provide and receive feedback, and continue to explore the priority of staff and organizational wellbeing.[21] (Theme 1)

The consultation and meetings with C4CW, [which] continues to enlighten [and] provide hope and relief to our leadership team is paramount to our resiliency. Our meetings are a safe place for reflection, support, and well-being that is vital to our mission.[22] (Themes 1, 2)

Annual Senior Leadership retreats … helped us understand and embrace the practices, identify our personal and collective "yes" to implementation, and develop our strategic plan to continue to embed the practices in our leadership/organizational culture. Facilitated learning dialogues, both planned and unplanned have been invaluable as we have identified "dilemmas" at the organizational, program and team levels.[23] (Theme 2)

The manner in which the training was framed … facilitated senior admin to "buy in" first, supporting and encouraging leadership to become excited about the Leadership Training, which in turn helped leadership to embrace and "sell" it to staff prior to staff orientation. Furthermore, the breakout sessions during the three day Leadership training really helped each broad set of programs drill down into the framework and "make it their own." It was great to see wisdom arising and an alignment of intention emerge across leadership leading to focused and well received Wisdom Dialog sessions.[24] (Themes 2, 3)

The beginning pictures [depicting aspects of the framework] were powerful. They grasped our attention and recognition of how growth and change can occur, and the importance of "collective" vs. "individual" efforts (whether agency or people) in creating sustainable change.[25] (Theme 4)

Though much of leadership's efforts focused how to adopt the WTI framework internally within the agency, many staff also connected the utility of the framework to our work directly with families.[26] (Theme 4)

What has worked well has been: … The freedom to change our minds/direction, question without feeling uncomfortable, knowing that all dialogue was accepted, appreciated and understood. The evolution of a clear direction after many "new revelations." Knowing the outcome substantiates the need for the journey. It was well worth it.[27] (Theme 5)

Participants from at least one organization mentioned the small grants, and participants from another organization mentioned the online resources, as aspects of WTI that also worked well.

---

[21] Organization progress report, January 2015.

[22] Organization progress report, January 2014.

[23] Organization final report, December 2015.

[24] Organization final report, December 2015.

[25] Organization final report, December 2015.

[26] Organization final report, December 2015.

[27] Organization progress report, August 2015.

WHAT COULD BE IMPROVED

Progress reports, key informant interviews, and survey data also offered suggestions on how the initiative could have been improved, although participants generated less data and reflections in response to this question, and no theme resonated with all four or even three organizations. Themes that arose included the following.

1. Increasing resources and processes to reinforce the Leadership for Collective Wisdom framework to deepen participants' engagement, learning, and embodiment. (n: 2)
2. Focusing early initiative engagements at the intra-organizational and program level as opposed to the inter-organizational level. (n: 2)
3. Continuing WTI and C4CW's support beyond the Innovation Project. (n: 2)

A number of sample quotes (noted in *italics*) illustrate these findings.

> *There is a need to continue returning to core Leadership for Collective Wisdom framework [concepts]. In some instances it requires new ways of thinking about the [organization] and participants need support in making these conceptual shifts.*[28] (Theme 1)

> *Perhaps in the initial introduction, to emphasize this as a gradual, individually-program-paced process. Once [we] focused more on understanding the foundation of the framework rather than thinking ahead about the "hows" and the "whens," the door was opened for a more deepened understanding.*[29] (Theme 2)

> *The only challenge was initially when [the] focus was on working with [all of the organizations together] vs. developing [each individual organization's capacity] and then aligning their efforts based on identified needs in developing partnerships.*[30] (Theme 2)

> *If going forward means moving from where the process is now toward something else, [we] could not identify improvements to the process now. The only thing would be some continued engagement as the organizations move from planning to action. C4CW is now in a greater position to assist the organization as challenges will emerge in implementing strategies. It would not entail the monthly meetings, but quarterly or as needed support.*[31] (Theme 3)

Participants from one organization thought that the early orientations of the initiative could be designed to better help people understand the overall arc of the process. Program staff from another organization struggled with adapting and translating the language of the Leadership for Collective Wisdom framework to make sense within their day-to-day responsibilities.

---

[28] Organization progress report, January 2015.

[29] Organization progress report, January 2015.

[30] Organization final report, December 2015.

[31] Organization progress report, August 2015.

SECTION 4: THE IMPACT OF WTI

The first set of learning questions that defined the focus of WTI focused on the impact of adopting and learning to embody the Wisdom Transformation framework by participating organizations.

Specifically, we assessed whether and how the adoption of the Wisdom Transformation framework helped participating organizations increase their capacity to:

- Learn to adapt better to the policy and fiscal volatility within the behavioral health system;
- Create a stronger and more positive internal environment for staff and others connected to the organization so they can better support the people they serve; and
- Cultivate more effective collaboration among each other and with BHRS.

This section analyzes the data to respond to these learning questions. We also explore what the data suggest about the potential for the Wisdom Transformation framework to help organizations improve outcomes for people suffering from or at risk of mental illness. While the timeframe for this project prohibited us from being able to document sustained impact on outcomes for people receiving services, the data we have collected allows us to offer beginning reflections about the potential for this lasting impact.

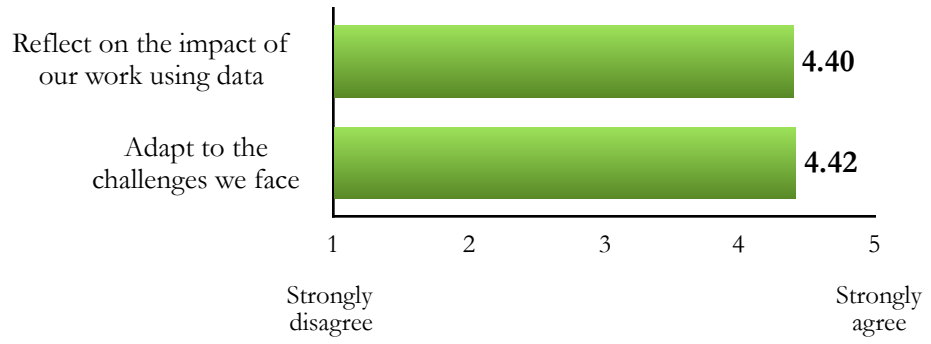
ORGANIZATIONS LEARNING TO BETTER ADAPT

BHRS adopted the Wisdom Transformation framework to help the department better navigate the fiscal and policy instability that accelerated as a result of the recession and its cascading effects. And although the recession's effects have diminished somewhat, the policy and fiscal instability within the system remains.

A major focus of this Innovation Project was to explore whether the Wisdom Transformation framework could similarly benefit participating organizations, increasing their ability to adapt and respond effectively to the system instability they encounter. The data suggests the answer to this question is clearly *yes*.

First, a significant majority of the Impact Assessment survey respondents agreed or strongly agreed that their organizations had an increased capacity to reflect on and adapt to changes as a result of participating in WTI. *None* of the 56 respondents disagreed with this statement.

Figure 4: As a result of participating in WTI, my organization/program has an increased capacity to: (N: 56)



More compelling than this simple quantitative data, organizations demonstrated a capacity for learning and adaptation through the application of various aspects of the framework across the whole organization, within senior leadership teams, and within particular programs.

Senior Leadership and Organization-wide effects

One organization developed a long-range strategic plan grounded in the commitments to leadership and results. Senior leaders have taken steps to integrate the Leadership for Collective Wisdom framework into all aspects of the organization, including staff surveys, performance evaluations, orientations for new staff, and others. One senior leader reflected:

> *I believe job satisfaction is higher. We are more transparent, more inclusive and more intentional in our words and actions. There has been a promising shift in our culture that has made us even stronger and more appealing for employees.*[32]

A second senior leader observed:

> *I was thinking about the move [to our new office location]. … [and] the potential for our culture to change, or for us to lose some of who we were in our previous location. … I feel like the wisdom transformation has allowed us to maintain [our culture] to a great degree but also respond to the potential for all of that to change, in a way that has been really productive and inclusive. … It's given us tools to respond in a really effective way whereas we may have just gotten caught up in getting this move done.*[33]

A second organization developed a first-ever, organization-wide budget as part of a strategic planning process that included major revisions to the organization chart and key job descriptions. This long-term budget, developed in response to changing community needs and the need for succession planning, was unanimously endorsed by the board and key community stakeholders as an essential adaptation for the organization's long-term sustainability. A senior leader from this organization observed:

> *The dilemma, adaptive or otherwise, was huge. I think [the result] was way past what we had anticipated, and I don't think we had anticipated being where we are today … So, I learned that really, anything is possible if you continue to work at it and go through all the ups and downs.*[34]

A third organization developed a series of responses to strengthen its recruitment, training, and retention of new staff. The advent of the Affordable Care Act and other changes in the labor market are putting pressure on the organization as long-term staff leave for private sector positions paying more than the organization can match. A senior leader described her team's evolving response as follows:

> *We are improving job descriptions across the agency so that there is greater clarity about roles and responsibilities. We are also [benchmarking] salaries, so that people feel appreciated, and we are continuing to renegotiate contracts to be able to grant more increases. We have been more open as a*

[32] Impact assessment, November-December 2015.

[33] Key informant interview, September 2015.

[34] Key informant interview and focus group, September 2015.

> *leadership team and increased our understanding of what we want, and now we have come up with something that will get us to where we want to be. This couldn't have been achieved with a top down process. Our organism is working through change toward a goal that we have put in place. It is like climbing a mountain as a team; we must help each other out.*[35]

A fourth organization's senior leaders demonstrated increased capacity to strengthen their teams' capacity for leader-ful behavior. One leader observed:

> *[WTI] has broadened my perspective of being not [just] more open to feedback, but more purposeful in soliciting feedback from staff. There are times, when in my exuberance about a particular thing, I will just go forward. Then I have to play catch-up, and that's not the best way to do that. This is sort of enlightening me to that process, or the fact that I do that. Second, as a leader, [it helped me] to be more purposeful about cultivating this way of being with our leadership staff in general. Certainly, when I work with parents, I knew it wasn't enough to be a role model. There has to be teaching as well. And, as a leader, I have been more a role model and not as purposeful in teaching or leading in this sort of capacity. So I think to be purposeful about cultivating the way of being in collective wisdom [has affected my understanding of leadership through WTI].*[36]

Another leader observed:

> *Apart from the work on results, the [Wisdom Transformation] WT has had a profound impact on the quality of [our leadership team's] relationships, and created a deeper trust and bond between us. I've seen individual growth and maturity develop as we embody the WT commitments and practices of self-leadership. Connecting the WT to individual challenges and goals has made a big difference in our understanding of what it means and takes to be a leader.*[37]

Program-level effects

Three of the four participating organizations also applied the framework to program-level efforts, typically involving the implementation of Wisdom Dialogues.

In one program, staff developed new processes for supporting participants to play a more active role in their own recovery. These new processes not only helped the participants, but also helped staff to better adapt to changes that could impact participants' progress. A staff leader described this process as follows:

> *[Our program] has spent the past six months developing an assessment process that identifies the particular needs of each resident, the kinds of support they need and the capacities the program needs to support their success. The process is evolving and has focused on the development of staff and youth surveys and how to have conversations among staff based on the results of the surveys. The structure the surveys gave to weekly staff meetings and the differing perspectives that were revealed led to productive discussions about additional support we could offer a young person and the clarity that in some cases we had offered all the support we could but there was a misalignment of intentions between what the program could offer and what the young person wanted or needed … This subtle shift in*

---

[35] Key informant interview and focus group, November 2015.

[36] Key informant interview and focus group, November 2015

[37] Organization final report, December 2015.

> *thinking about misalignment vs. failing as a program/staff is and will continue to have profound effects on staff and therefore on programming. It allows us to move from fear of failure to inquiry about what's working and not working and why.*[38]

Family Resources Centers (FRC) began a process of transforming their focus from delivering discrete units of available services to helping communities strengthen their capacity to promote the recovery and wellbeing of their members. One of the FRC leaders observed:

> *We have been focused on developing common results related to the movement toward and engagement of community. All … teams have engaged in work to help develop a survey with common outcomes and indicators. … Teams were able to review and reflect on the results, which were overwhelmingly positive and will help guide next steps as we move forward. … Leadership [team members] are learning how to hold Wisdom Dialogues with their staff/teams, to help understand what we're learning together and to address adaptive dilemmas as they arise.*[39]

Several programs implemented new approaches to decision-making for process improvements led by staff. Managers for these programs described these processes as follows:

> *[One of our programs] experienced tremendous growth. … Staffing is pretty much nine-months onsite at schools, but we've kept staff employed over the summer because it helps with retention. … Well, going from 25 to 50 staff, we don't have enough space for all of them over the summer, so it was a little dicey. It was people sitting around like 'What am I going to do?' and 'How do I work?' I suggested that the team start having conversations now about this adaptive dilemma. Is it really about how do we provide productive work experiences for people 12 months out of the year, and is there a different service delivery model that we might be able to implement that will be better? They're in the process of gathering that data. … When we had an experience like this before it might have just been 'Let's hold a meeting and figure out what we're going to do.' Now it's like 'let's start having some learning conversations, figure out what we need, and be more intentional about how we approach dilemmas.' We're practicing getting more eyes on it and creating a collective understanding before we jump to action.*[40]

> *For us, [scheduling holiday vacation] is a huge, huge issue. The nature of our program is 24/7 and there are people [who] literally don't see one another more than once every month or two. Our first learning dialogues were around creating a holiday schedule. That was a big point of contention. It was almost like there was campaigning going on—early in the year—about who would get what holiday off. It was about identifying what the problem is and looking at what the givens are, what is negotiable, what's not negotiable and then, bringing out the self-interests and putting everything on the table so it no longer becomes, "I don't have to think about what his family might have going on. I'm just thinking about what I want to do on my holiday." But when all those things are out on the table, it's hard to look away. … And to see the generosity and the graciousness that came out of that process. … It really helped everyone to think beyond themselves.*[41]

---

[38] Organization progress report, August 2015.

[39] Organization final report, December 2015.

[40] Key informant interview and focus group, October 2015.

[41] Key informant interview and focus group, November 2015.

> *One of the key lessons learned related to billing obligations. Some staff members were welcoming only what they wanted. … It was only later when we discussed at a much deeper level about what was getting in our way and how we could help each other to offset some of the hurdles we were having, while at the same time holding people accountable for hitting their floors … that [we made significant choices about personnel]. This had a huge impact on staff, and it also motivated staff to step up and join the intent of the group, understanding that we need everyone's effort to make this work. It became quite rewarding as we continued to pick up momentum, hitting our goal two months in a row, three, and then four. … The team was demonstrating that they were at capacity as a cohesive team to effect positive results and become excited about "being on a roll."* [42]

And almost all participating programs have implemented practices and processes to strengthen the engagement and leadership capacity of staff. Staff members from two different programs described this work as follows:

> *We had such monumental shifts [in our programs] that I think if we didn't have Collective Wisdom, we wouldn't have, at least for me, been able to really fulfill my own needs and the needs of the whole. … Collective Wisdom has been able to [provide a] structure for learning how to get alignment versus 'I don't know why my supervisor is doing this' or 'Why can't the county get that our population doesn't fit into their cookie-cutter mold.' I've been able to sort through those feelings and not take it personally, or feel defeated. It's just kind of like, 'Okay, so there is that ginormous log in the road and we're all going to kind of laugh about it, and eventually without realizing it, we'll all be able to move that log and work along side each other.' Collective Wisdom built that confidence.*[43]

> *We had received feedback that caused concern about the culture of this team. [A senior leader] decided to meet with the team, instituting the WT practices as she began to work with them. In the three meetings they held, much progress has been made in their relationships and their commitment to work together to improve the culture in their office. One of the keys was creating an environment where they could hold their stories lightly and welcome the experience of others. Another big turning point occurred with the leader of this team as she acknowledged her need to lead differently, modeling self leadership.*[44]

MORE POSITIVE INTERNAL ENVIRONMENTS

A second intended impact of organizations embodying the Leadership for Collective Wisdom framework is to strengthen their internal working environments so that staff are better able to support the recovery and wellbeing of the people they serve.

A significant majority of respondents to the Impact Assessment agreed or strongly agreed that their organizations were able to create a more positive working environment as a result of participating in WTI. *None* of the 55 respondents to this question disagreed with this statement.

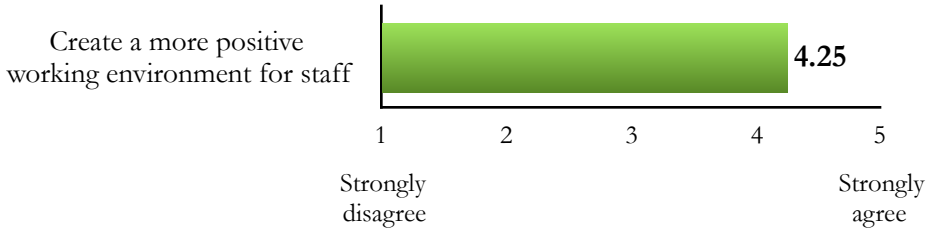
---

[42] Organization progress report, August 2015.

[43] Key informant interview and focus group, November 2015.

[44] Organization progress report, July 2014.

Figure 5: As a result of participating in WTI, my organization/program has an increased capacity to: (N: 55)



One senior leader described the impact she observed this way:

> *Employees are holding their stories lightly, welcoming all that arises, and there is overall a sense of calm that comes from embodying these practices. Wisdom Transformation is leading us to more thoughtful decision making, including "more eyes on the scallop" and being leader-ful. I have literally watched the change from senior management level to our receptionist and everywhere in between.*[45]

Another senior leader agreed:

> *The concepts associated with self-leadership have created better relationships, more thoughtful decision making, and employees are finding their voice. This has an overall positive impact on our culture which translates to job satisfaction which translates to working smarter.*[46]

And a staff member from a different organization described the impact of WTI this way:

> *To see the willingness, the desire, the wanting, of the organization that you work for to [commit to WTI]—it creates a better work environment, but it bleeds over. It creates better employees. You have tools that you didn't have before because of work to go home to your life. That's meaningful. That says a lot. That's huge. ..I don't want it to end. Just keep it going …*[47]

The data document that staff members' increased capacity for leader-ful behavior, a foundational concept of the Leadership for Collective Wisdom framework, was a key factor in creating a more positive working environment. The concept of being leader-ful distinguishes between formal authority and leadership. The LfCW framework recognizes that every person can exercise leadership —defined as acting to help create the conditions for collective wisdom to arise in support of profound action.

The data identify two types of leader-ful behavior that significantly contributed to improved working relationships and more positive internal environments: (1) initiating conversations with others to improve shared understanding and resolve issues, and (2) initiating actions that intentionally provide tangible support to others.

---

[45] Impact assessment, November-December 2015.

[46] Impact assessment, November-December 2015.

[47] Key informant interview and focus group, September 2015.

The data include numerous examples of staff members initiating conversations to resolve differences and/or to create shared understanding, including the following.

> *A shift is occurring and there are more employees seeking guidance in dealing with internal relationships. I see this as a positive behavior that people are finding their voice through the wisdom transformation practices and dialogues. Employees who would typically work around behaviors that aren't in line with our culture, values and the [Wisdom Transformation] are now coming forward and addressing the issues directly with the person. … This is a huge benefit and issues are getting resolved quicker. Starting a conversation with "this is my story …" tends to lessen defensiveness and negative responses. Once employees experience the positive outcome of these conversations they are more willing to address issues in a timely manner.*[48]

> *Staff are able to approach each other about situations that come up and use terms that we have learned to have a learning conversation. It has provided a way to talk and communicate with each other where it does not seem like a personal attack.*[49]

> *Although still present, there seems to be considerably less influence of attitudes and behavior based on third-party communication, rumors, and gossip. There is also greater willingness to communicate openly and directly, with less fear of judgment and reprisal, although the degree to which this has developed varies widely among staff members.*[50]

The following stories, shared by line staff from three different programs, are typical of the data about staff members' increased leader-ful behavior to more intentionally provide support to others.

> *The WTI trainings have been a rather unusual experience for me. I have never attended a training set up quite like it and it has been a rather interesting and hopeful journey. I found myself drawn most strongly to the portion of the training responding to orienting to the whole, in regards to seeing the whole and hearing the whole. I work predominantly night shifts and the interactions I am able to have with my team members is restricted to a once-a-month scheduled meeting. Staying informed and up-to-date with team communications is rather hard. After our first WTI training we had a staff meeting and one of our team members mentioned how someone had a rather incredible job—or did a rather incredible job handling a situation that had arisen on their shift. No one in the team had heard about it and we spent a good portion of time discussing how sometimes everyone gets a bit down due to lack of support. The feelings of isolation and stress, of wondering if we are actually doing our job and giving our job our all. After someone thought on how best to remedy this, the notion of the box was born [to document our appreciation of someone on a slip of paper]. It was a simple fix and an easy way for everyone in the office to give the support to each other and offset the feeling of being on our own. It gives us something to look forward to at the meetings and a fun event to recognize our coworkers and to be recognized ourselves. It allows all of us to feel appreciated and ensure that we always end meetings on a positive note.*[51]

---

[48] Organization final report, December 2015.

[49] Impact assessment, November-December 2015.

[50] Impact assessment, November-December 2015.

[51] Key informant interview, September 2015.

[WTI] has affected how we work together. Before [WTI], it hadn't been easy, it was stressful. Since we've been doing the Collective Wisdom, we've been able to support each other more. It can make me a lot better and it makes a better environment for us to feel comfortable being at work … It's not about showing up and just doing our job. It's about looking at each other and saying, 'Are you okay? What's going on?' It's not something we're doing just for our members, but we're doing it for each other as well.[52]

So that's made me step back and take a breath and get my team members' story and not just automatically—and embrace it and be okay with silence. Be okay with not knowing all the answers or not knowing everything right now. Be patient, it'll eventually come out. And then what happened with us as a team was we started to talk to each other collectively about, okay, "I'm doing this. I have this client. This is what I tried. Oh, I know this and this might work.' And then we started talking as a team together. Instead of having our weekly team meeting with our supervisor, we started having our own team meetings on a daily basis and going over what we were going to do. And we noticed that [one of our team members] would not face us. So I brought it to the team's attention and we had a conversation with her. And we were like, 'We feel you're not part of the team. What's going on? This is a collective wisdom thing. We're trying to get all different thoughts.' And in that conversation it was really great because she admitted, "I felt like I was being left out." We had the courage, I guess you could say to have this conversation amongst ourselves. Since then we've worked on it and now when we do our roundtable discussion, she turns around and tells us about her ladies. … She engages and shares whereas before she literally had her back to us. So I just took it upon myself. I was like we've got to figure this out because I don't like this uncomfortable feeling.[53]

Increased Capacity for Collaboration

The senior leaders from all four organizations reported that, as a result of WTI, their organizations experienced an increased capacity to more effectively collaborate with each other and with BHRS. The following stories are typical of the data about how organizations were better able to collaborate with each other.

The benefit of everyone having participated in wisdom transformation through the Center for Collective Wisdom has been a positive effect on communication, appreciation for the overall intent of the partners and greater understanding and willingness to move selves aside for the greater good of all communities. [Our organization] has been able to understand and appreciate those areas where other organizations are different, engage in meaningful dialogue and acknowledge that in order to achieve desired results strong partnerships will determine the outcomes.[54]

With other partner organizations who may experience frustration due to stories based on misperceptions about who we are or what we do, keeping in mind the WTI framework, and approaching individuals with genuine concern for and curiosity about the sources of their frustration, helps set the stage for a conversation focused on providing education to partner organizations, and

[52] Key informant interview and focus group, November 2015.

[53] Key informant interview, September 2015.

[54] Organization progress report, August 2015.

> *problem solving about how both entities can meet legal and ethical obligations, while still being in service of the guest considered for and/or being served.*[55]
> *Leadership continues to work alongside our partners at CSA, exploring ways to improve the system experience for participants. Our approach is informing the way we work together, promoting inquiry [and] welcoming all perspectives.*[56]

> *We had an experience with our partner [organization] as it relates to changes within a program. … Our initial response was frustration as we saw this as a major problem for us. We held a learning conversation … and really explored the stories we were holding about this and ultimately … we agreed that we would share our story … to both understand their perspective and help them understand ours. … As a result, we did something we have never done; tell a partner that we understood and would accept their decision and that we were okay with backing out of the partnership as this was staying true to what [our organization] needed to be an effective partner. They asked for time to consider this and I'm happy to report [the issue was resolved and we are still partners].*[57]

The following stories are typical of the data illustrating how organizations strengthened their collaboration with BHRS.

> *The Leadership for Collective Wisdom framework helped to improve [our] program's capacity and effectiveness with BHRS in several areas. Our ability to come to the contract monitoring meetings as a partner versus coming in as a one-down relationship … has been greatly improved. These conversations are tending to be more of learning dialogues and discussions about related information to have more informed opinions about service delivery. BHRS representatives … [also] contribute to these discussions in what feels like greater collaboration than in the past.*[58]

> *In interactions with BHRS, engaging others through the framework has helped remove antagonistic or adversarial dynamics that interfere with problem solving, and recognition that we share the same mission in our desire to be of service to others. It has also helped to encourage all involved in complex situations to step back, consider the complexity, and how that might lead to the perception/experience of feeling undermined or thwarted, when there is no such intention. It has helped make room for the intention behind perceptions to emerge, which almost always helps open communication and facilitate constructive problem solving.*[59]

> *The thing that shifted was me being able to go to BHRS and say this is a shared story. We're part of your system and we need to tell you this is our story, that we have 300 or 400 referrals we can't manage right now. We're at capacity, but we're holding a story that we're going to be out of compliance if we don't, so how do we as a System of Care start looking at this and prompting more conversations about how to look at that? Not just [our organization], but all of us orienting … to the whole, … The nice thing about it was the chief was like, "Well, it looks like I need to give you more support to*

---

[55] Organization final report, December 2015.

[56] Organization final report, December 2015.

[57] Organization progress report, January 2015.

[58] Organization final report, December 2015.

[59] Organization progress report, August 2015.

do your work and then, yes, you're right. This is not just your responsibility. This belongs to the whole system, so let's start looking at that as a system." In the past, when we'd sit and brew and stew about the stories that we're holding that [our patterns were] saying and that wasn't their story at all.[60]

Some of the ways we have been able to realize a more effective collaboration with BHRS is to explore much of the perceived problems(s) that really lean more toward systemic concerns or adaptive dilemmas [that have] come out of staff discussions where the stories we hold are not about an "us" or "them" mentality but really how an adaptive dilemma is impacting the system. [61]

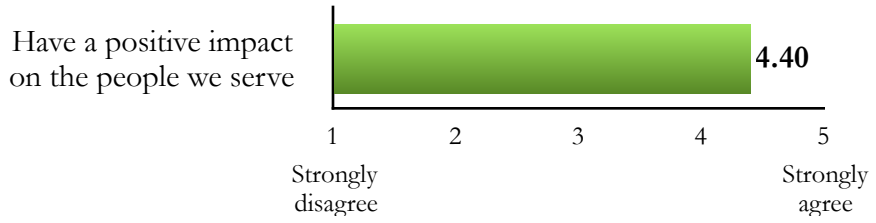
IMPROVED RESULTS FOR PEOPLE RECEIVING SERVICES

The principal focus of this project was to promote interagency and community collaboration, and the data suggest substantial progress toward this objective. The ultimate purpose of any transformation effort, however, and any project funded through the Mental Health Services Act, is to improve results for people who struggle with mental health issues.

Although the scope and timeframe of the project did not permit us to independently assess sustained improvement in performance measures for participating programs, the data we do have indicate the potential for sustained improvements in results.

First, a significant majority of the Impact Assessment survey respondents agreed or strongly agreed that participating in WTI increased their organization's capacity to have a positive impact on the people they served. None of the 57 respondents disagreed with this statement.

Figure 6: As a result of participating in WTI, my organization/program has an increased capacity to: (N: 57)



Moreover, participants offered multiple reflections connecting the positive impact of WTI on their programs and organizations to their capacity to effect more positive results for the people they serve. Some examples of these reflections follow.

We are seeing a pattern developing where the standard role of case management has shifted to more partnerships to obtain treatment outcomes and fostering learning conversations with clients. … We are

[60] Key informant interview, October 2015.

[61] Grantee report, August 2015.

also beginning to see the benefits of a collaborative work site that includes the folding together of [two programs].[62]

Our four Family Resource Centers have benefited … significantly thus far. Employing principles of WTI, the FRCs have more effectively engaged the populations they serve in open dialog regarding needs of the population. Through advisory boards, focus groups and outreach efforts, the FRCs have come together with their local communities to identify and bring specific services, trainings, and resources to the families in each of their regions.[63]

I've found that being able to come to work with a positive attitude has made me more effective at helping people. When I'm frustrated, it's kind of hard to pay attention to what they're saying. And the people we serve don't always say things directly because they don't always know what they want. But it's been helpful for me to learn how to present myself in such a way that they feel comfortable and they're more open to share with me what their concerns are. That can help me help them figure out what their needs are.[64]

The goal now is more on developing relationships than getting tasks done. The information will come from that relationship instead of just, 'Did you do this today?' … Wisdom transformation makes us stop and think about every person we meet and what our impact on them is, and how they perceive us.[65]

One of my biggest problems that I have is I assume. I will have a train of thought and then I will keep following that train of thought toward my logical outcome of what will happen. WTI has sort of helped break that rhythm … to actually talk to people and figure out what's going on instead of thinking I know best. … [T]he outcomes for the clients are a lot more positive.[66]

The dialogue we have with [people who receive services] has been positive. Feedback from [them] has been encouraging, as they have shared that they feel supported. Our data in the county surveys reflects this increase as well.[67]

[Our organization] has benefitted primarily as an organization, yet ultimately the community will achieve an even greater benefit. The ability to have realistic expectations about the structure and finances needed to ensure services are provided is a monumental achievement for the organization. This has led to focusing only on those services and activities that are important to creating change and engaging community. … Ultimately, the community and the organization can find great satisfaction in achievements within the community as a result of services and other efforts.[68]

---

62 Organization progress report, January 2015.

63 Organization final report, December 2015.

64 Key informant interview and focus group, September 2015.

65 Key informant interview and focus group, September 2015.

66 Key informant interview and focus group, September 2015.

67 Impact assessment, November-December 2015.

68 Organization progress report, August 2015.

A benefit I see is it can be very challenging to work with adults with intensive, psychiatric disabilities with high acuity, and maintain hope and promote wellness and recovery. So there is [a] relationship between staff well-being and the belief that people (clients) can have better lives, and make better choices that support more peace of mind and less suffering.[69]

One of the stories that our staff members hold and continue to evolve is, 'We're here as a service provider. People are coming to us to get a service and that's what we do.' We've been in the process of really changing that story with wisdom transformation, with a family strengthening philosophy. It's about building community, and we can't do that, on our own. … This movement to community has been wanting to happen for a long time. And we've just been in our own way. … What the data .. is showing is [that there are] all these folks out there who are wanting to engage as part of the community with us. We now have this opportunity, which is really cool.[70]

SUSTAINING THE TRANSFORMATION

Essential to realizing the potential for improved results is the commitment and capacity of organizations to sustain their transformation processes beyond the project. In their final reports, every organization expressed a commitment to continue their particular WTI work beyond the initiative.[71] Two stories in particular illustrate this commitment.

Our organization is adopting a 5-year strategic plan in which WTI is prominently incorporated. Over the past 2+ years we have seen the benefits of working within the WTI framework and we see the framework as a logical strategy for developing our next generation of organizational leaders. As part of our 5-year strategic plan we are looking at ways to make the framework as much a part of our culture as our values (which have been accepted, embraced and incorporated into our work agency-wide). In a recent development we are looking to "brand" the framework to match our other organizational documents so it can be clearly recognized as something in which we are invested. While giving credit to C4CW for all they have done to create and share WTI with us, our organization needs to make it our own so our employees can fully embody it.[72]

The consensus among leadership is, '[we want to sustain] all of it.' Practically, our plan is to keep WTI alive in our Leadership Meetings. We feel strongly that if Senior Administration and Leadership continue to embrace the framework, utilize the principles, and employ the language, WTI will naturally penetrate the entire agency and be adopted by staff across programs. In particular, we would like to continue the Wisdom Dialogue work regarding the animating question … Moreover, we would be pleased to see the general framework alive throughout the agency as it aligns meaningfully with our Strategic Plan.[73]

Leaders from participating organizations have also developed a proposal—endorsed in March 2016 by MHSA stakeholders—to sustain and deepen the changes begun through WTI through the use of

---

[69] Organization progress report, August 2015.

[70] Key informant interview and focus group, September 2015.

[71] Final Organization progress reports, December 2015.

[72] Organization final report, December 2015.

[73] Organization final report, December 2015.

Workforce Education and Training funds. We explore some of the reasons and implications of this proposal as part of the Section 6 discussion of recommendations for continuing WTI beyond this initiative. For now, the point is that all four organizations experienced substantial benefit from WTI for their capacity to achieve and improve positive results for the people they serve, so much so that they initiated conversations with BHRS and stakeholders about continuing and extending the initiative beyond this project.

This section explored and documented the benefits of organizations learning to adopt the Wisdom Transformation framework. These benefits include:

- Increased capacity to adapt and respond effectively to complexity;
- More positive internal working environments for staff, volunteers, and others associated with the organization; and
- Increased capacity for collaboration among programs within the same organization, among partner organizations, and with BHRS.

And again, the data suggests that these benefits have already begun to translate into sustained and improved positive outcomes for people receiving services, though we cannot assert this last benefit conclusively, given the timeframe and data limitations of the initiative.

We might describe this analysis as the *why* of this exploration: why might other mental and behavioral health systems and organizations want to undertake a process to adopt the Wisdom Transformation framework for their own purposes?

In Section 5, we turn to the *how* of this exploration: what challenges did we encounter, and what did we learn about what helps organizations effectively adopt and embody the framework?

SECTION 5: CHALLENGES AND LESSONS LEARNED

A central focus of this project was the exploration of what would help organizations successfully adapt the Wisdom Transformation framework into their day-to-day operations and larger cultures. Our beginning learning questions for this part of the exploration included:

- What processes would help community-based organizations—each with different missions, cultures, and histories—successfully adapt the Wisdom Transformation framework within their particular programs and services?

- What processes would help build effective intra-organizational learning communities among staff members, community leaders, family members, and people who receive services?

- Whether cross-organizational learning communities and peer allies are promising strategies for sustaining long-term transformation efforts?

This section explores what we learned in response to these questions, and details a number of the challenges that brought forth these lessons.

WHAT HELPS ORGANIZATIONS SUCCESSFULLY ADOPT THE FRAMEWORK

We have learned a number of lessons about what helps organizations successfully adopt the framework, including the need for:

- Assessing readiness for undertaking an ongoing transformation process, given the current challenges confronting an organization;
- Regularly assessing the commitment within the organization to continue the process;
- Re-framing and translating the framework to fit each organization's unique culture;
- Engaging senior leaders first, and coaching them as allies, to help sustain the process; and
- Using technology and online resources to support the ongoing transformation.

Assessing readiness for undertaking an ongoing transformation process

WTI emerged as a proposal to support six organizations who, in the year prior to the start of the Innovation Project, had participated in an intensive discernment process about how to adapt and integrate the BHRS transformation framework to support their work. Delegations from all six organizations had exposure to the original version of the framework, and had participated in extensive conversations about how the framework aligned with their distinct organizational cultures and could help them improve the positive impact of their behavioral health services in the county.

Despite this in-depth discernment process, two organizations withdrew from the initiative during the first year, and one decided to postpone its engagement until the second year. The two organizations that withdrew from the initiative were statewide organizations that provide services in multiple counties. The senior-most leaders of these organizations do not reside in Stanislaus County, and had not participated in the prior trainings and conversations.

For one of these organizations, another internal transformation process had begun at the same time as WTI. The Stanislaus County leaders of this organization initially perceived the Wisdom Transformation process as highly compatible with their larger organization's change effort. Over time, however the organization's statewide and county leaders concluded that introducing the Wisdom Transformation framework in Stanislaus County alone, while the entire organization was undergoing a related but distinct internal transformation process, would create too much confusion among staff.

For the other organization that withdrew, while at least one senior leader in Stanislaus County wanted to continue WTI, most of the senior leadership team felt overwhelmed by new initiatives recently begun by the organization (both in Stanislaus County and across the rest of the organization). The leaders from this organization could not marshal the focus or time to fully engage in the initiative.

For the organization that postponed its participation, senior leaders discovered they had underestimated significantly the time and effort a major accreditation process would require of staff across the organization. They began to engage with WTI in January 2015, after they had successfully completed the accreditation process.

These first year developments presented the first major challenge for the project. As we reflected on these developments, we reached several conclusions and made several adaptations in the project.

First, when inviting multi-county organizations to participate in a county-based transformation process, we should engage state-level leaders in the assessment process along with the county-level leadership team. This would have meant, at minimum, holding one or more conversations with state-level leaders to explain the purpose and arc of the transformation process. Ideally, state-level leaders would have been part of the delegations that participated in the initial orientation sessions to the framework, and would have helped develop the initial plans for their county-level teams. These changes would either have identified the misalignment within the two organizations earlier, or would have helped create the statewide support they needed to continue their engagement.

Second, in subsequent interviews with county leaders from one of the organizations that withdrew, we discovered that many of them were hesitant about the initiative from the beginning, but were worried about the implications of choosing not to participate. They wanted to be good partners with BHRS, one of their major funders, and did not want to be seen as resisting a process that was clearly important to BHRS senior leaders.

This discovery reinforced a central orientation of our approach in WTI—namely, working with each organization to create a process aligned with the capacity and commitments of people within the organization, and with the organization's larger culture. and priorities. This process of transformation, of intentionally engaging all four dimensions of change in support of effective action and improved results over time, cannot be mandated by an external funder. A system to create an Electronic Health Record can be mandated; an ongoing process of transformation to cultivate cultures of collective wisdom can be *invited,* but not mandated.

Regularly assessing the commitment within the organization to continue

And this invitation must be continually extended, and the commitment to the process regularly renewed. A significant learning through WTI was the validation of our initial hypothesis that nurturing the capacity to embody the Leadership for Collective Wisdom framework requires

consistent opportunities for practice and social reinforcement over time. While one-time training events provide an essential forum for developing intellectual understanding of key concepts, ongoing practice in real settings over time is needed to produce sustainable changes in mindsets, behaviors, cultural norms, and institutional policies and procedures.

Many naturally occurring dynamics can inhibit and challenge our innate capacity for learning and growing together: individual and group emotional reactions and attachments to particular mental models; conflicts among staff and others that fester over time; changes in leadership; new regulations requiring significant program changes; shifts in budgets; and on and on. All of these dynamics and potential developments are constantly present, and any one or more of them can quickly deteriorate into the conditions for collective folly. To cultivate the conditions for collective wisdom to emerge in the midst of these constant challenges requires ongoing attention, practice, and discipline, as an integral part of the work. As one program staff member observed:

> *With trainings that we go to such as a day, or half-day training, I think actually sometimes it's a Band-Aid. I think you really have to be dedicated to be able to continue your learning. And sometimes that's difficult because things get in the way, so you can't really practice it. But since [C4CW has] been here on a regular basis with us, I think it helps us really embrace it more, kind of soak it up more. Just because we don't understand the term or the idea [at first], we'll get it again, and then once we do get it, we are able to transfer it to our staff. And they've gone to a few trainings, too, and it's the same thing: once they get it, they will transfer it to new staff or to their personal lives or to the participants. … So, I think just having the consistency that it's not just a one-day kind of thing has really helped the process in making sure that we continue the learning even when [C4CW is] not coming back anymore.*[74]

A senior leader from another organization made this point in a different way:

> *The only challenge that I can think of is the constant challenge to balance workloads and pace our work. What we are learning is that the time we invest in WTI activities is enhancing and enriching our work. While it is an investment of time and energy, our staff is beginning to recognize that by applying these practices to their work (meetings, decision-making, leadership approaches), it is improving outcomes and informing systems.*[75]

And a line staff member made the distinction between training events and the invitation extended through WTI this way:

> *People were able to reflect and see how they were responding to certain things … —self-leadership and how that's all something that comes from within, not from just saying we're all going to be leaders now. Those staff have really just embraced all that we have learned and have been able to be intentional about what they do during their day and with their programs. And then the staff that have a difficult time reflecting, I've noticed I had to be more intentional about journaling and getting them to try too—it's hard because my staff at first thought that this was a program, and so it was really talking to them and helping them understand that it's not really a program, it's … a way of being.*[76]

---

[74] Key informant interview and focus group, September 2015.

[75] Organization progress report, January 2015.

[76] Key informant interview and focus group, September 2015.

Re-framing and translating the framework

As we outlined in Section 1, one of the early adaptations we made was to translate the framework so that it was more relevant and appropriate to community-based and non-profit organizations. The internal realities for these organizations, and the perspective and frames of reference for their staff, are often quite different from those of a county-wide department.

We first simplified the language of the four commitments, and developed illustrations and applications more appropriate for community-based and non-profit organizations. We quickly discovered that we needed to do more. Within BHRS, the four commitments of the transformation framework have been developed and taught as co-equal. Within the WTI organizations, however, the four commitments were not co-equal.

At the beginning of WTI, every organization chose to begin their process with the commitment to leadership, followed closely by the commitment to results. These commitments were foundational for every organization. The remaining two commitments—community and sustainability—became more contextual. We did not drop these commitments, but rather incorporated particular aspects of their content and orientation as appropriate to support Wisdom Dialogues emerging through the application of the first two commitments. For example, the commitment to community was central to a Wisdom Dialogue that emerged among Family Resource Centers, and the commitment to sustainability was at the heart of the transformation process for one of the participating organizations. What changed was that we did not insist that every participant from every organization, or even every senior leader from every organization, had to master the content and orientations of every commitment.

This adaptation significantly reduced some of the complexity of the framework, and made it easier for managers, line staff and volunteers to engage more immediately in the process. We believe this adaptation could serve BHRS as well, particularly as senior leaders and mid-level managers consider how to introduce the framework to new staff who have not had any exposure to the framework or the larger transformation process.

Engaging senior leaders first, and coaching them as allies

Central to the success of WTI was our decision to work more deeply with senior leaders from each organization first before we began to directly engage others in the organization.

The original orientation and training sessions for WTI engaged learning delegations from each organization comprised of a cross-section of senior leaders, mid-level managers, line staff and others. Our intention for creating this structure for the initial learning delegation was to seed the transformation process at all levels of each organization from the beginning of the initiative.

As we moved from these first orientation sessions into the planning process, however, we shifted course, concluding that we had to engage senior leaders at a far deeper level before beginning trainings or other engagements with mid-level managers, program staff, and others. Why?

First, senior leaders' ability to discern how best to roll out the transformation process within the multiple contexts of their organization was crucial for WTI's success. A commitment to engage the whole organization does not necessarily mean engaging the whole organization at the same time. For example, within one organization, a group of staff members was beginning a new program. To

require that they immediately begin participating in the Wisdom Transformation process would have likely overwhelmed them.

Second, as senior leaders began using the language of the framework and modeling the commitments and practices, staff and others in the organization began to take the process more seriously, and understand that this was not a one-time experience but reflected a commitment to a deep level of engagement and change. This early adoption by senior leaders helped prepare the ground for C4CW team members to begin working directly with program and line staff. As a manager from one organization reflected:

> *This structure facilitated senior admin to "buy in" first, supporting and encouraging leadership to become excited about the leadership training, which in turn helped leadership to embrace and "sell" it to staff prior to staff orientations. Furthermore, the breakout sessions during the three day leadership training really helped each broad set of programs drill down into the framework and "make it their own." It was great to see wisdom arising and an alignment of intention emerge across leadership leading to focused and well received Wisdom Dialogue sessions.*[77]

A part-time employee in another program reflected on how essential senior leaders' active modeling was for staff and volunteers to trust that it was safe to try out new skills and behaviors, such as offering a divergent perspective during meetings and discussions:

> *Without that safety I'm not sure any of us could venture out and do what we've done through this [process]. But we feel … my senior leader has created that. Totally created that. … If people aren't willing to verbalize what their true interests are, you're not ever going to have a good relationship with the staff. And if there's not a good relationship with the staff, the results that you have with the people you serve are not going to be good. … So I think Wisdom Transformation has given us tools and a certain level of safety where we can talk about those things.*[78]

Building on this early success with senior leaders, we made another course correction mid-way through the initiative. Originally we expected to train 2-3 people from each organization as peer allies, "in-house experts" on the Wisdom Transformation framework who would be available to continue supporting the transformation process once the Innovation Project was complete.

As we thought more about this structure, however, we began to see that we had reflexively gravitated to a Train the Trainer model for this role, despite our clear understanding that this process was not about a discrete *training,* but about modeling and inviting a different way of being and learning in the midst of day-to-day responsibilities. Once we recognized this misalignment of structure and intention, we shifted to developing a senior leader mentoring model instead, providing additional training and 1:1 coaching for participating senior leaders.

While we cannot say with certainty that this hypothesis will prove true, we have received numerous stories, and have observed first-hand myriad examples of senior leaders progressing to a next level of embodiment of the framework. And data from a pre- and post-assessment are also promising.

---

[77] Organization final report, December 2015.

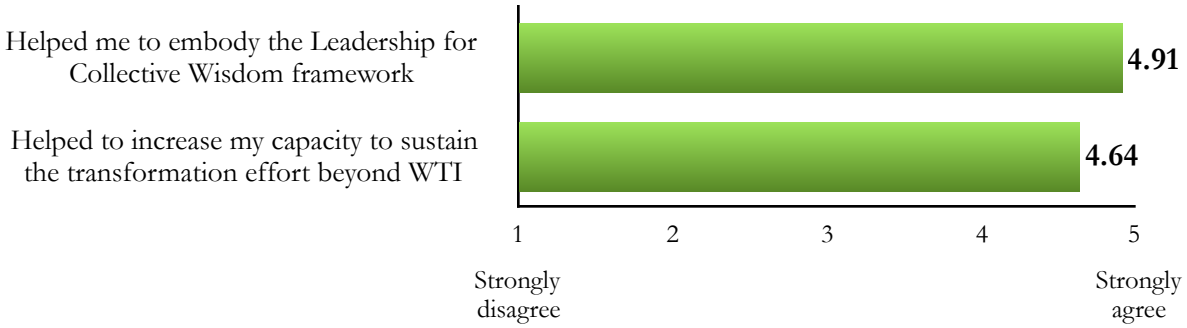
[78] Key informant interview and focus group, September 2015.

Eleven senior leaders from two of the four organizations[79] received periodic 1:1 coaching support, primarily by video conference and phone, between February and December 2015. Each participant completed a self-assessment instrument before beginning the coaching sessions (Time 1), and again after completing the process in December 2015 (Time 2).

At the end of this process, participants reported both a statistically significant increase in their perceived capacity to embody the Leadership for Collective Wisdom framework, and in their experience of joy, enthusiasm, and gratitude.[80]

Focusing particularly on the question of sustainability beyond WTI, in the Time 2 assessment, the mean score of responses for the question of whether the coaching sessions helped participants to embody the framework was **4.91**, and **4.64** for the question of whether they were better able to sustain the transformation beyond WTI.

Figure 7: The coaching sessions with John and/or Rose: (N: 11)



Using technology and online resources to support the ongoing transformation

We experimented with using technology and online resources to support the organizations during the initiative, and to be available as resources even after the Innovation Project concluded.

First, we used video conferencing technology for planning meetings and coaching sessions to great effect. We used the same video conferencing platform for a series of webinars with new staff and community volunteers in one of the participating organizations. Through this experience, we have developed a beginning list of best practices to maximize the benefit of webinars as a modality for teaching aspects of the Leadership for Collective Wisdom framework. Specifically, we now believe that webinars are most effective when they:

---

[79] Of the 4 participating organizations, only 2 organizations were able to participate in the additional training and 1:1 coaching sessions for senior leaders. One organization began the initiative too late to allow senior leaders to effectively participate in this process. The other organization's adaptive dilemma was too consuming to allow time for senior leaders to participate.

[80] The total combined score for 28 questions related to the embodiment of the LfCW framework increased from a mean of 106.1 (SD=9.44) at Time 1 to 118.9 (SD=9.64) at Time 2, a statistically significant finding at t=5.25; p=.000. The score for the question assessing the experience of joy, enthusiasm, and gratitude increased from a mean of 4.0 (SD=0.77) at Time 1 to 4.6 (SD=0.93) at Time 2, a statistically significant finding at t=3.46; p=.006.

- Involve staff and volunteers who are at similar levels of understanding about the framework —e.g, when the webinars are used to conduct a beginning orientation for new staff and volunteers, or to deepen an understanding of a particular commitment among people who have some experience working with the commitments and practices.

- Are followed by facilitated conversations led by organizational leaders (which has the added benefit of being a leadership development opportunity for the managers).

- Are combined with in-person engagements, especially when there is a greater level of complexity in the content and a deeper level of holding is necessary.

We have also developed on online website—c4cwwti.org—that is available to all of the WTI organizations. We developed this website in response to requests for resources to help orient new staff, Board members, volunteers, and others. The website contains text and brief videos teaching the essential aspects of the Leadership for Collective Wisdom framework. The responses to the website has been very positive, and people from three of the organizations are regularly accessing the website.

BUILDING EFFECTIVE INTRA-ORGANIZATIONAL LEARNING COMMUNITIES

A particular focus of WTI, beyond discovering what can help organizations successfully adapt the Leadership for Collective Wisdom framework, was how to help organizations build effective intra-organizational learning communities.

There is of course a connection between these two questions. The data shared in previous sections document how the commitments and practices of the framework can support the emergence of such learning conversations and communities among staff, community partners, family members, and people who receive services. The more that staff, volunteers, and others learn to embody the commitments of self- and collective leadership, the more they will be able to create safe spaces to engage with each other in service of achieving and sustaining profound results.

Two additional lessons emerged through WTI in response to the question about learning communities, and the learning conversations that help them thrive: the first is about data, and the second is about process.

Data and data capacity

Senior leaders and managers from every WTI organization were eager to work with data in service of improving the results of their programs, as were most line staff and volunteers. So what was the problem? Actually, there were many.

Some programs simply did not have protocols in place to collect data, much less report and reflect on it. A number of programs, however, were collecting prodigious amounts of data, typically to comply with requirements of various funders. Unfortunately, more often than not, the data requested did not address questions that were vital to staff, reflecting more of a bias toward compliance than results and learning.

And even if the data collected did matter to staff, it typically traveled in a single direction: from line staff and managers who collected and turned in raw data to data staff within the organization, who

then assembled the data into reports that were then sent to the funders. Rarely did the data travel back to line staff to support learning conversations about what the data meant, and what implications it had for program impact and improvement. And if the data was returned to the organization, it often came back too late to matter, or in a format that made it difficult for staff to comprehend.

Given this experience, many line staff, and program managers too, learned to see data and data collection as at best a nuisance, and at worst a barrier to getting meaningful work done.

Through our work with the WTI organizations, and two programs in particular, we have developed some beginning reflections about how to help staff work with data in service of learning conversations among themselves and with partners.

First, the data has to matter to staff. "Because the funder says so" may be true, but if this is the only reason staff are collecting and reporting data, they will not likely engage in meaningful learning conversations among themselves or with others. When we began working with these two programs, one of the first questions we explored with staff and volunteers was: "If there was one thing you could improve about this program and the results you are getting, what would it be? And why this?" Once we could identify the question(s) that most mattered to staff and volunteers, then a conversation about data was in service to what the group was committed to learning and improving.

Related to this first reflection, staff and partners also have to trust that the data they are collecting will be used to help them learn and improve, and not as a weapon against them. The experience of "blame and shame" conversations can be profoundly traumatic, even years later. In one program, even with the senior leader in the room assuring staff that the data we were exploring and the dialogues we were proposing were for *them,* staff and managers could still return to a place of fear and hesitation. In these instances, we returned again and again to the commitments and practices of the Leadership for Collective Wisdom framework, and in time the team moved into a remarkable dialogue about how to transform their program for greater impact, and how to improve the data they needed to support this ongoing transformation.

In addition to staff and partners wanting the data, and trusting that the process of working with the data will be focused on learning and mutual accountability, for data to be useful it has to be timely and accessible. One way to ensure timely and accessible data is by helping programs develop their own data sources, collection protocols, and simple report formats to help frame the learning conversations. This is time-consuming work, but not trivial. Helping staff and partners learn how to access and report on data in a timely way is essential for making learning conversations possible.

A process to engage complexity: Wisdom Dialogues

As we engaged with teams and programs within each of the four organizations, we began to see patterns about what can help groups embody the commitments and practices of the framework when they were tackling complex issues. Ultimately we created a process that we call Wisdom Dialogues to capture our learning about these patterns.

The purpose of this process is to give groups who are committed to embodying the Leadership for Collective Wisdom framework a road map for how to address complex issues and adaptive dilemmas. Indeed, all four organizations have engaged in Wisdom Dialogues to successfully address one or more adaptive dilemmas, including:

- Redesigning programs for better impact;
- Making significant progress on team productivity goals;
- Developing plans for long-term sustainability; and
- Improving staff recruitment, training, and retention practices.

There are five stages to a Wisdom Dialogue. These include:

Stage 1: Define the question
What's the animating question? Is this a vital question to us?

Stage 2: Document givens
What are the givens and non-negotiables?

Stage 3: Discern the movement
What would progress look like? What aspects of reality across all four dimensions of change are aligned and mis-aligned with progress?

Stage 4: Develop a plan
What do we commit to do? By when? How will we assess and document progress and impact?

Stage 5: Act • Assess • Reflect • Adapt
Begin implementation • Schedule periodic wisdom dialogues to reflect on data, assess progress, and adapt

The process is scalable. For some issues, a Wisdom Dialogue can be completed in a single session. For more complex adaptive dilemmas, it may take several sessions just to clarify the animating question and the givens and non-negotiables.

Wisdom Dialogues share a number of similarities to other planning process structures, including participatory action research, the Plan Do Study Act process, RBA's seven questions for program performance, and others. Indeed, we incorporate aspects of RBA and other frameworks into this process. Some of the reasons we created the Wisdom Dialogue process, and some of its defining characteristics, include the following:

- The process is precisely tailored to help groups address a broad range of issues while embodying the Leadership for Collective Wisdom framework.

- Often groups need to work to define the issue they are trying to resolve—what we call the animating question. Stage 1 of a Wisdom Dialogue not only invites group members to discover and precisely define this question, but also to reflect on whether the question is vital to the group. Wisdom Dialogues are not for pretend conversations or exercises. Why spend time going through a process to address a question that no one has passion for or a deep commitment to resolve?

- Right away this first exploration focuses the group on an essential concept of the Leadership for Collective Wisdom framework: the concept of *intention.*

- None of the Wisdom Dialogues we facilitated through WTI started with a blank slate. It was essential for people to understand and document the givens and non-negotiables for each

adaptive dilemma or animating question they addressed. Often conflict can arise among stakeholders not because of divergent interests or perspectives, but because of a lack of shared understanding about the constraints (or lack thereof) that may be framing a potential exploration. This exploration of givens and non-negotiables introduces group members to another basic concept in the Leadership for Collective Wisdom framework: the distinction between *facts* and *stories*.

- In Stage 3, we invite people to focus on what success would look like if they made progress in addressing the animating question. We invite this exploration without forcing them at this stage to define specific performance measures.

- Once group members have articulated success well enough, then they use the four dimensions of change to assess what aspects of the current reality are aligned or misaligned with our success. This helps groups explicitly differentiate and assess the interior and exterior dimensions of reality, a foundational concept for the Leadership for Collective Wisdom framework.

- We invite people to decide what they want to do after they have assessed the current reality, so that they do not move to action before considering interior and exterior dimensions of reality.

- And after people have decided what they want to do, then we invite them to discern how they will assess progress (how much and how well) and impact (anyone better off). We have found that participants have greater willingness to wrestle with the question of how they will assess progress after they have experienced their collective excitement about what they want to do together and why.

BUILDING EFFECTIVE CROSS-ORGANIZATIONAL LEARNING COMMUNITIES

In addition to the question of intra-organizational learning communities, WTI also intended to explore whether *cross-organizational* learning communities and peer allies are promising strategies for sustaining long-term transformation efforts. We have already addressed the question of peer allies earlier in this section.

The question of cross-organizational communities, however, yielded an unexpected result. At the outset of WTI, we projected that staff across the participating organizations would form learning communities over time, grounded in a shared commitment to results and the Leadership for Collective Wisdom framework. This part of the Innovation Project was fully endorsed by the organization leaders, who had been meeting together for a year prior to the launch of this Innovation Project.

Once implementation began, however, and each organization began to move more deeply into its own transformation process, all of our perspectives changed. While all four organizations are funded by BHRS and provide mental health services, their cultures and histories are quite different. As organizations began to develop their individual plans, these differences became more pronounced. Each organization was charting its own course, and each path was significantly different from that being pursued by the other organizations.

So when it came time to begin planning for the first cross-organizational experience, all of the organizational leaders expressed a strong preference for delving more deeply into their own intra-organizational transformation processes rather than investing time and resources in the cross-organizational work.

After many conversations with senior leaders and reflecting on the data, the story we now hold is that the proposed cross-organizational work was simply premature. Having made substantial progress on their individual transformation plans, leaders of the WTI organizations are now proposing the creation of one or more cross-organizational learning communities to address systemic adaptive dilemmas. We address this and other proposals in the next section.

SECTION 6: BUILDING ON THE PROGRESS OF WTI

All WTI organizations made progress in addressing adaptive dilemmas through the adoption and application of the Leadership for Collective Wisdom framework, demonstrating in the process an increased capacity to:

- Better adapt to the policy and fiscal volatility within the behavioral health system;
- Create stronger and more positive internal environments for staff and others connected to the organization; and
- Support more effective collaboration among each other and with BHRS.

The organizations showed clear signs of healthier and more resilient cultures, cultures defined by the capacity to cultivate the conditions for collective wisdom. This progress is already paying dividends in improved services and supports for people struggling with mental health issues, and preliminary data point to improved results over time.

WTI also demonstrated a number of promising practices and documented compelling lessons about how to help community-based organizations successfully adapt the Leadership for Collective Wisdom framework within their particular programs and services.

So now what?

WTI organizational leaders had clear responses to this question. Building on the progress of WTI, leaders from participating organizations recommended:

- Organizing inter-agency Wisdom Dialogues to address systemic adaptive dilemmas;
- Strengthening the capacity for mental and behavioral health organizations and providers to work together as a more coherent system; and
- Leveraging the lessons of WTI to amplify the larger change agendas unfolding across the County.

WISDOM DIALOGUES TO ADDRESS SYSTEMIC ADAPTIVE DILEMMAS

WTI organization leaders have proposed, and stakeholders have endorsed, a potential MHSA project to:

- Address one or more systemic adaptive dilemmas through multi-stakeholder Wisdom Dialogues, focusing particularly on solutions that do not require additional revenue;

- Help selected BHRS and community leaders learn how to design and facilitate multi-stakeholder Wisdom Dialogues to address future adaptive dilemmas; and

- Help selected BHRS and community organization staff members learn how to develop and report data to support multi-stakeholder Wisdom Dialogues.

This proposed project would support multi-stakeholder engagements to address some of the behavioral health system's most intractable challenges. Examples of adaptive dilemmas that could be addressed include:

- The shortage of psychiatric and locked facility beds for people who are in conservatorship or otherwise experiencing severe symptoms from serious and persistent mental illnesses;

- Developing treatment and support approaches that promote strengths-based care and long-term behavioral health and wellbeing within the current reimbursement system that focuses on symptoms-based responses; and

- Developing more effective responses for children who are suffering severe emotional distress, but who cannot access or qualify for Full Service Partnerships, and for whom Crisis Stabilization responses are not enough.

Again, these are only examples of adaptive dilemmas that the four participating organizations recognize within the current system. If the project is approved, BHRS Senior Leaders and stakeholders would develop agreement about which adaptive dilemmas to address through this process.

The proposed project calls for using the Wisdom Dialogue process to address systemic adaptive dilemmas, while simultaneously building the capacity of identified staff and community members to design and lead future Wisdom Dialogues.

Some of the reflections from organization leaders and participants that led to the creation of this proposed project include the following.

> *I don't think it's currently on BHRS' radar as a regular practice when they face an adaptive dilemma to [engage the broader community]. Is it sitting in the office with two or three BHRS people or is it let's invite the community–whatever that looks like–into the conversation in a broader way? That's something that will be helpful. I have high hopes. … I trust BHRS. I think they want to do the right thing. I'm so grateful for the resource they gave to us to be able to do this process. It truly benefited us in ways I never even imagined. … I think they want to do this too.*[81]

> *BHRS has a new leadership team and they have the opportunity to really learn from each other and others. It doesn't take that much time. One of my biggest concerns about this was that it was going to take a lot of time. We're all very busy and we've got to get things done. But it's really not taking any more time to work this way. It's just working differently.*[82]

> *I know I don't hold the decision-making power. I don't even presume to do that. But it's the data collecting, the voices being heard part, which is the going slow to go fast. You can frame a whole conversation like they did for the substance abuse [stakeholder] process. They set the parameters and process ahead of time. We want to engage everybody in the learning, and we want the richness of this experience. Bottom line was that BHRS had the authority to create the budget. We all knew that. … But get more eyes on it, maybe there's a creative solution that they're not even thinking about.*[83]

---

[81] Key informant interview and focus group, September 2015.

[82] Key informant interview and focus group, September 2015.

[83] Key informant interview and focus group, September 2015.

Strengthening the Capacity of the Larger Behavioral Health System

The first recommendation—funding Wisdom Dialogues to address systemic adaptive dilemmas—is a specific illustration of the second, more general recommendation. Participants at all levels of WTI organizations encouraged BHRS to explore strategies that leverage the success of WTI to build the capacity of organizations and providers to act in concert with BHRS as a larger, more integrated system. Two quotes illustrate this larger theme:

> *It will be fantastic [to engage the larger system]. We have not only experienced changes in staffing, BHRS has experienced changes as well. I think it would be phenomenal if we could all come together as one team. It would strengthen the concept of partnership. Sometimes the power of collective wisdom and the power of coming together as a collaborative can be totally missed. … BHRS did their thing [wisdom transformation]. We did our thing. But we've never come together. … There are many wholes, but we want to do it as a greater whole.*[84]

> *BHRS offers a lot of training based on educational units to ensure licensure but the number of trainings for internal health are few. But we need an intentional training like within the Wisdom Transformation Initiative. We have to have something that talks about holding our stories lightly and examples of collective folly. We should take away the scariness and the awkwardness of collective folly. … Maybe we can have panels of contractors who have gone through Collective Wisdom and share what that looks like because it's really neat to have other contractors also have this language, this new insight. This lightbulb keeps going on for us and our BHRS counterparts aren't really quite there. And we're like, gee, you could be there. 'Can we share that with you?' There is a lot of typical routine work but here we are seeing Collective Wisdom as an adaptation to where we want to be. … They will have no notion of this if they haven't been exposed to it.*[85]

Another way BHRS could strengthen its capacity and the capacity of its partners to function as a larger system would be to pursue strategies to systematically enhance the data capacity of its programs and funded partners, consistent with the lessons of WTI. The Department has already begun this work; the lessons from WTI suggest some ways it could be expanded and enhanced, perhaps in partnership with the Community Services Agency (CSA), Health Services Agency (HSA), and/or other large agencies and funders that have a similar stake in increasing the capacity of community-based partners to work effectively with data.

WTI as a Bridge to Larger Change Initiatives in the County

WTI did not unfold in isolation; it developed at a time when other institutions and community partners were beginning large-scale change initiatives of their own, including most notably the Focus on Prevention Initiative. Not surprisingly, many WTI participants are connected to these other change initiatives, and anticipated the potential leadership role that the behavioral health system could play in these efforts.

> *The exciting thing is if we're truly going to have these conversations, then we're looking around the room going 'We need to invite the senior leaders or chiefs from Community Services Agency or Probation because then they also start to see the whole, because their systems touch it too.' We would*

[84] Key informant interview and focus group, September 2015.

[85] Organization final report, December 2015.

> *also need to invite the Chief of Police from Modesto to this conversation. It could be really cool to start looking at [adaptive dilemmas] from a perspective where we start growing other organizations' capacities to look at things more collectively.*[86]

> *[We should]encourage more BHRS staff and its contracted partners to embrace and utilize the LfCW framework to bring everyone together for dialogues. Perhaps we could find a way to bring this training to a larger Stanislaus County audience, including faith-based organizations.*[87]

Six years ago when BHRS was just beginning its journey of transformation, department leaders were virtually alone in their conviction that a new way was needed.

No longer.

In particular, the Focus on Prevention Initiative provides a unique opportunity for BHRS and its partners to leverage the learning of WTI. Launched by the Board of Supervisors in 2014, the Focus on Prevention Initiative (FPI) reflects a growing awareness among leaders across the county that what has worked before is no longer enough.

Inspired in part by the BHRS transformation process and WTI, this long-term effort has embraced much of the Wisdom Transformation framework, including the commitment to results, and essential aspects of the commitments to community capacity-building and leadership development. Stan Risen, CEO for Stanislaus County, has summarized the aspiration of FPI this way:

> Our hope is that *Focus on Prevention* doesn't just become an initiative or the latest fad. Instead, we want this effort to form the foundation for an ongoing transformation and culture change that inspires a deeper experience of connection and tangible improvements in the quality of life for Stanislaus County's residents.[88]

Two of the five priority results for this initiative—'Our families are healthy physically, mentally, emotionally, and spiritually' and 'Our families and neighbors who are homeless, or at risk of homelessness, permanently escape homelessness'—are central to the mission of BHRS. And the defining value of FPI—*there is no other*—speaks directly to the calling of the behavioral health system to help people who struggle with mental and behavioral health issues to become valued members of our communities.

By sharing the story and lessons of WTI with the Focus on Prevention Initiative, and with other change efforts emerging across the county, BHRS can further amplify the original impulse that gave rise to WTI and its own transformation process. Indeed, from this perspective WTI has already succeeded, inspiring substantial innovation and learning not only within the behavioral health system, but in sectors and efforts across the county. No small achievement.

---

[86] Key informant interview and focus group, September 2015.

[87] Organization final report, December 2015.

[88] Boggs, Keith. "More Than an Ounce of Prevention: An Interview with County CEO Stan Risen," Stanislaus Magazine, March/April 2015, p. 22.

Garden Gate Innovative Respite Project

Elisa Duke Heslin

Turning Point Community Programs

Garden Gate Innovative Respite Project ("GGIRP") was developed on the foundation of the prior existing program, Garden Gate Respite ("GGR"), a 6-bed facility started in 2000 through AB34 and AB2034 to address the needs of the local population identified by law enforcement as homeless and mentally ill through the provision of hospitality and welcoming by consumer or peer staff for a very short stay to culminate in the screening by another agency to determine which individuals may meet criteria for outpatient mental health services and direct them to a Medi-Cal assessment process. The duration of a stay was 24 hours or less, except in the case of weekends and holidays when stays concluded at the first available opportunity for such a screening. Discharges were issued by the other agency. Referrals were limited to those provided by law enforcement, and resources were ultimately determined to be underutilized.

The doorway to respite broadened to accept referrals provided by public mental health outpatient providers, funding moved to MHSA CSS funds, and documentation expanded with the needs of the COC HMIS system. On the heels of early MHSA implementation, the economy entered a recession, and local services were impacted as MHSA funds are revenue-based. In a single fiscal year, the need for acute psychiatric hospital beds increased dramatically while county mental health staffing was also significantly reduced. On the periphery were other factors contributing to the traditional system of mental health in which intervention was only available during an acute crisis: the assumptions that formal treatment is required for wellness; that individuals are interested in treatment, know what treatment may consist of, or actively participate in treatment; that the only resource for crisis is the hospital or to struggle alone.

The local MHSA Stakeholders, Mental Health Board, and County Board of Supervisors concluded there was "a better way," and moved forward with a learning project proposal, out of which was birthed the Garden Gate Innovation Respite Project, a new 5-bed facility next door to

the original Garden Gate Respite, funded through MHSA Innovation. However, innovation in delivery of services was not the purpose, though of course services are important. The purpose of the project was to learn through service provision whether a culture shift was possible, and if so, its ultimate impact on a paradigm shifts in thinking both within he system and to those the system of mental health services supports: consumers and family members.

Method

This project examined the ways in which respite services supported consumers of mental health services ("guests"), their adult family members or other support persons, and systemic "ripples" through service provision such as impact on hospitalizations.

Participants

GGIRP served 610 unduplicated (910 duplicated) individuals during the course of the project. Detailed demographic information is provided in the appendix. Guests were referred to GGIRP through a pre-approved list of local service providers who were oriented to the program and also had some degree of expertise and experience identifying individuals thought to experience mental illness. These agencies included: any law enforcement agency in the county (e.g., police or sheriff's department patrol units, jail, state and federal parole), any mental health provider in the county (i.e., public and private providers, as well as the Veterans' Administration), and select community agencies (e.g., local shelters including domestic violence shelter, community drop-in centers linked with mental health services, and professional payee services). Innovation practices for services were considered best practice and implemented identically at GGR. Therefore, admissions simply alternated between the houses to keep the census even,

except in cases where one house was found to better meet guest needs, such as needing an ADA-accessible bathroom or ramp, which were only available at GGR. Program eligibility also was identical to GGR.

To qualify for services, referred guest standard eligibility criteria was that they be residents of the county, 18 years old or older, identified by the referring party as having a known or suspected mental illness as the primary risk factor considered, and having met all these, meet one or more of the following secondary risk factors: homeless or at risk of homelessness, at risk for criminal activity or arrest, at risk for psychiatric hospitalization, or at risk for victimization in the community.

Consideration for secondary risks included not simply whether an individual was homeless in the traditional sense, such as staying in a shelter or at an illegal park camp site, but also whether they lived with family members who were in a dispute or otherwise a tense situation, and the consumer maintaining stable housing might be positively impacted by the family members having a time of respite and then the guest returning home. Another example is someone who lives independently and experiences an increase in symptoms, and needs some support during a medication change, and is then able to go home. Risk for criminal activity or arrest could be easily determined by the referral of a law enforcement officer, but also if a guest had been engaging in behaviors which could have resulted in arrest or citation if they had been observed by an officer. Common examples of behaviors in this risk category include loitering, trespassing, illegal camping, theft or burglary, prostitution, trafficking, and assault/battery, intoxicated and disorderly in public, violation of no-contact orders, violation of parole or probation, and selling or using illegal substances. Similarly, risk of victimization may be obvious, such as an individual who appears very elderly or frail, but also includes those who victimize others and as a result are also

at increased risk for victimization. An example could be an individual who steals substances from a dealer and is then assaulted. Last, risk for psychiatric hospitalization does not include those who meet criteria for an involuntary hold; such individuals must be placed in an acute setting. However, individuals often struggle with a crisis prior to meeting criteria. An example is a person who staff noted had a crisis evaluation every year on the same date; upon inquiry, this person shared it was the anniversary of a parent's death. With respite support, the person was able to avoid a hospitalization for the first time in several years. All respite services were voluntary and provided at no cost through MHSA funding.

Project Design and Measures

The project, its measures, and objectives were created through the MHSA stakeholder process. As such, the measures were not subjected to evaluation of reliability or validity. Measures were all self-reported by using a 5-point Lichert-like scale. Measures consisted of statements with which responses could be issued in the following range: Strongly agree, agree, neither agree nor disagree, disagree, or strong disagree (not applicable was also an available response). This scale was used to report law enforcement satisfaction (at intake), guest satisfaction (as close to discharge as reasonably possible), and family member satisfaction (during or after stay, with written consent of guest). Stakeholders developing measures included consumers of mental health services, family members of consumers, local mental health agency representatives including private and contracted providers, and other interested parties. GGIRP staff also assessed guests at intake and discharge for a Milestones of Recovery Scale ("MORS") score, which was inaccessible for reporting purposes. MORS is a validated measurement tool.

The project was implemented by GGIRP directors and staff with structured monthly feedback from guests through an on-site Roundtable, and quarterly feedback from service partners and community members through an Implementation Workgroup Meeting. Staff also sought insight feedback from the guests and their self-reported family members during the course of each guest's stay, as well as collaborative daily input from outside service providers.

Procedure and Materials

Guests were referred to respite by the referring party calling to inquire whether a bed was available by biological sex (male or female bed; or whether the person identified as transgender, in which case a protocol was implemented to reduce any potential for their victimization), as the bedrooms were single-sex though the houses themselves were co-ed. The referring party then would provide the individuals name and date of birth so staff could screen for specific eligibility in addition to the standard eligibility criteria. A list of previous guests specifically identified as ineligible or eligible under specific conditions is maintained and updated by the program directors using a password-protected file. A printed version also was available to staff and secured in compliance with HIPPA and other health privacy laws. All entries to the list were made in consultation with the individual guest's service provider, and was regularly reviewed by the contract monitor as well as housing and outreach representatives in a confidential meeting to ensure appropriate entries and use. Three lists were maintained: those ineligible due to significant and persistent unsafe behaviors such as assaulting staff or peers, those individuals temporarily ineligible (30, 60, or 90-day suspension of services due to inappropriate or unsafe behaviors on site which could not be directed, in addition to individuals whose services providers had asked not be admitted due needing a greater level of support than respite could safely provide during pursuit

of conservatorship), and those individuals with specific conditions which determined their eligibility (e.g., someone who had shingles must be determined by a medical professional not to be contagious prior to referral).

If the referred individual was found to be eligible, someone from the referring agency was required to transport or otherwise meet them at the site, as the intake process required both the individual being referred, and a representative of the agency providing the referral to be present at the same time. Staff would inquire as to an estimated time of arrival and call to check-in if this period lapsed without arrival. Upon both the referred person and an agency representative appearing, staff would commence the intake process, which included consent for services in the form of agreeing to abide by “House Rules” and general program policies, provided in detail verbally and in writing, and followed by guest signature. The rules enumerate the program purpose and structure, behavioral expectations, limits to confidentiality, safety and property policy, and so on. Intake generally required 15-20 minutes to complete. The representative would complete a referral form and guest contact record, unless they were law enforcement officers, in which case they would complete the referral form and police survey. An intake packet is attached for reference. During intake, staff also inquired with the person and the agency as to the goal for their stay at GGIRP and a projected timeline for achieving that goal, as GGIRP used a self-help model and services are client-directed.

After intake, the individual program participant is then referred to by staff as a guest of respite, accurately reflecting their temporary relationship while also avoiding any stigmatizing labels. The guest was oriented to the site by the staff person and also tended to any immediate needs the guest had, such as providing items for a shower and clean donated clothing, or preparing food. The guest was given an open bed, either a room with two single twin beds or a

room with a bunk bed and single twin. In order to mitigate fall risk, the top bunk was always issued last. The house is located in a residential neighborhood, and kept in good repair without any signage indicating its purpose. The inside of the house was furnished for comfortable and home-like, with the exception of a small office corner with two computers at a desk. Staff use their and guest first names, wear casual clothing, and provide peer support in a warm, approachable manner. Guests are encouraged to exercise independence within the structure of the house rules, but reasonable precautions for safety are taken, such as staff securing cleaning supplies, sharp knives, when not in use, and staff using the stove and oven to mitigate risk.

Each morning following intake, Monday through Friday, the guest is required as a condition of their stay to meet collaboratively with the GGIRP case manager and their primary mental health provider/case manager. If they do not have such a connection to services, then they are required to meet with a contacting agency outreach team to complete a screening for formal services in addition to meeting with the GGIRP case manager. In other words, every guest actively participates in a daily intensive, interagency, collaborative, case management process to determine a service/discharge plan using motivational interviewing as services are client-directed and implemented using a self-help model. GGIRP case managers, in consultation with directors, support progress toward this goal, and evaluate progress every 24 hours.

GGIRP case managers are on site seven days per week, from 8:00am through 4:00pm. These staff members create summary progress notes in the county behavioral health electronic health record system, peer-review records, and create discharge plans in addition to other duties. Other shifts are maintained by a paraprofessional peer-support staff. Staff working 4:00pm to 12:00am provide support groups on site, ranging from recovery-directed (Seeking Safety, Dual Recovery Anonymous) to interest-driven (Poetry Night, Game Night, Movie Night), to skill-

building (Stress Reduction, Baking). Staff working from 12:00am to 8:00am often performs program-specific data-entry and crisis intervention. Each shift has a specific list of tasks to attend to (provided in appendix). In effect, this daily evaluation dictated that an guest whose goals could be met in 4 days, should have a stay of neither 3 days nor 5 days, reflecting efficacy in use of resources. On the seventh day, GGIRP's contract required that an extension of up to 7 additional days must be submitted to the county contract monitor, and each 7 days thereafter another request would need to be submitted, with a maximum stay of 27 days.

Results

Detailed quantitative data and analytical narrative is provided in the Appendix. In this section, learning outcomes will be reported in brief as the overarching questions shaping the program will be explored.

Regarding Learning Question 1, "Can a "culture" shift occur in the community? Creating better alignment between need and support available? Creating a more effective way of supporting individuals and families that experience the negative consequences of mental illness?" Stakeholders defined this as the respite population reaching out for links to support, and also specific peer support links. To that end, 550 (90.2%) of unduplicated individuals had at least 1 successful linkage and 81.8% (3,439 of 4,203 total referrals) were successful. A majority of individuals linked to Mental Health Services (BHRS/Contractor) (21.1%, n=885), Peer Support (19.1%, n=802), and Shelter/Housing (17.1%, n=717). Additionally, peer support groups were begun and hosted on site at least once per day by staff.

Learning Question 2 is, "Can this project approach allow individuals to step away from their illness, increase self-esteem, promote recovery, reduce stigma and contribute to healthier,

happier and more productive members of the community who are less dependent on the behavioral health service system in a crisis?" Stakeholders did not identify an outcome or measurement for this. Use of the Guest Satisfaction Survey seems appropriate here as it records the guest's self-reported satisfaction on 12 different perspectives, including opportunities to engage in peer support, knowledge of resources in the community other than a psychiatric hospital, and whether they feel more hopeful or empowered as a result of services. A total of 419 surveys were completed, and 91.2% of guests agreed or strongly agreed that they were satisfied with all services.

Learning Question 3 is, "Can we assist people to avoid the trauma of psychiatric hospitalization by offering community-based peer support paired with short-term respite care?" Stakeholders indicated desired outcomes included pre-post respite stay measures of aggregate hospital days at 1 year. However, annualized (not aggregate) data, extrapolating from known data, was provided and apparent contradictions with other data have led to this not being a valid measure. Additionally, due to the short-term structure of the program, long-term measure, and possible confounding variables and artifacts, respite impact at one year would be difficult to measure. In April 2014, staff began recording referrals to avoid psychiatric hospitalization. Between that date and April 30, 2016, a total of 732 referrals were made to respite, of which 367 (50.1%) were to avoid a hospitalization.

Regarding Learning Question 4, "Can we learn a new cost effective approach to significantly reduce psychiatric hospital admits and possibly other related costs to the behavioral health and related systems; such as emergency rooms and jails?" Stakeholders indicated a desired outcome of project hospital days cost as correlated to pre-post stay measures. These figures are not available due to previous cited complications with validity.

Stakeholders indicated that through addressing the overarching questions, respite then would learn how to connect individuals to community supports and related outcomes would be significantly impacted. In the instance of Learning Question 5 through 7, “Does offering a safe and trusting short-term living environment to individuals in a mental health crisis provide sufficient basis for them to connect with inclusive and welcoming community based support? Does offering a safe and trusting short-term living environment to individuals in a mental health crisis provide sufficient basis for their family members to connect with inclusive and welcoming community-based support? Can we move outside the paradigm of thinking that there are only two choices for people in mental health crisis: “treatment vs. no treatment”? Stakeholders indicated that this should be measured through links to community resources previously reported, as well as family or social support links and whether these individuals are aware of support in the community other than a psychiatric hospital. Every individual served at intake was offered staff support for the guest’s family or support persons. Of those guests offered this support, 82 family surveys were successfully completed. Participating family members or support persons indicated at a rate of 88.5% that because of this project “I know that there are resources, other than the psychiatric hospital, available to help support me and my family member/loved one cope with their mental illness,” while guests of respite reported the same at a rate of 91.0%. Furthermore, 284 referrals (6.8% of total) were successful in linking guest with family/social support, and 85.7% of guests completing a survey reported Garden Gate had helped them reconnect with a family member or loved one.

Stakeholders did not indicate a desired measure for Learning Question 8, “Can we move outside the paradigm of “treatment vs. no treatment” to assist people in avoiding the trauma and isolation of no support?” However, this is reflected in the mission, eligibility criteria, and outcome

reporting previously indicated about 50% of all referrals are made in order to avoid a hospitalization.

Outcomes for learning Question 9, “Respite approaches are known to be successful. Will the following differentiation between this project and existing practices help move us outside the paradigm of “treatment vs. no treatment” as the primary alternatives? A collaborative workgroup will coordinate efforts to ensure adherence to the proposed learning approaches to integrating: culturally specific, community-based peer support and family support,” are reported in workgroup surveys conducted at least quarterly per stakeholder requirements. They survey examines workgroup satisfaction in 14 items, ranging from whether the individual felt comfortable sharing to whether the project is integrating culturally-specific criteria into its approach on a Lichert-like scale (except question 12, which is reported yes/no regarding verbal participation): 94.4% of all 44 attendees reported they strongly agreed, agreed, or somewhat agreed that they were satisfied.

Discussion

The issues to be addressed by the innovation are significant. First, stakeholders noted respite should address “ineffective or nonexistent supports for individuals experiencing a mental health crisis (and/or co-occurring substance use problems) to the extent that the vulnerable individual seeks psychiatric hospitalization as a remedy.” At the time the project was conceived, this was a fair representation as MHSA was in its infancy and previous to this, system focus was on treatment rather than outreach or prevention. At the present, MHSA programs, including PEI, O&E, and others, have acted as a prism. A spectrum of services in between hospitalization and struggling alone exist, of which respite is one way of support. An average of just over 50% of all referrals are made in order to avoid a hospitalization, reflecting a remarkable achievement.

These referrals exist within a subset of the population that meets standard eligibility criteria including homeless individuals with high law enforcement contact and hospitalizations who are at risk for victimization in the community. By definition, these guests are already struggling and lack access to services promoting wellness such as therapy, case management, and/or medications, and treatment for co-morbidities (chronic unmanaged health conditions, substance dependence) as well as lacking shelter, housing, and clothing (basic human needs), and opportunities to increase quality of life where they may identify with meaning and joy in a non-disabled role (volunteer, employee, parent, parishioner). Respite's focus on outreach and engagement may sometimes be less effective for some individuals than if respite mission focused on PEI or a rapid housing and stabilization mission. This is not to say that the current mission is unhelpful, rather, the mission has served to identify more opportunities to support the community we serve, and future projects could consider these approaches as well as the current approach. Outcomes reflect most guests discharge to their previous living situation, or a shelter. A gap in our system of services is the availability of anything in between those two extremes (stable housing or no housing), the next front after learning about serving the spectrum in between "treatment or no treatment," that needs to be addressed. Meeting this basic human need – or not – would tackle an entire category of risk that deeply impacts mental health services, co-occurring services, medical services, and law enforcement services.

Another interesting point is the stakeholder focus on co-occurring substance or alcohol use. The instance of this could be anecdotally placed at about 85%. Often, respite was confused with the things that guests need but which we don't provide, including substance use dependence treatment, mental health treatment, and emergency shelter services. The most appropriate place of treatment locally which has a co-occurring track requires a $200 co-pay over Medi-Cal for

inpatient treatment and is usually impacted and thus admission dates can often be measured in weeks, which often exceeds the time frame that respite can support. If individuals are not able to admit to treatment from the supportive structure of respite, they will often relapse and have to start the assessment process over again. Medi-Cal mental health assessments are often scheduled 4 weeks away, exceeding the respite contract limit. This means that guest may end up working a short-term plan at respite that does not help their long-term needs, or the guest may end up working a plan that creates additional risks, such as entering a free work-based recovery program in large metropolitan areas about 2 hours' drive from Modesto. These programs usually do not allow its participants to take psychiatric medications, which can result in relapse or hospitalization and law enforcement contact followed by being homeless in an unfamiliar area with no support. Guests have identified this as an opportunity at an alternative to living on the streets if it goes according to plan, but have little or no contingency if they are unsuccessful.

At times, respite is also confused with a mental health treatment program such as a psychiatric hospital for acute holds, or as a crisis residential program with 24-hour case management-level support. However, on occasion agencies call prior to conducting a crisis evaluation as a respite bed would prevent an individual from meeting grave disability criteria, and are gently asked to evaluate the individual prior to calling to see if a bed is available. On occasion, law enforcement agencies who have heard of respite through another officer friend may think respite is a place someone being held on a 5150 can be placed, or on the converse, think respite is a conventional shelter and are unaware of any mental health services. These occurrences are infrequent and usually are genuine misunderstandings from new staff who are then oriented to the program and able to utilize resources appropriately.

Adding to this complication are longstanding relationships with other agencies that existed prior to the innovation project when respite provided only peer support and hospitality. Transition from one model to a very different innovation model, though accepted as best practice, proved difficult on many fronts. There was a significant culture shift in interagency relationships as previously another agency had made discharge plans, while under Innovation, respite case management staff make these in collaboration with the guest and outside provider. This has eased through making the distinction that respite relationships with guest are always acting in alignment with the treatment plan developed in the long-standing relationship between the outpatient provider and the guest and should never be at cross-purposes. The daily collaborative approach to case management has done well at ensuring the service plan is being carried out and by existence leaves little space for the "Uncoordinated outreach and peer support efforts between agencies and community-based programs" Stakeholders asked to be addressed. Indeed, the effectiveness of connecting individuals with resources relies heavily on this coordination and respite outcomes would look very different indeed if this unified approach was lax.

Another area of difficulty is in internal staff relationships, as some peer support staff expressed feeling "less than" with the addition of case management staff who met minimum qualifications equal to that of county staff occupying equivalent positions, while other staff felt entitled to positions simply because of their longevity. Merit increase freezes, a tight budget, and high turnover also contributed to a cool internal climate. The addition of the respite directors near the start of the innovation project was challenging for these reasons, and required a strong focus on recruiting strong candidates for open positions, a focus on build staff communication skills and self-leadership, and developing staff unity through ensuring equal expectation of staff (such as

mandatory meetings all must attend), staff appreciation of each other acknowledged at each staff meeting, annual staff appreciation event by directors, and so on.

Respite directors participate in interagency partnerships across systems including the Modesto Recovery, a public-private partnership of recovery providers hosting by faith-based sectors and public recovery services, the Continuum of Care addressing chronic homelessness, the Modesto Police Department Restorative Policing Meeting in which agencies collaborate to address the needs of individuals with high law enforcement contact, and the Prevention Focus Initiative, a local multisector commitment to address homelessness and prevention across systems. Deep learning has occurred in community capacity building, with diverse service partners coming together to recognize no one agency or field or study has all the knowledge, services, or funds to hold all the struggles of the marginalized. Focus on Prevention's core value is that "we are one – there is no other," and places significant value on the expertise and stories of those with lived experience.

Indeed, respite addressed "Individuals in a mental health crisis often feel isolated, alone, and vulnerable which makes it hard to reach out for support," through intensive collaborative case management which focused on helping individuals build support in the community, such as by encouraging the attendance of AA meetings or peer support groups or drop-in centers, assisting in connecting any identified support (including religious communities the guest self-reports as helpful, of which mental health services have traditionally been, at best, indifferent) and attempting to build rapport through in-house support groups to build peer relationships. The short-term structure of the program means that it must act as a place to start building support, a jumping-off point rather than a place to build stability. The success of this approach is likely reflected in the guest's internal motivation as staff observes through external action, of course, but

also their functional deficits, access to other resources, acuity of symptoms, and triage of beds when the census is high. The most common experience is a 1-day stay at respite through the statistical average is 4.0 days, indicating 50% experience a stay of shorter duration and 50% experience a stay of longer duration. There is a limit as to what can be accomplished in such a short time, and this may be reflected also in the duplicated individuals served being about 3 times higher than unduplicated. On the other hand, evaluating stays every 24 hours, and the ability to discharge or extend as warranted is a tool of great use to leverage the resources of the program to fully serve the mission and needs of the guests that a more rigid structure could not support.

A place where respite services may shine is the stakeholder mandate to address “Repeat hospital admissions for individuals who are not connected to community supports or service programs.” The majority of referrals to respite came from Telecare Transition TRAC, another partnering contract agency. Transition TRAC is the program which meets with individuals while they are hospitalized and provides intensive case management services for 60 days for the ourpose of avoiding readmission. This was followed by Modesto Police Department, often conducting welfare checks or deciding whether to place an individual on an involuntary hold, followed by CERT referrals. Community Emergency Response Team, or CERT, are the public mental health clinicians who conduct crisis assessments to determine whether a hold will be maintained or lifted. If an individual does not meet criteria for 5150, CERT can refer to respite. A previously stated, about 50% of all respite referrals are made in order to avoid a hospitalization; records indicate guests discharge from respite to a psychiatric hospital just 1.7% of the time through the duration of the project. This also addresses the Stakeholder concern that respite address “Soaring cost of psychiatric hospitalization that is diminishing resources in the behavioral health system.”

Stakeholders indicated “Individuals and their families who are experiencing a mental health crisis often feel isolated, alone, and don’t know where to go except to the psychiatric hospital.” Respite is proud to be a place individuals can go to receive support other than the hospital; as previously reported, most guests and their family member, at rates of more than 80%, specify that as a result of this project, they are aware of other resources in the community to support them. When respite has the opportunity to connect with a family member, a NAMI referral is made in order to connect peer families. Guests are often referred to their families in addition to mental health drop-in centers, non-crisis peer support lines, and secular and faith-based recovery groups for support.

Of significant interest is the Stakeholder report that “Families of individuals with mental illness don’t have enough, if any, support from other families and as a result feel helpless, ineffective, and angry at the ‘system’ for ailing their mentally ill family member. Families don’t have enough opportunities to learn self-care and receive support from other families members who have ‘been there and done that.’” Results indicate that guests connect with their families much more often than respite staff was able to do so (284 successful referrals to family/social support versus staff successfully collecting 82 surveys). This could reflect the rapport that it takes time to build being difficult to do in a program that typifies a 24-hours stay, or a lack of family rapport with the guest or staff, or lack of any connection between guest and family, or a combination thereof. Overall, a total of 71.3% reported being able to connect with peer families as a result of the program, but this includes individuals misunderstanding the survey due to taking it over the phone, not knowing what a peer family is, and respite being unable to connect families directly and simply relying on providing a referral to NAMI and the family member either already having a connection, or reporting their degree of interest in making one. The statements of the

family survey do not allow the person being surveyed to indicate whether connecting with a peer family is of interest. Thus having the opportunity to connect with a peer family and satisfaction with that connection may not be applicable, but the person may mark disagree. Or they may reflect on relationships of support they currently have that are unrelated to respite services and mark agree though this is no reflection on the program. It also does not allow the flexibility strained familial relationships may need to respond to questions. For instance, family members sometime– are unwilling to speak with the guest and only willing to talk to staff (or vice versa), so reporting on whether they have been able to reconnect is sometimes reported as "disagree" though "not applicable" may be more appropriate. Anecdotally, the final question was an open-response to self-care, and many respondents were able to provide relevant responses. It may be the case that the assumption that families need a formal connection to peer families is either not able to be reasonably executed within respite structure, or perhaps recognizing "peer family connection vs no support" may be just as tied to system perception as "treatment vs no treatment"; perhaps both are true. It seems likely that families may need individualized strengths-based plans for support just as guests do, reflecting their access to resources, deficits, and interests.

Limitations

There were significant limitations in data reporting due to numerous factors. First, the data reported is stored by another entity, and is not always accessible to use. If so, correlations demonstrating impact may have been possible, such as an increase in MORS score relating to length of stay. Another issue is the data provided is not always helpful, and sometimes confounded by artifacts, such as pre-post measures at one year. Aggregate data is not available, so annualized was examined, but not applicable due to regression artifacts. Stakeholder process is a

priceless asset that reflects the rich diversity of the community and subset of providers, however, this also means that project are not held to a peer-review process and measures are not evaluated for validity and reliability. Are we measuring the thing we intended to measure? Is that measure accurate? We cannot say for sure.

Learning

We can say that we need to ask, are the interests of the mental health system aligned with the interests of those outside, looking in? Perhaps this is most clear in the family survey, where stakeholder interest and family interests are likely the same (obtaining support) but may have very different trajectories or perceptions about what kind of support interests them; the measure measured assumptions, but we learned. We learned that respite may not be a realistic venue for this connection to be made, but more than that, we learned that the dichotomy doesn't serve anyone very well. We have considered treatment versus no treatment, now we realize we have to consider family needs (formal connection to peer families versus no formal connection) in the same way, as well as housing needs (stable housing versus shelters).

We began to understand that though we speak about moving away from "treatment versus no treatment" our structure requires guests to undergo a screening for formal treatment, and assessments and appointments roll on as they always have. Case managers ask for permission to provide bus tickets to a worship service a guest would like to attend because it is where they feel hopeful, or a family picnic where estranged individuals can decide if they feel comfortable moving forward together. It feels strange, but freeing, to do so after years of only providing them for doctor, therapist, and medication appointments. We learned that having someone available to walk with a guest to AA means they will probably attend, and that sitting with a guest in a doctor

appointment means an assessment may increase in accuracy for those with significant cognitive deficits, we learned that some guests need a peer to navigate to the next link, and that respite has none of those things....but we know who does because of our collaborative interagency approach. Because of that approach, we can leverage resources and move service mountains that otherwise might be an impenetrable barrier.

We relearned a lot of things we thought we already knew about recovery: that guest are peers and we respect their autonomy, and that guests are not always ready for recovery the way we think they should be, maybe not the 2nd time or the 3rd time, but our job is to be there every time, ready to meet them where they are. We relearned that formal treatment is not always required, and people tend toward wellness. We relearned that guests have something to teach us, even with our own lived experience, about living with uncertainty, finding hope, and finding a way forward when we feel stuck with the help of others.

We learned, in a deep way, that our futures are tied together in our community and living together in a small home has helped us to see each other in a rare and unique way.

TURNING POINT
COMMUNITY PROGRAMS
A Path to Mental Health

Garden Gate Innovative Respite Project [GGIRP]

PROGRAM OUTCOMES REPORT

October 1, 2013 – April 30, 2016

605 5th Street,
Modesto, CA 95351
(209) 341-0718

TABLE OF CONTENTS

Garden Gate Innovative Respite Project
[GGIRP]
October 1, 2013 – April 30, 2016

Our Vision

To expand the bridge between Garden Gate into the community, making connections to resources and programs that will facilitate the recovery process for the individuals we are privileged to serve.

WHAT WE DO

Turning Point Garden Gate Innovative Respite Project (GGIRP) in Modesto provides a safe home-like environment for individuals who are homeless or at risk of homelessness and known or expected to be experiencing symptoms of mental illness.

This program links these at risk individuals to community resources and encourages a focus on wellness through enhanced services such as: in-house case management services, psycho-educational groups, group activities, guest speaker presentations, and guest/alumni Roundtable meetings that inform services. These services are provided in addition to the provision of basic care such as home-cooked meals and clothing.

Open 24/7, the center works together with law enforcement, Stanislaus County Behavioral Health, Recovery services, and other Community Partner Agencies to reduce incarceration, risk of victimization, criminal activities, incidence of homelessness, and acute psychiatric hospitalizations. The center works with an outreach team to engage and connect individuals with needed services.

Stanislaus County Mental Health provides funding for this program through the MHSA.

STAFFING

Garden Gate Innovative Respite Project (GGIRP) is staffed 24-hours a day, seven days a week with two paraprofessionals who are awake and alert at all times. Turning Point continues to employ a culturally diverse staff. GGIR staff continues to provide client-driven advocacy and support within a “moving toward wellness” framework. They also facilitate community collaboration and capacity-building within an atmosphere of cultural awareness, sensitivity, and tolerance. In spite of the challenges inherent in their work, all of the staff strives to maintain a basic attitude that is pleasant, congenial, and supportive.

BEST PRACTICES

The following represent the current groups at the Garden Gate Innovative Respite Project which offer additional support to its individuals.

Consumer-Driven, Strength-Based Philosophy	Consumer-driven services ensure that clients make the choices that guide their recovery by helping them establish their own life goals to strive for. Our strength-based approach helps clients focus and build on the innate strengths they possess but may have overlooked. There is also an emphasis on establishing healthy peer relationships and engaging in leisure activities.

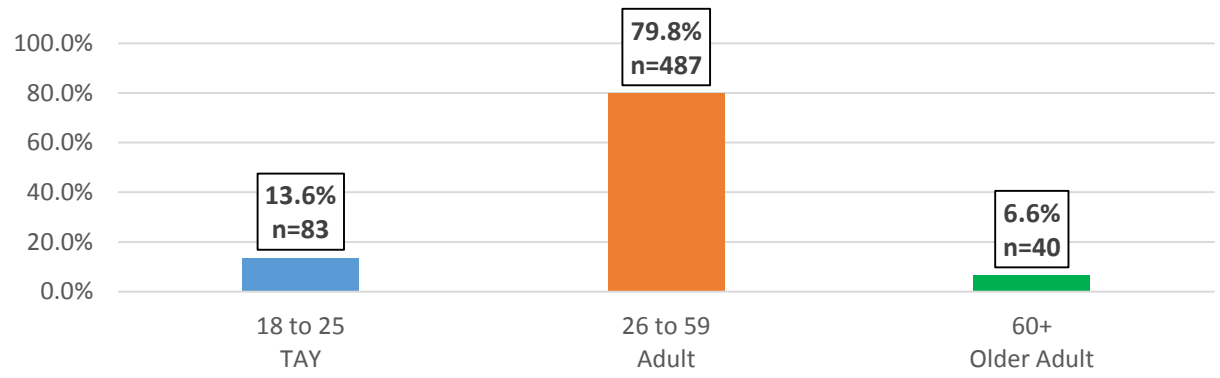
NUMBER OF INDIVIDUALS ENROLLED

Status	10/1/2013 – 4/30/2016
Individuals Served (Unduplicated)	610
Individuals Served (Duplicated)	927

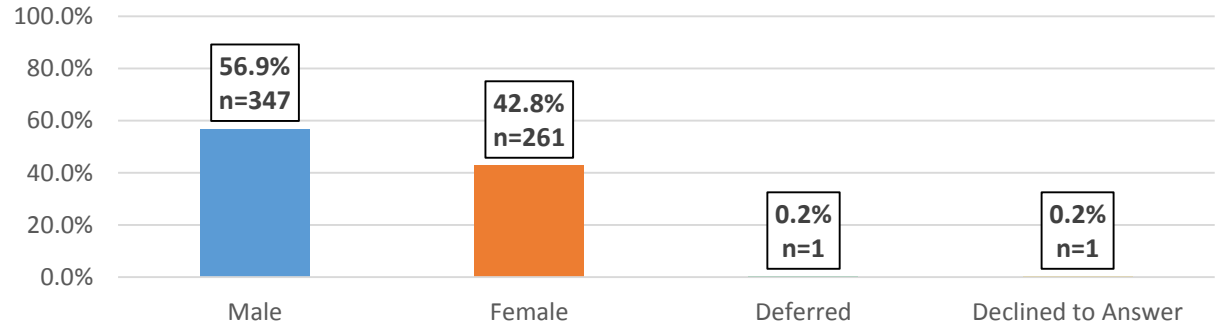
SECTION I: DEMOGRAPHICS

All demographic outcomes below are based on the unduplicated count of 610 individuals served.

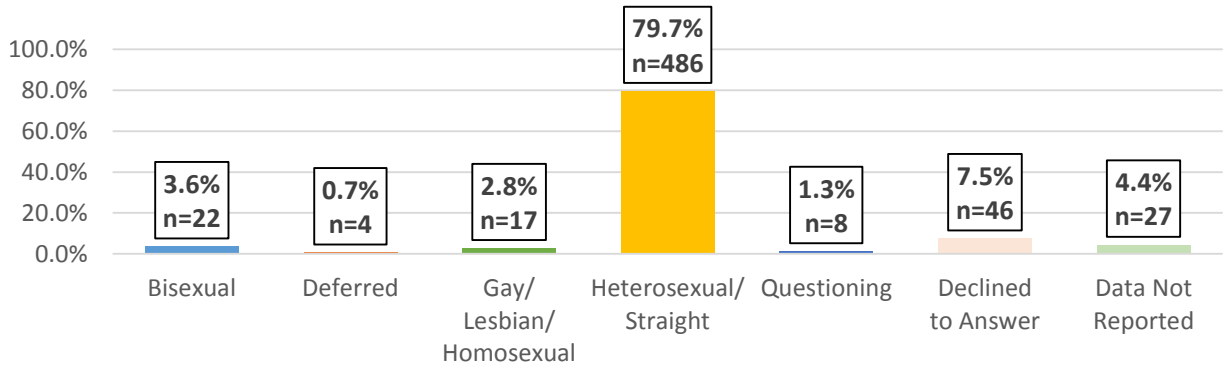
Age Groupings by Percentage



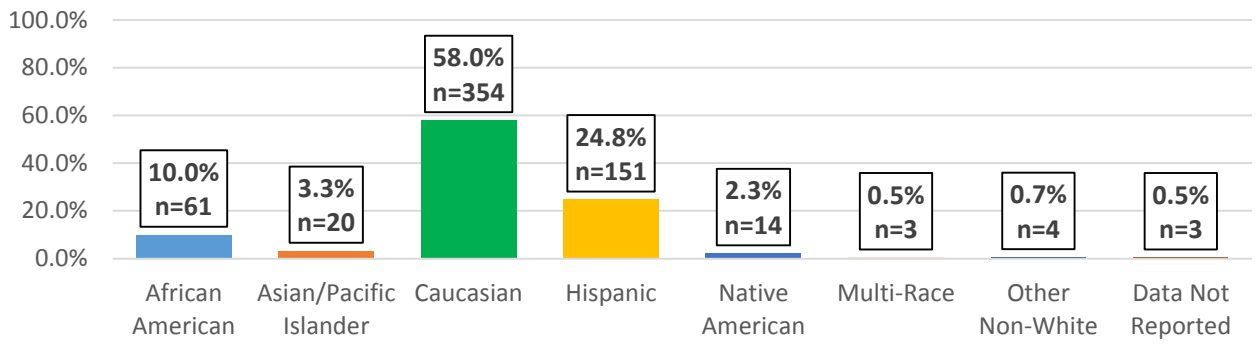
Sex (Gender Self-Identified)



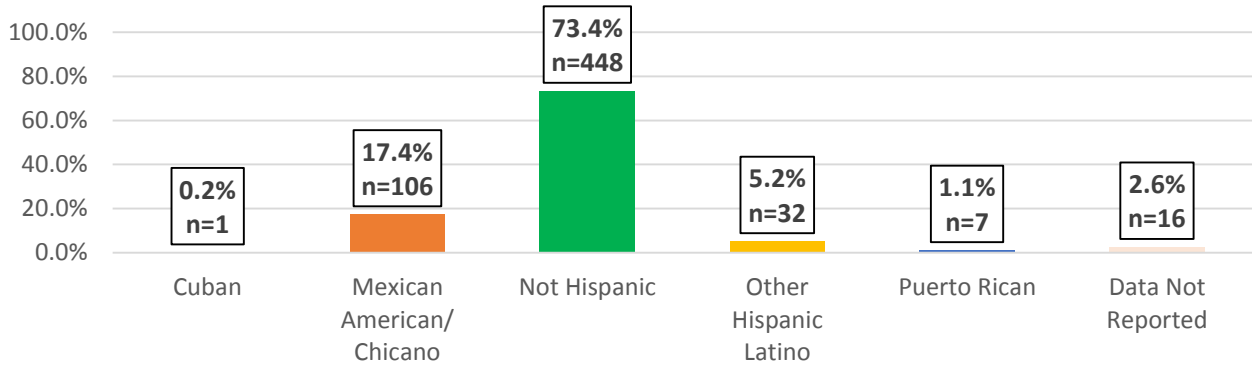
Sexual Orientation



Race



Ethnicity



Veteran Status

	October 2013 – April 2016 (N=610)	
Status	**#**	**%**
No	571	93.6%
Yes	26	4.3%
Declined to Answer	13	2.1%

SECTION II: REFERRALS AND COMMUNITY LINKAGES

Referral Sources

Outcomes below represent all referrals received between October 1, 2013 and April 30, 2016. Due to clients being discharged and returning to the program within the same reporting period, and perhaps being referred from a different source than their prior admission, duplicates have been included.

	October 2013 – April 2016	
	#	%
AB109	31	3.3%
Ceres PD	1	0.1%
Community Emergency Response Team (CERT)	100	10.8%
Empowerment Center	14	1.5%
High Risk Health & Senior Access	17	1.8%
Integrated Forensics Team (IFT)	57	6.1%
Josie's Place Service Team	14	1.5%
Modesto PD	169	18.2%
Modesto Recovery Services (MRS)	76	8.2%
PATH (BHRS Outreach)	31	3.3%
Stanislaus County Sherriff	52	5.6%
TRAC - FastTRAC	2	0.2%
TRAC - Josie's TRAC	22	2.4%
TRAC - MRS TRAC	6	0.6%
TRAC - Outreach	19	2.0%
TRAC - Partnership	21	2.3%
TRAC - Transition Team	193	20.8%
TRAC - TRMS	7	0.8%
TRAC - Wellness	1	0.1%
TRAC - Westside	13	1.4%
Turlock Recovery Services (TRS)	12	1.3%
Turlock PD	1	0.1%
Turning Point ISA	34	3.7%
Other	29	3.1%
Data Not Available	5	0.5%
Total Referrals	**927**	**100.0%**

As can be seen from the table above, the majority of referrals came from TRAC Transition Team between October 2013 and April 2016 (20.8%, n=193). A large portion also came from Modesto Police Department (18.2%, n=169) and Community Emergency Response Team (10.8%, n=100).

Additionally, of the 927 referrals made between October 2013 and April 2016, 197 (21.30%) were made for those at risk of arrest, 807 (87.1%) were made for those at risk of victimization, 877 (94.6%) were made for those at risk of homelessness, and 250 (27.0%) were made for those at risk of being involved in criminal activity. Additionally, beginning in April of 2014, GGIR began to track whether referrals were made to avoid an acute psychiatric hospitalization. Between April of 2014 and April 2016, a total of 732 referrals were made, and 367 (50.1%) of those were made to avoid an acute psychiatric hospitalization.

Community Linkages by Category

Due to clients having been discharged and returning within the reporting period, and possibly being linked to different resources, for the October 2013 to April 2016 reporting period, all 4,203 episodes of services are included instead of the 610 unduplicated. The following table represents all linkages for the reporting period, and is divided into 13 distinct categories as labeled below.

	October 2013 – April 2016	
	#	%
AOD Services	408	9.7%
Clothing	50	1.2%
Community Participation/ Involvement	81	1.9%
Family/Social Support	284	6.8%
Food/Food Pantries	54	1.3%
Health Education	46	1.1%
Medical	372	8.9%
Mental Health Services (BHRS/Contractor)	885	21.1%
Mental Health Services (Community)	24	0.6%
Mental Health Services (Private)	28	0.7%
Other	452	10.8%
Peer Support	802	19.1%
Shelter/Housing	717	17.1%
Total Linkages	**4203**	**100.0%**

The majority of individuals were linked to organizations or services that fell under the category of Mental Health Services (BHRS/Contractor) (21.1%, n=885). The next highest frequency fell under the category of Peer Support (19.1%, n=802), followed by Shelter/Housing (17.1%, n=717).

Linkages that fell under the "Other" category included the following: child and family advocacy; court-mandated services; disability advocacy; domestic violence support; education resources; employment services; faith-based or spiritual community support; fiduciary resources or support; law enforcement assistance or reporting; legal advocacy or resources; mail services; state identification card services; transportation services; veteran advocacy; and victim advocacy or support.

Of the 4,203 attempts at linking clients with services, 3,439 (81.8%) were successful. Additionally, a total of 550 (90.2%) unduplicated individuals had at least 1 successful linkage.

SECTION III: SERVICE UTILIZATION

Average Length of Stay

Between October 2013 and April 2016, the average length of stay per individual was approximately 4.0 days, ranging from anywhere between 1 and 36 days with a mode of 1 day.

Average Daily Population

There was an average of 3.3 individuals served daily between October 2013 and April 2016.

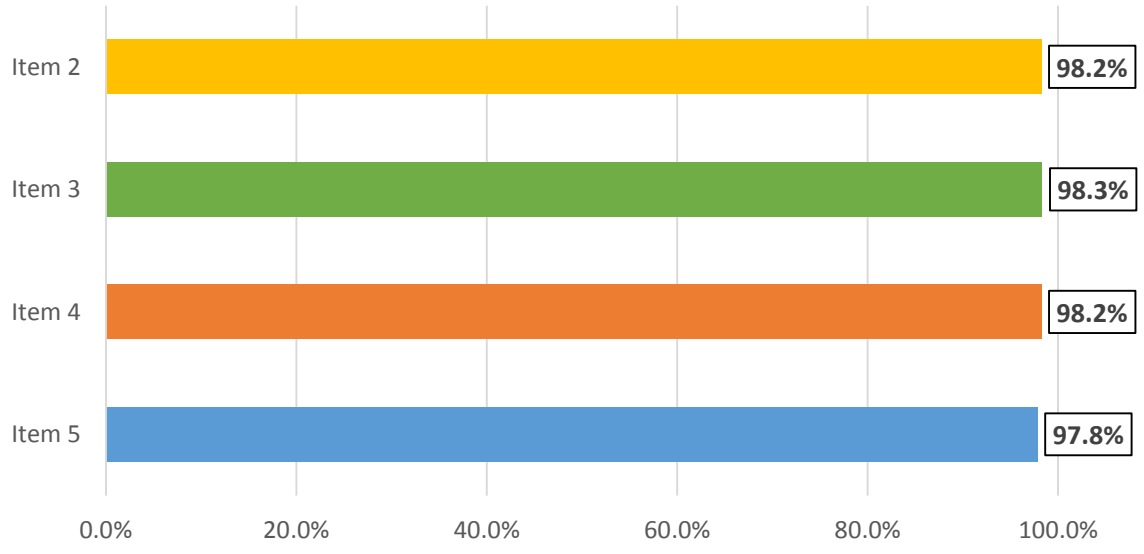
SECTION IV: SURVEY OUTCOMES

Police Department Survey

A Police Department Survey is distributed in order to collect the police department's opinions on the services provided at the Garden Gate Innovative Respite Project. A total of 203 surveys were completed during the October 2013 through April 2016 reporting period. Below is a legend of the item numbers and corresponding question texts, followed by a bar chart showing overall satisfaction percentages of the responses per item. Item one is the only exception, as its responses are on a different scale from the remaining four questions. The remaining questions fall on a 5-point scale ranging from "very satisfied" to "very unsatisfied".

Item #	Question Text
1	Have you previously utilized the Respite Center?
2	How would you rate the Respite Center as a beneficial tool for the Modesto PD?
3	How would you rate the efficiency of the staff at the Respite Center?
4	Are you satisfied at the accessibility of the staff at the Respite Center?
5	Are you satisfied that Respite Center's client criteria meets the needs of the population that MPD comes in contact with?

	October 2013 – April 2016			
	Yes		No	
	#	%	#	%
Item 1	165	81.7%	37	18.3%

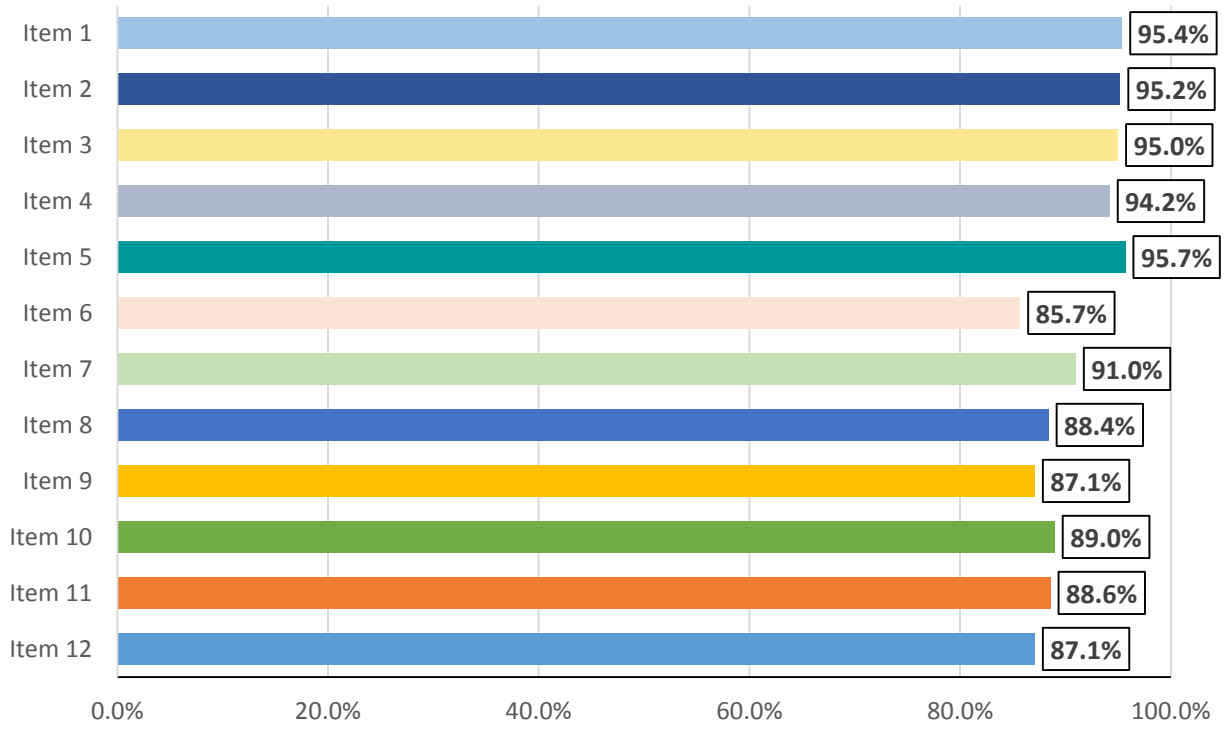


Overall, GGIRP received a satisfaction rate of 98.1%.

Client Survey

Client surveys are distributed in order to obtain information on individual's experiences at GGIRP. A total of 419 surveys were completed during the October 2013 through April 2016 reporting period. Below is a legend of the item numbers and corresponding question texts, followed by bar chart showing overall satisfaction percentages of the responses per item. The questions fall on a 5-point scale ranging from "strongly agree" to "strongly disagree", with an option for "not applicable".

Item #	Question Text
1	I am satisfied with the services I received at Garden Gate.
2	I am satisfied with the way staff interacted with me.
3	I am satisfied with the quality of food provided to me by Garden Gate staff.
4	I am satisfied with the level of safety at Garden Gate.
5	Garden Gate staff made me feel welcomed.
6	I have been able to reconnect with my family member/loved one.
7	I know that there are resources, other than the psychiatric hospital, available to help support me to cope in times of crisis.
8	I feel more hopeful and empowered in my ability to cope.
9	I have been able to connect with peers who were/are mental health consumers.
10	I am satisfied with the experience I had connecting with peers.
11	My contact with peers has helped me feel supported.
12	My contact with peers has helped me learn to practice self-care.



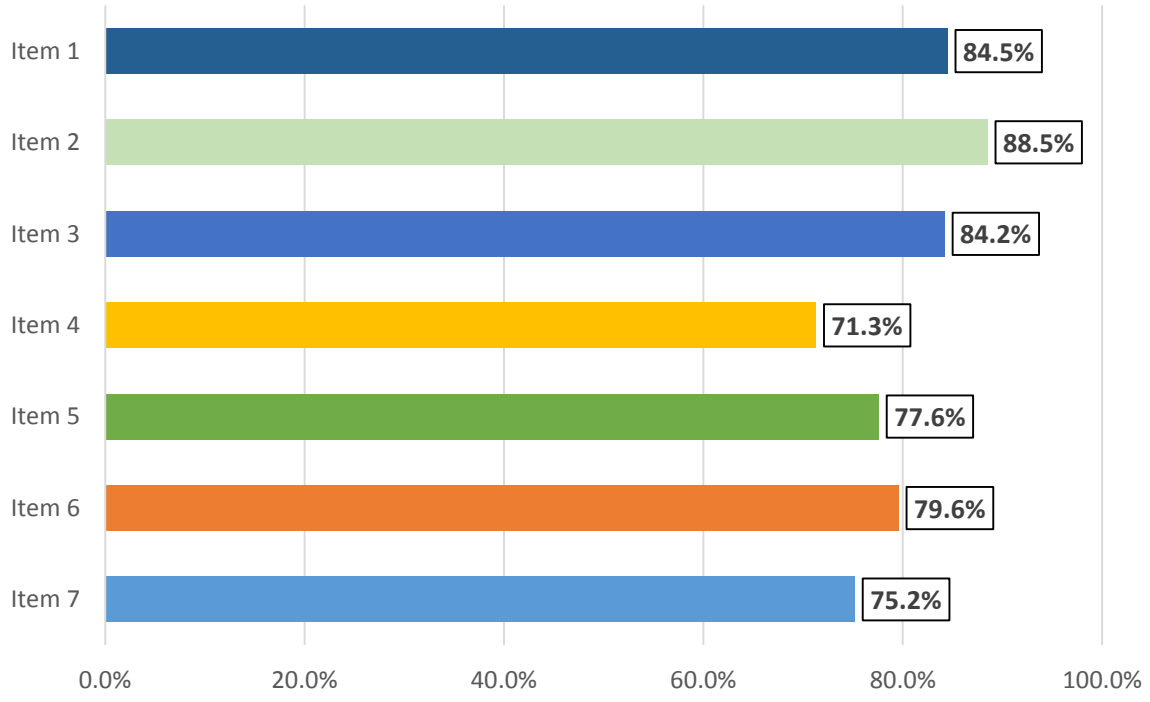
The majority of individuals served through the Garden Gate Innovative Respite Project had favorable satisfaction rates with the services they received. This is a very positive outcome.

Overall, GGIRP received a satisfaction rate of 91.2%.

Family Support Person Survey

For the Garden Gate Innovative Respite Project, a total of 82 surveys were completed between October 2013 and April 2016. Below is a legend of the item numbers and corresponding question texts, followed by a bar chart showing overall satisfaction percentages of the responses per item. The questions fall on a 5-point scale ranging from “strongly agree” to “strongly disagree”, with an option for “not applicable”.

Item #	Question Text
1	I have been able to reconnect with my family member/ loved one.
2	I know that there are resources, other than the psychiatric hospital, available to help support me and my family member/loved one cope with their mental illness.
3	I feel more hopeful and empowered in my ability to help my family member/loved one.
4	I have been able to connect with other families who also have family members experiencing mental illness (“peer families”).
5	I am satisfied with the experience I had connecting with peer families.
6	My contact with peer families has helped me feel supported while supporting my family member/loved one.
7	My contact with peer families has helped me learn to practice self-care while supporting my family member/loved one.



Overall, GGIRP received a satisfaction rate of 81.5%.

Garden Gate Innovative Respite Project Implementation Workgroup Survey

A Garden Gate Innovative Respite Project Implementation Workgroup meets at least quarterly. Members of the general community are welcomed to provide feedback regarding the Project's adherence to learning approaches to integrating culturally specific, community-based peer support, and family support, outlined in the Innovative Respite Work Plan and inform service provision. Often represented are BHRS and Turning Point employees, NAMI volunteers, law enforcement officers, disability and recovery advocates, and family members and consumers of mental health services. Each meeting includes an anonymous survey provided to participants in order to measure participant perceptions of progress toward identified outcomes, as well as the effectiveness and impact of the Workgroup's collaborative effort.

Below is a legend of the item numbers and corresponding question texts, followed by a comparison between all surveys thus far, of overall satisfaction percentages of the responses per item.

Item #	Question Text
1	The group worked towards addressing at least one or more of the Learning Questions outlined in the Innovation Work Plan Narrative.
2	I believe the Garden Gate Innovative Respite Project is integrating culturally specific criteria into its approach.
3	I believe the project is integrating community-based peer support into its approach.
4	I believe the project is integrating family support into its approach.
5	During the meeting, a summary of progress made to date was given verbally and/or in writing to the group.
6	The progress that was reported at the meeting was clear and easy to understand.
7	I am satisfied with the progress made up to this point.
8	I am confident that we will reach any new goals that were set today before the next meeting.
9	I have a clear idea of what is required to make this project successful.
10	Currently, I can say that I am confident in this project's ability to be successful.
11	Currently, I can say that I am confident in this work group's functionality.
12	I supplied some input to the group today (yes/no).
13	I felt comfortable giving my input to the group.
14	I felt my input was responded to in a respectful manner.

Garden Gate Innovative Respite Project Implementation Workgroup Survey (continued)

	Survey #1	Survey # 2	Survey #3	Survey #4	Survey #5	Survey #6	Survey #7	Survey #8	Survey #9	Survey #10	Overall
Total Surveys Completed	**7**	**12**	**3**	**14**	**5**	**12**	**17**	**14**	**13**	**15**	**112**
Participant's Position											
BHRS Employee	1	1	1	2	2	0	6	10	4	**6**	**33**
TPCP Employee	1	1	2	3	0	1	5	3	4	**0**	**20**
NAMI Representative	1	1	0	0	0	0	0	0	0	**2**	**4**
Mental Health Services Consumer	2	2	0	0	0	3	0	0	0	**0**	**7**
TPCP Empowerment Project Advocate	2	0	0	0	0	2	0	0	0	**0**	**4**
Other/Unknown	0	7	0	9	3	6	6	1	5	**7**	**44**
Survey Item Responses											
Item 1*	91.4%	88.1%	95.2%	95.2%	94.3%	89.3%	89.9%	91.8%	93.4%	92.9%	**92.0%**
Item 2*	94.3%	84.5%	90.5%	94.9%	91.4%	85.7%	88.2%	91.8%	94.5%	93.3%	**90.9%**
Item 3*	91.4%	86.9%	100.0%	92.9%	94.3%	90.5%	90.8%	93.9%	95.6%	90.5%	**92.1%**
Item 4*	91.4%	84.5%	90.5%	92.9%	94.3%	91.7%	86.6%	87.8%	92.3%	89.5%	**89.8%**
Item 5*	88.6%	88.1%	100.0%	91.8%	97.1%	92.9%	85.7%	90.8%	96.7%	95.2%	**91.8%**
Item 6*	91.4%	85.7%	95.2%	92.9%	91.4%	86.9%	89.9%	91.8%	93.4%	94.3%	**91.2%**
Item 7*	94.3%	83.3%	95.2%	92.9%	94.3%	91.7%	90.8%	90.1%	93.4%	91.4%	**91.2%**
Item 8*	85.7%	85.7%	90.5%	90.8%	94.3%	84.5%	91.6%	87.8%	90.1%	87.6%	**88.8%**
Item 9*	91.4%	88.1%	95.2%	89.8%	94.3%	89.3%	89.3%	86.7%	93.5%	87.6%	**89.8%**
Item 10*	88.6%	84.4%	100.0%	94.9%	94.3%	89.3%	95.5%	92.3%	92.2%	91.4%	**92.0%**
Item 11*	88.6%	83.1%	90.5%	93.9%	94.3%	89.3%	94.6%	91.2%	93.5%	90.5%	**91.3%**
Item 12*	100.0%	83.3%	100.0%	57.1%	100.0%	75.0%	43.8%	61.5%	63.6%	78.6%	**69.2%**
Item 13*	94.3%	87.0%	100.0%	92.9%	94.3%	92.1%	74.1%	88.3%	91.1%	96.9%	**87.2%**
Item 14*	91.4%	97.4%	100.0%	88.6%	94.3%	92.1%	55.4%	90.0%	92.9%	96.9%	**84.5%**

*Items are defined on the preceding page (page 13).

Overall, an average of 94.4% of the items in the survey were responded to as either “Strongly Agree”, “Agree”, or “Somewhat Agree”. A breakdown by item is presented below.

	Strongly Agree	Agree	Agree Somewhat	Total %
Item 1*	62	40	5	**96.4%**
Item 2*	59	40	8	**95.5%**
Item 3*	62	42	4	**96.4%**
Item 4*	51	47	9	**95.5%**
Item 5*	64	39	3	**94.6%**
Item 6*	58	43	6	**96.4%**
Item 7*	61	38	7	**95.5%**
Item 8*	49	46	9	**92.9%**
Item 9*	51	44	9	**95.4%**
Item 10*	59	41	4	**97.2%**
Item 11*	54	43	9	**99.1%**
Item 13*	56	25	4	**89.5%**
Item 14*	58	18	1	**82.8%**
Overall Average	**57.2**	**38.9**	**6.0**	**94.4%**

*Items are defined on page 13.

As can be seen from the table above, the majority of individuals responded to each item as either “Strongly Agree”, “Agree”, or “Somewhat Agree” ranging between 81.2% and 98.8%. This is a very positive outcome.

Item 12 has been excluded from the table due to the fact that is uses a different response scale of either “yes” or “no”.

SECTION V: DISCHARGE DISPOSITION

Between October 1, 2013 and April 30, 2016, a total of 609 unduplicated individuals were discharged (one individual was discharged after the end of the reporting period). Due to some individuals having multiple admissions and discharges within the reporting period, the chart below reflects the total number of discharges, which is equivalent to 296 (one discharge occurred after the end of the reporting period).

	October 2013 – April 2016	
	#	%
Board and Care	19	2.1%
DBHC	16	1.7%
Family	63	6.8%
Home (Previous Living Situation)	102	11.0%
Medical Hospital	25	2.7%
Modesto Gospel Mission	94	10.2%
Motel	25	2.7%
Non-Related Individuals	41	4.4%
Own Apartment	5	0.5%
Room and Board	50	5.4%
Salvation Army	68	7.3%
SRC/Residential SA Treatment	74	8.0%
Streets	29	3.1%
Transitional Housing	32	3.5%
Turning Point Supportive Housing	2	0.2%
Other	50	5.4%
Data Not Available	231	24.9%
Total	**926**	**100.0%**

As can be seen from the table above, the majority of clients did not have a discharge destination recorded between October 2013 and April 2016 (24.9%, n=231). Otherwise, the majority of individuals were either discharged to their previous living situation (11.0%, n=102) or to the Modesto Gospel Mission (10.2%, n=94).

APPENDIX B

TURNING POINT

Turning Point Respite At Garden Gate

Opening/Closing

Guest Name: _____

Opening (this section to be completed upon admit):

Effective Date (date of admit): ☐☐/☐☐/☐☐☐☐

Form completed by (Staff Initials/County I.D. #): _____

SubUnit:
- ☐ Garden Gate Respite (7005) OR
- ☐ Garden Gate Innovative Respite Project (7006)

Closing (this section to be completed upon discharge):

Effective Date (date of discharge): ☐☐/☐☐/☐☐☐☐

Form completed by (Staff Initials/County I.D. #): _____

Reason:
- ☐ Client Incarcerated
- ☐ Death of Client
- ☐ MH – Client Moved Out of Area
- ☐ MH – Client Withdrew, Tx Partially Completed
- ☐ MH – Client Withdrew, No Improvement
- ☐ MH – Discharge/Administrative Reasons
- ☐ MH – Discharge/Unilateral Decision
- ☐ MH – Mutual/Tx Goals Partially Reached
- ☐ MH – Mutual/Tx Goals Not Reached
- ☐ MH – Mutual/Tx Goals Reached
- ☐ Other

PSC Use Only:	☒	Initial	Date
EHR Open	☐	_____	__/__/__
Demographic	☐	_____	__/__/__
EHR Close	☐	_____	__/__/__
Summary Progress Note	☐	_____	__/__/__
Database Entry	☐	_____	__/__/__

OFFICE USE:

Client #: ☐☐☐☐☐☐☐

TURNING POINT
COMMUNITY PROGRAMS

Turning Point Respite At Garden Gate

Referral For Garden Gate Services

REFERRING AGENCY/REPRESENTATIVE INFORMATION

Last Name: _____ **First Name:** _____

Phone: (___) ___ - ____

Agency/Program (please check one):

- ☐ AB109
- ☐ Ceres PD
- ☐ CERT
- ☐ Community Navigation Team
- ☐ Empowerment Center
- ☐ HRH & SA (High Risk Health & Senior Access)*
- ☐ IFT*
- ☐ Josie's Place Service Team
- ☐ King Kennedy Collaborative
- ☐ Modesto PD
- ☐ MRS
- ☐ PATH (BHRS Outreach)
- ☐ TRS
- ☐ SATT
- ☐ Stanislaus County Sheriff
- ☐ Turning Point ISA
- ☐ Turlock PD
- ☐ Telecare Recovery Access Center (TRAC):
  - ☐ TMRS
  - ☐ Wellness
  - ☐ FastTRAC
  - ☐ Partnership*
  - ☐ Josie's TRAC*
  - ☐ Transition Team*
  - ☐ Westside*
  - ☐ Outreach/Engagement
  - ☐ MRS TRAC*
- ☐ Other_____

*Programs with 24/7 services

What circumstances caused you to bring the individual in to Respite?

_____

_____

_____

Is the individual ambulatory (can they get around the house by themselves independently, or by using a cane, walker, or wheelchair, etc.)?	☐ YES	☐ NO
Does the individual have a history of violence?	☐ YES	☐ NO
Is the purpose of this referral to avoid an inpatient psychiatric hospitalization?	☐ YES	☐ NO

OFFICE USE: Client #: _____ DATE: ___/___/____ TIME: ___:___ AM/PM

TURNING POINT
COMMUNITY PROGRAMS

Turning Point Respite At Garden Gate

Police Department Survey

Guest Name: _____

Date: _____

Have you previously utilized the Garden Gate Respite Center?	☐ YES ☐ NO

How satisfied are you with the following:

	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
1. The Garden Gate Respite Center being a beneficial tool for the Modesto Police Department	5	4	3	2	1
2. The efficiency of Garden Gate Respite Center staff	5	4	3	2	1
3. The accessibility of the Garden Gate Respite Center	5	4	3	2	1
4. The Respite Center's client criteria meeting the needs of the population that MPD comes into contact with.	5	4	3	2	1

OFFICE USE:

Client #: | | | | | | | | SubUnit _____ Staff Initials/County ID#:_____

TURNING POINT
COMMUNITY PROGRAMS

Turning Point Respite At Garden Gate

MORS Scoring Sheet

Guest Name: _____

Questions to Ask Yourself:

1. Is the consumer struggling (1-5) or succeeding (6-8)?
2. What is the consumer's level of risk? Is the individual exhibiting behaviors that reflect "Extreme Risk", "High Risk", or "Poorly Coping" (relatively low risk)?
3. Is the consumer engaged or not engaged?

Intake

Score: _____

Date: ___ /___ /_____ **Staff Initials/County ID#:**_____

Comments:

_____

_____

_____

Discharge

Score: _____

Date: ___ /___ /_____ **Staff Initials/County ID#:**_____

Comments:

_____

_____

_____

OFFICE USE:

Client #: | | | | | | | | SubUnit _____

Turning Point Respite At Garden Gate

Admission Form

Guest Information

Admission Date: ____/____/____

"Add Client" Information

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **First Name:** ☐☐☐☐☐☐☐☐☐☐☐☐ **MI:** ☐

DOB: ☐☐/☐☐/☐☐☐☐ **SSN:** ☐☐☐-☐☐-☐☐☐☐ **Sex:** M ☐ F ☐

Address (If applicable): _____

Street Number Street Name City Zip Code

- If no address, "What zip code did you reside in before you came here?": ☐☐☐☐☐

Phone: (☐☐☐) ☐☐☐-☐☐☐☐

"Demographic" Information

If No SSN, Reason Not Provided:
- ☐ Decline
- ☐ Not Applicable
- ☐ Unable to Answer

DOB Is:
- ☐ Actual
- ☐ Estimated

Ethnicity and Race: (Please see "Race and Ethnicity" form)

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other (Refer to BHRS Hot Sheet values) _____

If not English: "Are you comfortable communicating in English?"
- ☐ Yes
- ☐ No (Interpreter or Language Line services needed)

Veteran Status:
"Have you ever served in the United States military?"
- ☐ Yes (During which conflict? Refer to BHRS Hot Sheet values)_____
- ☐ No
- ☐ Decline to State
- ☐ Unable to Answer

Sexual Orientation:
- ☐ Bisexual
- ☐ Declined to Answer
- ☐ Gay/Lesbian/Homosexual
- ☐ Heterosexual/Straight
- ☐ Questioning

Emergency Contact Information

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **First Name:** ☐☐☐☐☐☐☐☐☐☐☐☐

Relationship:_____ **Phone:** (☐☐☐) ☐☐☐-☐☐☐☐

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit _____ Staff Initials/County ID#:_____

Guest Health Information

"Do you have any physical health problems that you might need assistance with?": ☐ YES ☐ NO

"So that we can be as helpful as possible, do you have any mental health issues that we should know about": ☐ YES ☐ NO

"Have you been admitted to a psychiatric hospital within the last 12 months?" ☐ YES ☐ NO

If ***YES***, "How many days total do you think you spent in the psychiatric hospital during that time? # Days: _____

Was this Guest at Risk of:

- ☐ **Arrest** (brought in by police upon being observed while engaging in unlawful behavior, such as panhandling, loitering, trespassing, threatening behavior, etc.)
- ☐ **Victimization** (vulnerable to other due to mental status, poor boundaries, frailty, etc.)
- ☐ **Homelessness** (without long-term housing, potential loss of current housing, etc.)
- ☐ **Criminal Activity** (not brought in by police, but was observed to have been engaging in unlawful behavior, such as panhandling, loitering, trespassing, threatening behavior, etc.)

Personal Belongings

Review the "Personal Belongings Policy" with the guest, and obtain their signature accepting or declining locker access.

"Do you have any personal belongings, including valuables or medications, you'd like to store in a locker?"

I have read and/or reviewed the Personal Belongings Policy with staff, and have decided that:

☐ Yes, I would like to be loaned a locker and padlock during my stay. I agree that I am responsible for securing my belongings in it, holding the key, that I may not be able to access my belongings until the next business day should I lose the key, and that if a lock needs to be cut to access my belongings, I will not be issued another. (Locker Number Assigned: _____)

☐ No, I do not wish to be loaned a locker and padlock. I take responsibility for keeping my personal belongings with me and/or safe at all times.

_____ _____
Guest Signature Date

_____ _____
Witnessed By (Staff Member) Date

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit _____ Staff Initials/County ID#:_____

TURNING POINT
COMMUNITY PROGRAMS

Turning Point Respite At Garden Gate

Race/Ethnicity Form

Guest Name:_____ Date: _____

Which, if any, of the following do your consider to be your primary race?:

Choose up to 5

- ☐ Amerasian
- ☐ Asian (Other)
- ☐ Assyrian (Iran)
- ☐ Assyrian (Iraq)
- ☐ Black/African American
- ☐ Cambodian
- ☐ Chinese
- ☐ Eskimo/Alaskan Native
- ☐ Filipino
- ☐ Guamanian
- ☐ Hawaiian Native
- ☐ Hispanic (Black)
- ☐ Hispanic (Non-White)
- ☐ Hispanic (White)
- ☐ Hmong
- ☐ Indian (Asian)
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mien
- ☐ Multiple
- ☐ Native American
- ☐ Non-White Other
- ☐ Pacific Islander (Other)
- ☐ South Asian (Other)
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Unknown

Which, if any, of the following do your consider to be your ethnicity?:

- ☐ Not Hispanic
- ☐ Mexican American/Chicano
- ☐ Cuban
- ☐ Puerto Rican
- ☐ Other Hispanic Latino
- ☐ Unknown/Not Reported

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit _____ Staff Initials/County ID#:_____

Turning Point Garden Gate Respite House Rules

Our goal is to provide a safe, welcoming environment during your stay:

PROGRAM MISSION & STRUCTURE

1. Your time here is an opportunity to connect with resources to help you establish and maintain wellness in the community. To achieve this, we encourage you to collaborate with the Personal Service Coordinator (PSC) assigned to support you in identifying and working toward agreed-upon goals for the length of your stay.

2. We encourage you to participate in at least one group or other recovery-based activity (in-house or in the community) per day, in order to help build coping skills and peer support that will be essential to your continued success upon discharge.

3. Please remember that this is a temporary, short-term stay. There is no guaranteed length of stay. Your stay will be reevaluated by PSCs (in consultation with supervisors) every 24 hours.

4. If you are brought in by law enforcement (e.g. police/sheriff) or CERT, you must remain on site until you meet with a member of Telecare Outreach & Engagement team. If you do not to meet with them for any reason, you may be discharged.

SAFETY & CONDUCT

5. No weapons, drugs, or alcohol are allowed on the property at any time. For the safety of everyone, guests may be asked to empty their pockets or bags at any time to assure that no prohibited items are brought onto the property. Discovery of prohibited items at any time may result in immediate discharge.

6. Threats of violence to staff, guests, or self are taken seriously, and may result in your discharge, as well we temporary or permanent ineligibility for Respite services.

7. All guests and staff are expected to be courteous and respectful. Engaging in conduct that is disruptive to the house or neighborhood may result in your discharge.

8. Staff cannot hold personal belongings, or dispense medications at any time. You are responsible for securing personal belongings and medications at all times. If you choose, you may have use of a locker to store these items during your stay.

9. PERSONAL BELONGINGS, INCLUDING VALUABLES AND MEDICATIONS, LEFT FOR MORE THAN 24 HOURS AFTER DISCHARGE WILL BE DISCARDED WITHOUT NOTICE.

10. In consideration of all guests, please limit calls on the guest phone to 20 minutes.

11. No caffeinated beverages are allowed after 10:00 PM.

12. For your safety, socks, slippers, or shoes must be worn at all times.

13. Staff may restrict the content of television, music, or other media broadcast in the house if the content is inappropriate or upsetting to others.

14. To protect the privacy of all guests, lingering in the office areas is not allowed.

15. You must check in and out with staff when leaving the site or returning. When out, you must call or return at least every 4 hours to maintain your bed. Staff must give prior approval for any absence longer than 4 hours. If you leave the grounds for more than 4 hours without prior approval and/or without checking in, you may be discharged without further notice.

16. You must remain on site between the hours of 10:00pm and 6:00am. Staff approval is required to leave during that time. Leaving during these hours or staying out past 10:00 pm without prior approval may result in discharge without notice.

17. Any visitors to the site must be 18 years of age or older (no minor children permitted), and must adhere to the same rules of conduct for house guests.

SMOKING

18. Borrowing cigarettes from staff or clients is not permitted.

19. There is no rolling of tobacco allowed in the house or front porch. If you have loose tobacco, please let a staff member know, and they will provide you with a plastic bag to store it in.

20. There is no smoking of any kind (including "e-cigs" or vapor cigarettes). You may smoke only in the designated gravel area near the rear parking lot. Smoking inside the house may be grounds for immediate discharge as it presents a safety risk.

SANITARY CONERNS

21. To prevent potential for pest infestation, the volume of belongings allowed at Respite is limited to the capacity of a 24-gallon plastic storage bin (24" x 20" x 20"), approximately the size of a large carry-on bag. No belongings are allowed inside the house until they have been laundered, inspected, and deemed appropriate by staff. No exceptions can be made.

22. To prevent bug and other pest infestations, no food or drinks are allowed in bedroom or living room areas. They are allowed only in the kitchen and dining room.

23. For sanitary reasons, guests and staff must wear gloves when handling food items.

24. You are responsible for keeping your living area neat and clean. If you create a mess of any kind, accidentally or otherwise, you are expected to clean it and/or assist staff in doing so.

CONFIDENTIALITY

25. I understand that if I disclose any information to staff regarding abuse of a child, dependent adult (including individuals with physical or psychiatric disabilities), or elderly person, staff will be required by law to report this information to an investigating agency.

Guest Agreement:

By signing below, I agree to abide by all house rules, and cooperate with the general policies of the facility.

Guest Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

I, _____, acknowledge receipt of the Notice of Privacy Practices by signing this form. The Notice of Privacy Practices provides information about how Turning Point Community Programs (TPCP) may use or disclose protected health information about me. I was encouraged to read the document in full.

This Notice of Privacy Practices is subject to change. I understand that I can obtain a copy of the revised notice at one of the programs or sites of Turning Point Community Programs or from the Privacy Officer or other ways explained in the Notice I received.

I also understand that any self-publication (including the posting, broadcast or transfer) of my Protected Health Information (PHI), that reveals or otherwise contains individually identified provider information posted on a blog, internet website, or other printed/electronic form or forum, constitutes a waiver of any protections afforded such PHI under HIPAA, as well as any other applicable regulations, rules or laws. Further, any self-publication of my PHI permits provider to respond to the original publications to the extent necessary to defend, limit and challenge the factual assertions contained within such publications. Any and all comments and publications will be considered self-disclosed/waived protections of my PHI to the extent such publication is made.

I acknowledge receipt of the Notice of Privacy Practices of Turning Point Community Programs.

_____ _____

Signature Date

I acknowledge receipt of the Notice of Privacy Practices of the County of Sacramento.

_____ _____

Signature Date

OR

I acknowledge that I have been offered to receive the Notice of Privacy Practices of Turning Point Community Programs. I have read the Notice of Privacy Practices in the presence of TPCP staff and have chosen not to receive my personal copy. I understand that I can obtain a copy at any time from one of the sites of TPCP or from the Privacy Officer.

_____ _____

Signature Date

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signed acknowledgement of receipt is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

____ Refused to sign ____ Unable to sign ____ Mailed to client Date: _____

Staff Comments

_____

Signature of provider representative: _____ Date: _____

Turning Point Community Programs
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT
(File in HIPAA Section)

Turning Point Community Programs (TPCP) Garden Gate Respite/Garden Gate Innovative Respite
Consent to Release of Confidential Personal Information

I, (print name) _____, (date)_____
authorize the staff members of TPCP Garden Gate Respite and/or Garden Gate Innovative Respite and the following individuals and/or Service Partners to communicate with and disclose to one another all information regarding my mental and physical health status, and service/resource/support needs observed, obtained by, or disclosed to Garden Gate staff members during the course of my stay:

	Name (Person or Agency):	Address:	Phone:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Initial each category that applies:

_____ my name and other personal identifying information;

_____ my status as a participant in support and referral services;

_____ mental and physical health status;

_____ identified needs and service recommendations made by Garden Gate staff members;

_____ other _____

The purpose of the disclosures (authorized in this consent) is to assist Garden Gate staff in identifying any mental health, physical health, and practical needs I may have, so that they may provide me with appropriate referrals and linkage to outside services/resources/supports to get these needs met.

I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows (circle only one selection):

(1) One year from the date that is listed on the top of this form: _____

(2) Six months from the date that is listed on the top of this form: _____

(3) Other: _____

I understand that this authorization is voluntary; that my personal information may be protected under federal or state confidentiality laws. I understand that federal privacy laws protecting my personal confidential information may not apply to the recipient and may not prohibit the recipient from disclosure.

I understand that I may choose not to sign this authorization and this will not affect my ability to obtain services.

Date: _____ _____
Signature of Garden Gate Guest

Date: _____ _____
Signature of Witness (Garden Gate Staff Member)

TURNING POINT

Turning Point Respite At Garden Gate

Needs Assessment

Guest Name:_____ Date: ____/____/____

Identified Need List

1	=	AOD Services
2	=	Clothing
3	=	Community Participation/Involvement
4	=	Family/Social Support
5	=	Food/Food Pantries
6	=	Health Education
7	=	Medical
8	=	Mental Health Services (BHRS/Contractor)
9	=	Mental Health Services (Private Provider)
10	=	Peer Support
11	=	Shelter/Housing
12	=	Other

eferral	**REFERRED TO: What <u>specific</u> support person, agency, or other resource did you refer the guest to? (Use the <u>actual name</u> of support person, agency, etc.)**	**IDENTIFIED NEED (Number corresponding with need listed above)**	**Did guest try to connect with this referral source?**	**Was linkage successful?**
A			☐ YES ☐ NO	☐ YES ☐ NO
B			☐ YES ☐ NO	☐ YES ☐ NO
C			☐ YES ☐ NO	☐ YES ☐ NO
D			☐ YES ☐ NO	☐ YES ☐ NO
E			☐ YES ☐ NO	☐ YES ☐ NO
F			☐ YES ☐ NO	☐ YES ☐ NO
G			☐ YES ☐ NO	☐ YES ☐ NO
H			☐ YES ☐ NO	☐ YES ☐ NO
I			☐ YES ☐ NO	☐ YES ☐ NO
J			☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit _____ Staff Initials/County ID#:_____

Turning Point Respite At Garden Gate

TURNING POINT

Guest Contact Record

Guest Name:_____	Date: ____/____/____
Staff Member Name_____	

BEHAVIOR (What was the individual's behavior and/or attitude observed or reported to be? Did the guest disclose any symptoms, behaviors, or concerns? _____

_____

_____

_____

_____

_____

_____

_____

IDENTIFIED NEEDS (What service, support, or practical needs do you see, or hope the guest will meet as a result of their stay here?)_____

_____

COPING STRATEGIES (Does the individual have constructive coping skills they know/can use to address emotional needs? What, if any, maladaptive coping skills do they tend to use? What type of coping skills would it be helpful for them to develop?)_____

_____

INTERVENTION/PLAN **(NON-TURNING POINT EMPLOYEES: What is the intended destination/specific discharge plan for this individual, and where are you at in facilitating this process?** TURNING POINT EMPLOYEES: What did you do today to help this individual address identified needs, or facilitate the outpatient service provider's discharge plan?):

_____

_____

_____

_____

_____

_____

SUGGESTED APPROACHES/OBSERVATIONS (What has been successful? What has either not been helpful or actually escalated problems/distress?)_____

_____

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit _____ Staff Initials/County ID#:_____ Time: ☐☐:☐☐ AM/PM

Turning Point Respite At Garden Gate

TURNING POINT

Guest Contact Record

Guest Name:_____ Date: ____/____/____

Staff Member Name:_____

BEHAVIOR (What was the individual's behavior and/or attitude observed or reported to be? Did the guest disclose any symptoms, behaviors, or concerns? _____

_____

_____

_____

_____

_____

_____

_____

IDENTIFIED NEEDS (What service, support, or practical needs do you see, or hope the guest will meet as a result of their stay here?)_____

_____

COPING STRATEGIES (Does the individual have constructive coping skills they know/can use to address emotional needs? What, if any, maladaptive coping skills do they tend to use? What type of coping skills would it be helpful for them to develop?)_____

_____

INTERVENTION/PLAN **(NON-TURNING POINT EMPLOYEES: What is the intended destination/specific discharge plan for this individual, and where are you at in facilitating this process?** TURNING POINT EMPLOYEES: What did you do today to help this individual address identified needs, or facilitate the outpatient service provider's discharge plan?):

_____

_____

_____

_____

_____

_____

SUGGESTED APPROACHES/OBSERVATIONS (What has been successful? What has either not been helpful or actually escalated problems/distress?) _____

_____

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit _____ Staff Initials/County ID#:_____ Time: ☐☐:☐☐ AM/PM

Turning Point Respite At Garden Gate

TURNING POINT COMMUNITY PROGRAMS

Guest Satisfaction Survey

If survey not completed, check reason:	☐ Guest declined to participate	☐ Guest not available

Guest Name: _____ **Date:** _____

Please circle a response to the following statements:

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Non Applicable
1. I am satisfied with the services I received at Garden Gate Respite Center.	5	4	3	2	1	0
2. I am satisfied with the way staff interacted with me.	5	4	3	2	1	0
3. I am satisfied with the quality of food provided to me by Garden Gate Respite Center staff.	5	4	3	2	1	0
4. I am satisfied with the level of safety at the Garden Gate Respite Center	5	4	3	2	1	0
5. Garden Gate Respite Center staff made me feel welcomed.	5	4	3	2	1	0
Because of the services I received through the Garden Gate Respite Center:						
6. I have been able to reconnect with my family member/loved one.	5	4	3	2	1	0
7. I know that there are resources, other than the psychiatric hospital, available to help support me to cope in times of crisis.	5	4	3	2	1	0
8. I feel more hopeful and empowered in my ability to cope.	5	4	3	2	1	0
9. I have been able to connect with peers who were/are mental health consumers.	5	4	3	2	1	0
10. I am satisfied with the experience I had connecting with peers.	5	4	3	2	1	0
11. My contact with peers has helped me feel supported .	5	4	3	2	1	0
12. My contact with peers has helped me learn to practice self-care.	5	4	3	2	1	0

OFFICE USE:

Client #: | | | | | | | | SubUnit _____ Staff Initials/County ID#: _____

TURNING POINT
COMMUNITY PROGRAMS

Turning Point Respite At Garden Gate

Discharge Form

Discharge Date: ____ /____ /____

Guest Name: _____

Reason For Discharge

- ☐ Failed to Return (left and didn't return, failed to check in to hold bed)
- ☐ Time Expired (authorized time period has ended)
- ☐ Housing Obtained
- ☐ Failed to Cooperate (did not follow program rules)
- ☐ Did Not Meet Program Requirements (has/can utilize adequate housing, non-ambulatory, medically compromised, etc.)
- ☐ Able to Return to Previous Living Situation
- ☐ Safety Issues (verbal/physical aggression, threats, property destruction)
- ☐ Moved out of County
- ☐ Entered Other Residential Treatment
- ☐ Guest Decision/Request
- ☐ Other_____

Level of Needs Being Met

Needs related to the guest's stay were:

☐ Fully Met ☐ Partially Met ☐ Not Met

Discharged To Location

- ☐ Motel
- ☐ DBHC
- ☐ Modesto Gospel Mission
- ☐ Salvation Army Cold Weather Shelter
- ☐ Salvation Army Hot Weather Shelter
- ☐ Salvation Army Transitional Living
- ☐ Streets
- ☐ SRC/Other Residential SA Treatment
- ☐ Family
- ☐ Non-Related Individuals (friends, roommates, etc.)
- ☐ Home (previous living situation)
- ☐ Own Apartment (NOT Transitional or Supportive housing)
- ☐ Medical Hospital
- ☐ Room and Board
- ☐ Board and Care
- ☐ Transitional Housing
- ☐ Turning Point Supportive Housing
- ☐ Unknown
- ☐ Other _____

OFFICE USE: Client #: ☐☐☐☐☐☐☐ DATE: ☐☐/☐☐/☐☐☐☐ TIME: ☐☐:☐☐ AM/PM

GARDEN GATE RESPITE MEDICATION/PERSONAL BELONGINGS POLICY

All Respite guests have the option of storing personal belongings, including valuables or medications, in a locker. If a locker is requested, staff will assign you a locker, padlock, and key for you to borrow for the duration of your stay.

Personal belongings rules:

- Should you choose to borrow a locker, you are responsible for securing your own personal belongings in it.
- You are responsible for holding the key to the locker. Should you lose the key, you may not be able to access your belongings until the next business day (Monday through Friday).
- **If you lose a key, and/or a padlock must be cut off of your locker to access your belongings, you will not be loaned another padlock and key set.**
- Should you decline to be loaned a locker with a padlock and key set, you are still responsible for keeping your personal belongings with you and/or safe at all times.
- Garden Gate staff members are not allowed to hold personal belongings for guests at any time, regardless of the reason.
- Garden Gate staff members are not allowed to hold or dispense any medications for you at any time. If you wish to secure your medications, you must do so in a locker.
- You must be able to manage your own medications. Although staff may agree to try to help you remember to take your medications, this cannot be guaranteed, and you are ultimately responsible for taking your medications in a timely manner.

Locker procedure:

- To be loaned a locker, you must check the "Yes" box in the "Personal Belongings" section on the Admission form and sign.
- If you are loaned a padlock and key, you will be required to return them at end of your stay. Keep the key on your person or in a safe place at all times.
- You are free to access your locker at any time during your stay.
- Should you lose your key, report it as missing to staff immediately.
- At discharge time, you should be sure to empty the locker to avoid loss of items, and as a courtesy for the next guest to use.
- At discharge time, you must return the padlock and key to staff.
- BELONGINGS LEFT IN LOCKERS FOR MORE THAN 24 HOURS AFTER DISCHARGE WILL BE DISCARDED WITHOUT NOTICE!!

Stanislaus County HMIS

Client Informed Consent and Release of Information

You are requesting or receiving services from _____ (Agency Name) who is a member agency of the Stanislaus Housing and Support Services Collaborative (SHSSC), a group of area service providers that is required to maintain a database of client information to measure and report on the impact of services on ending and preventing homelessness. This database is called the Stanislaus County HMIS (Homeless Management Information System). As a potential or actual client of services, we collect the information listed below to more effectively deliver services in Stanislaus County and to maximize the level of federal funding obtained for our county.

In addition to collecting and sharing the specific data listed below the Stanislaus County HMIS is used to generate general reports on homelessness and reports required by the agencies funding the services you are receiving. These reports **DO NOT** have personal identifying information such as names, social security numbers, date of birth, addresses, or phone numbers.

NOTE: Strict controls are in place to protect your Information which is only accessible to authorized personnel of member agencies of the collaborative.

I authorize the following information to be entered into the Stanislaus County HMIS and **shared** between SHSSC partner agencies:

Identifying Information: *Name, Social Security Number, Date of Birth, Gender, Ethnicity & Race, Marital & Family status, Household Relationships, Phone Numbers, and Address.*

I authorize the following information to be entered into the Stanislaus County HMIS but **not shared** between SHSSC partner agencies and only accessible by this agency, the HMIS System Administrator, and funding agency authorized users (If Applicable)*:

Basic Information: *Whether or not you have a disability, Veteran, General Health, Education, and Employment status*

Housing Information: *Homeless status, Residence Prior to Program Entry, Zip Code of Last Permanent Address*

Financial Information: *Income and Sources including Non-Cash Benefits*

Disabling Condition: *Physical Disability, Developmental Disability, HIV/AIDS, Mental Health, Substance Abuse, Chronic Health Condition*

Other: *Domestic Violence status, Program Entry Date and Program Exit Date, Services Rendered and Destination After Program Exit*

**Only Applicable if Agency is receiving funding for this program through local government.*

I understand that I may cancel this authorization at any time by written request, but the cancellation will not be retroactive (No records in the system will be removed).

I understand that I have the right to view my HMIS record and will have a report prepared within 72 hours of my written request.

I understand that if I refuse consent to share this information I cannot be denied services.

This release expires 18 months from the date signed below.

Signature of Client	**Printed Name of Client**	**Date**

Stanislaus County HMIS Shelter Data Intake

1. **Project Entry Date (e.g., 05/24/2010)** *[Please complete one for each adult]*

		/			/				
Month			Day			Year			

2. **Name** (first, middle, last name, suffix (e.g., Jr, Sr, III)

First name																	
Middle name																	
Last name																	
Suffix																	

3.Name Data Quality

- ☐ Full name reported
- ☐ Partial, street name, or code name reported
- ☐ Client doesn't know
- ☐ Client refused

4. Social Security Number

			-			-				

5.Date of Birth (e.g., 10/23/1978)

		/			/				
Month			Day			Year			

6. SSN Data Quality

- ☐ Full SSN reported
- ☐ Approximate or partial SSN reported
- ☐ Client doesn't know
- ☐ Client refused

7. DOB Data Quality

- ☐ Full DOB reported
- ☐ Approximate or partial DOB reported
- ☐ Client doesn't know
- ☐ Client refused

8. Gender

- ☐ Male
- ☐ Female
- ☐ Transgender male to female
- ☐ Transgender female to male
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Other [If other, Specify]

9. Race *[More than one race is permitted]*

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native / Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Client doesn't know
- ☐ Client refused

10. Ethnicity

- ☐ Non-Hispanic / Latino
- ☐ Hispanic / Latino
- ☐ Client doesn't know
- ☐ Client refused

11. Veteran Status

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

12. Disabling Condition

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

Stanislaus County HMIS Shelter Data Intake

13. Residence Prior to Project Entry *(i.e., the night before project entry)*

☐	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	☐	Rental by client, with VASH subsidy
☐	Foster care home or foster care group home	☐	Rental by client, with GPD TIP subsidy
☐	Hospital or other residential non-psychiatric medical facility	☐	Rental by client, with other ongoing housing subsidy
☐	Hotel or motel paid for without emergency shelter voucher	☐	Residential project or halfway house with no homeless criteria
☐	Jail, prison or juvenile detention facility	☐	Safe Haven
☐	Long-term care facility or nursing home	☐	Staying or living in a family member's room, apartment or house
☐	Owned by client, no ongoing housing subsidy	☐	Staying or living in a friend's room, apartment or house
☐	Owned by client, with ongoing housing subsidy	☐	Substance abuse treatment facility or detox center
☐	Permanent housing for formerly homeless persons (such as: CoC project; HUD legacy programs; or HOPWA PH)	☐	Transitional housing for homeless persons (including homeless youth)
☐	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	☐	Other (if other, specify) _____
☐	Psychiatric hospital or other psychiatric facility	☐	Client doesn't know
☐	Rental by client, no ongoing housing subsidy	☐	Client refused

14. Length of Stay In Previous Place

☐	One day or less	☐	More than three months, but less than one year
☐	Two days to one week	☐	One year or longer
☐	More than one week, but less than one month	☐	Client doesn't know
☐	One to three months	☐	Client refused

15. ZIP CODE of last Permanent Address: Zip Code ___ ___ ___ ___ ___

☐	Client doesn't know	☐	Client refused

16. TIME ON STREET, EMERGENCY SHELTER OR SAFE HAVEN Client entering from the streets, ES or SH?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

17. If Yes, Approximate date started?

		/			/				

18. Regardless of where they stayed last night, number of times the client has been on the streets, in ES, or SH in the past three years including today?

☐	Never in the past 3 years (If checked, then skip to #20)	☐	Four or more times
☐	One time	☐	Client doesn't know
☐	Two times	☐	Client refused
☐	Three times		

Stanislaus County HMIS Shelter Data Intake

19. Total number of months homeless on the street, in ES, or SH in the past three years?

- ☐ One month (this time is the first month)
- ☐ 2-12 **(enter # months _____)**
- ☐ More than 12 months
- ☐ Client doesn't know
- ☐ Client refused

20. COVERED BY HEALTH INSURANCE (IF YES, Please answer all questions below) *[All Clients]*

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

Medicaid	No	☐
	Yes	☐
Medicare	No	☐
	Yes	☐
State Children's Health Insurance Program	No	☐
	Yes	☐
Veteran's Administration (VA) Medical Services	No	☐
	Yes	☐
Employer-Provided Health	No	☐
	Yes	☐
Health Insurance obtained through COBRA	No	☐
	Yes	☐
Private Pay Health Insurance	No	☐
	Yes	☐
State Health Insurance for Adults (Medi-cal)	No	☐
	Yes	☐

21. DOMESTIC VIOLENCE Experience: Is client a domestic violence victim/survivor?

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

↓ **[IF YES]** When Experience Occurred?

- ☐ Within the past three months
- ☐ Three to six months (excluding six months exactly)
- ☐ Six months to one year ago (excluding one year exactly)
- ☐ One year ago or more
- ☐ Client doesn't know
- ☐ Client refused

↓ **[IF YES]** Are you currently fleeing?

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

Case Information: Garden Gate Staff Comments:	**HMIS Information: HMIS Staff Comments:**
Form Completed by:	Staff Entering Data into HMIS:
Date Completed:	Date Entered into HMIS:

Stanislaus County HMIS Shelter Data Intake

1. Project Exit Date (e.g., 05/24/2015)

		/			/				

2. DESTINATION:

☐	Deceased	☐	Rental by client, with VASH housing subsidy
☐	Emergency Shelter, including hotel or motel paid for with emergency shelter voucher	☐	Rental by client, with GPD TIP housing subsidy
☐	Foster Care home or foster care group home	☐	Rental by client, with other ongoing housing subsidy
☐	Hospital or other residential non-psychiatric medical facility	☐	Residential project or halfway house with no homeless criteria
☐	Hotel or motel paid for without emergency shelter voucher	☐	Safe Haven
☐	Jail, prison or Juvenile detention facility	☐	Staying or living with family, permanent tenure
☐	Long-term care facility or nursing home	☐	Staying or living with family, temporary tenure (e.g. room, apartment or house)
☐	Moved from one HOPWA funded project to HOPWA PH	☐	Staying or living with friends, permanent tenure
☐	Moved from one HOPWA funded project to HOPWA TH	☐	Staying or living with friends, temporary tenure (e.g. room apartment or house)
☐	Owned by client, no ongoing housing subsidy	☐	Substance abuse treatment facility or detox center
☐	Owned by client, with ongoing housing subsidy	☐	Transitional housing for homeless persons (including homeless youth)
☐	Permanent housing for formerly homeless persons (such as: CoC project, or HUD legacy programs, or HOPWA PH)	☐	Other _____
☐	Place not meant for habitation (e.g. a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	☐	No exit interview completed
☐	Psychiatric hospital or other psychiatric facility	☐	Client doesn't know
☐	Rental by client, no ongoing housing subsidy	☐	Client refused

3. EXIT REASON:

☐	Left for Housing before completed	☐	Completed Program
☐	Non-Pay of Rent/Occupancy charge	☐	Non-Compliance with Project
☐	Criminal Action/Property Destruction	☐	Max Time Allowed in Project
☐	Needs could not be met by Project	☐	Disagreement with Rules/Person
☐	Death	☐	Other _____
☐	Unknown/Disappeared		

Case Information: Garden Gate Staff Comments:	HMIS Information: HMIS Staff Comments:
Form Completed by:	Staff Entering Data into HMIS:
Date Completed:	Date Entered into HMIS: