Sacramento County
Mental Health and Quality of Life Response

Community Input on Goals and Design

Purpose

The County of Sacramento engaged community members to gather input on an emergency response for mental health and quality of life crises, including homelessness. This report describes community recommendations for a mental health and quality of life response.

Format

Behavioral Health Services provided the following two options for community input:

- **Listening Sessions & Follow-up Survey**. Two virtual Community Listening Sessions were held on October 29 and November 4, 2020. A total of 50 County staff from Health Services and other County departments supported the events. After the events, a survey was distributed to participants to identify their background and demographics, as well as collect feedback about their experience of the event.

  To be as inclusive as possible, interpretation was available in the following languages for both events: Arabic, Chinese, Hmong, Russian, Spanish, Vietnamese, American Sign Language (ASL) and Real Time Captioning (RTC). Upon request, interpretation was available in Tagalog for the November 4th event. Mental Health Counselors were also available for both events to provide support as needed.

- **Community Input Survey.** To accommodate people who were unable to attend a virtual session, an online survey was distributed with the same questions from the listening session and the background and demographic questions referenced above.

The questions asked during the Listening Sessions and on the Community Input Survey were:

A. What do you think the goals for a Mental Health and Quality of Life Response should be?
B. What types of crisis situations would you want this team to respond to?
C. How would you like to access this response?
D. What do people experiencing these types of crises need?
    a) What qualities and skills are important for the response team to have?
    b) Who should be on the response team?
E. What services should the response team be able to provide?
F. What type of follow up support would you like to receive after the crisis?

To gather more feedback about quality of life responses, a conversation with five homeless advocates was held on November 20, 2020. Additional details on the Listening Sessions can be found in Appendix A.

Participants

A total of 568 individuals participated in a Listening Session event (192 participants) or the Community Input Survey (376 participants).

568
Community members provided input about the ideal response to mental health and quality of life crises

Stakeholder Groups

Most participants (84%, 475 people) provided information about their backgrounds and demographics, including roughly half of Listening Session Participants (52%, 99 people).

As shown below, over half of participants had direct personal experience with mental health crises or experience responding to mental health crises as a friend, family member, or provider. Over one-quarter of participants had experience responding to homelessness as a friend or family member, and a few people had direct experiences of homelessness (3%) or worked with people experiencing homelessness as providers or advocates (1%). Additionally, 22% of participants identified as interested community members without any direct experience related to mental health or homelessness; 3% of participants were current or former foster youth; and 2% were veterans.

Participant Backgrounds related to Mental Health and Homelessness

- **57%** **Friends or family members** of someone who has experienced a mental health crisis
- **28%** **Friends or family members** of someone who has experienced homelessness
- **25%** People who have **experienced a mental health crisis**
- **20%** **Behavioral health (BH) provider or staff**
- **3%** People who have **experienced homelessness**
- **2%** **Member** of the Sacramento County Mental Health Board or Mental Health Services Act (MHSA) steering committee
- **1%** **Homeless service provider or advocate**

In addition to the stakeholder groups listed above, participants identified as working in the following professions: Education (12%), Ethnic services provider (3%), Faith-based service provider (6%), Law enforcement (2%), Physical health provider (9%), and Social service provider (19%).

Community Member Demographics

The demographics of participants who completed the demographic survey are roughly proportional to the County population for American Indian/Alaska Native and Black/African American, and somewhat overrepresented for White/Caucasian. The racial/ethnic groups that appear to be somewhat underrepresented among participants are Asian American, Hispanic/Latino, and multiracial, despite targeted outreach to community centers representing these racial and ethnic groups. Future outreach efforts will include a focus on engaging these populations.

Race/Ethnicity	**Overall Participants** (n=444)	**County Population[1]**
American Indian/Alaska Native	3%	1%
Asian American, Native Hawaiian and Pacific Islander	9%	17%
Black/African American	10%	10%
Hispanic/Latinx (of any race)*	10%	24%
Multiracial	3%	8%
White/Caucasian	65%	53%

**Note that County Population total exceeds 100% due to the tabulation of Hispanic/Latinx of any race.*

Over three-quarters of respondents identified as female (77%); 21% identified as male; 1% identified as transgender; 1% identified as non-binary or genderqueer; 0.4% identified as intersex, and 0.2% identified as two-spirit.

The primary language of the vast majority of participants was English (97%). Other languages spoken by 1% or less of participants include Spanish, Armenian, American Sign Language, German, Hmong, Portuguese, Mandarin, and Mien.

Next Steps

Per Supervisor Kennedy's guidance to propose alternatives for a Mental Health Response, the next steps for the County are to analyze proposed models and potential pilot approaches; assess cost and determine fiscal options; and obtain Board approval for pilot program by February 2020. A plan will be developed for an advisory board with community member representation to provide input on the response and help inform its development and implementation.

Mental Health and Quality of Life Response: Summary of Community Input

The top themes that participants identified for a Mental Health and Quality of Life response are as follows:

Goals for a Mental Health and Quality of Life Response (p. 5)

1. **Safely de-escalate crises.**
2. **Provide linkages to accessible and affordable mental health resources to decrease repeat crises and emergency department visits.**
3. **Offer a response team that does not include law enforcement staffing.**
4. **Ensure the model is community-based.**
5. **Decrease criminalization of mental health and homelessness.**

Types of Crises (p. 8)

- Mental health/psychiatric
- Substance use
- Domestic violence and sexual assault
- People experiencing homelessness
- Other crises (e.g., welfare checks, child and vulnerable people protection, elder abuse)

Access to the Response Team (p. 9)

New 3-digit emergency phone number that is independent from 911

"No wrong door approach" to access the response team through existing service phone numbers (e.g., 211, 311, and 911)

Include **language interpretation** and ability to **access via a website**

Response Team (p. 9)

Composition

1. Mental health clinicians
2. Peers with lived experience
3. Social workers
4. Medical clinicians

Skills and Expertise

- De-escalation
- Trauma-informed
- Background in behavioral health
- Responsive to race, culture, gender & disability

Crisis Services (p. 13)

- Housing & shelter
- Mental health assessment & services
- Food, water & other survival needs
- Medical care & medication
- Crisis stabilization & respite centers

Follow Up Support (p. 14)

- Ongoing follow up & case management to connect individuals to services and social support
- Transportation & financial assistance
- Wraparound services; including family & loved ones in the follow up planning
- Needs assessments for people experiencing homelessness

Key Findings

For each question, the most commonly selected responses (up to 5 themes per question) are highlighted and described. Illustrative quotes for the main themes are also presented.

A) Goals for a Mental Health and Quality of Life Response

The top 5 overall goals that participants identified for a Mental Health and Quality of Life response are as follows:

1. **Safely de-escalate crises.**
   This includes ensuring physical and emotional safety by de-escalating and stabilizing the crisis with compassion and without the presence of weapons. It also includes efforts to maintain a safe environment and conduct safety planning. In addition, some participants mentioned providing resources to family members and loved ones to help address the needs of the individual in crisis.

2. **Provide linkages to accessible and affordable mental health resources to decrease repeat crises and emergency department visits.**
   This includes assessing individuals' needs and the circumstances that led to the crisis, then supporting them in accessing ongoing, affordable care for mental health and/or substance use. It includes providing case management services and following up as needed. Some participants also advised that this should include free, COVID-19-safe transportation to receive mental health care and wrap around services.

3. **Offer a response team that does not include law enforcement staffing.**
   Participants described a variety of crises, including some personal experiences, for which a law enforcement response was not warranted or well-suited. They suggested an unarmed mental health response team that is separate from law enforcement to respond to mental health and quality of life crises.

   Some people indicated that skilled mental health professionals can de-escalate aggressive individuals experiencing mental health crises, and others indicated that law enforcement presence was necessary for violent situations.

4. **Ensure the model is community-based.**
   This refers to staffing the response team with community-based organizations and connecting individuals to community-based services including mental health care. Participants described a need to focus on serving individuals in the community while avoiding hospitalization or incarceration.

   Some participants specifically referenced existing community-based organizations that are currently addressing these crises, particularly "Mental Health First." Some participants also recommended that a community advisory board be established to provide input on the response design and implementation.

5. **Decrease criminalization of mental health and homelessness.**
   This refers to diverting people experiencing mental health and quality of life crises from police contact, arrest, and incarceration.

Participant Quotes for Mental Health and Quality of Life Response Goals

Goal	Participant Quotes
1. Safely de-escalate crises	"The goals should be to primarily deescalate the situation in a non-violent way. The team responding should show compassion and not be threatening in any way. The person in crisis needs to be respected." "Maximizing care and minimizing threat - definitely no armed response in the absence of obvious peril to others." "Helping the person in crisis deescalate so they're safe in the moment, provide no-pressure options for connections to resources specifically related to their mental health and/or quality of life crisis that they can access right away or at a future time."
2. Provide linkages to accessible and affordable mental health resources to decrease repeat crises and emergency department visits	"The goal is to 1. Assure the person in crisis is in a safe environment, and 2. The person in crisis (and family or caretakers) have clear options for addressing the health crisis that are affordable and realistic." "Safety plans made in case of potential future crises and/or threat to others or one's self, clear explanations as to how to access MH care and how to navigate paying for it." "Basic needs being met first, then follow up with dignified mental health care and/or addiction treatment and personalized advice/counseling to come up with a long-term plan."
3. Offer a response team that does not include law enforcement staffing	"People respond better to peer support rather than law enforcement. A mobile integrated model with clinicians, peers, and substance use disorder specialists should be used to avoid emergency room visits or jail." "Any incident where there has not been a report of violence, for example, a domestic disturbance call from a neighbor or family member where there's only a report of raised voices but not violence, should get a community services response, not an armed response from police. Police have too much on their plates already - they're playing family counselor, mental health therapist, and nurse all at the same time. Saving armed responses for potentially violent (where credible specific and direct threats of violence have been made) or violent situations would be advisable." "As someone who works in mental healthcare, I am often confronted by aggressive, occasionally violent individuals experiencing a mental health crisis and I am trained how to respond without further escalating the situation or pulling a gun. This is what we need in the community."

Goal	Participant Quotes
4. Ensure the model is community-based	"Connect with community supports to help me navigate after the immediate crisis has passed." "Need to be from the community and familiar with the community. Continue services and invest in programs like Mental Health First, Street Team EMS doctor." "Coordinating with agencies who already have a relationship with community (i.e., La Family, Hmong) members in a joint response to resolve the crisis." "Implement a community advisory board with impacted people to inform the design and implementation of an alternative, non-law enforcement response for mental health and homeless needs."
5. Decrease criminalization of mental health and homelessness	"Eliminate situations where people with mental health crises are being put in County Jail-that is not going to help. First point of contact should be with MH professional who can help take you to the right place." "It's important to not criminalize mental health issues." "Respect and kindness from a responder with primary expertise in mental health; not a first responder with primary expertise in criminal activity." "Goal #1: Make sure we have resources through this line that have a response team that will treat anyone going through a mental health crisis with respect and care and get them the resources they need (instead of going to incarceration)."

Personal Stories

Several participants shared personal stories that illustrate the key themes, as demonstrated by the following excerpts:

"I am a Family Medicine physician living and working in Sacramento. I strongly support having an alternative response to calling 911 for people who are experiencing a mental health crisis. As a physician, I have seen countless times when calls to the police or to security escalate a tense situation rather than deescalating. Simply seeing officers in uniform trigger patients and it becomes much more difficult to provide the care that they need. Every time I am called about an agitated patient, I request the police/security to stay outside of the room and out of view so that I can talk with the patient in a calm environment without fear. I have not been afraid of harm to myself and if I or another health care provider is able to talk with the patient, we are often able to deescalate. It is much harder to deescalate when the police/security are present and creates more safety concerns for all parties involved."

Personal Stories (continued)

"…When I was going through an episode I was scared, and the cops scared me more. I was aggressive because I was scared."

"Recently, a patient of mine was concerned that their loved one has not slept in 5 days and they were saying things that didn't make sense. This person seemed to be hearing and seeing things that nobody else did. The family member had tried calling the person's primary care doctor but there were no available appointments, and they are becoming increasingly worried that their loved one would hurt themselves or get worse. So they call 911, the police show up, when the person wouldn't engage with them, the police attempt to arrest this person and when this person resists arrest, they had to restrain him which ultimately lead to him breaking his arm and being put in county jail with a broken arm.

In my opinion: what this person needed was someone to listen with undivided attention to understand where they were mentally and their families concerns. Then a plan needed to be developed as to how to get this person who was clearly in a mental health crisis into medical care. The family would have benefited from reflective listening in nonjudgmental way, take time to understand the root of the crisis and affirm the complex factors that have played into getting this person where they are.

When this person resisted arrest, as to be expected, using techniques to deescalate if someone is in crisis or making threats would have been helpful. You want someone who understands resources available and can explain how to access options as well as refer you to a higher of level care when needed."

B) Types of Crises to which the Team Should Respond

The majority of participants indicated the response team should ideally respond to **mental health, psychiatric, and substance use** crises. Many people also noted it would be helpful for the response team to address situations involving **domestic violence and sexual assault**, **people experiencing homelessness**, and **other types of crises** including welfare checks, child protection, vulnerable people protection, and elder abuse.

As one respondent described:

> *"Respond to suicidal threats, odd behaviors, delusions, hallucinations, or angry behavior that may make community members feel uncomfortable. Families calling about family members who are not eating, self-isolating, not taking care of themselves; elder abuse.*
>
> *Do not think they should respond to people with weapons or domestic violence due to safety concerns. Perhaps give people who call for domestic violence the option of law enforcement or social worker coming out to support."*

C) Access to the Response Team

Most participants expressed a need for **a new 3-digit emergency phone number** that is independent from 911 to dispatch the mental health and quality of life response. Some participants also noted that it would be helpful to also utilize a **"no wrong door approach,"** so people are able to access a mental health and quality of life response team through existing service phone numbers such as 211, 311, and 911.

Some participants advised that the access line should include **language interpretation**. Several participants noted that they would like **access via a website**, and that it would be helpful to publicize the new number through a **communications campaign**.

Quotes that illustrate these key themes include:

> *"Definitely explore alternatives to 911 that is a dedicated 3-digit number; online data entry/intake form available that may be able to be addressed the next day & needs to be a commitment to respond within 24-48 hours vs the community member needing immediate help."*
>
> *"An alternate phone number for mental health INSTEAD OF 911 is of vital importance. Law enforcement has their hands full with criminal calls with the mental health element. Lessen their burden with an alternative phone number!"*
>
> *"Those in crisis need to know that they can get better, they will get better, there are resources in the community that can help and help ASAP. An UNARMED response team available 24/7 (as opposed to the current team that is only available during business hours) that has a licensed mental health professional AND a social worker (therapist are not trained to be a community navigator)."*
>
> *"Independent dispatch systems, not connected to law enforcement, that give immediate and low barrier access to services. The #1 priority reflected in People's Budget survey data is community-based mental health support. This requires an independent emergency phone number and 24/7 dispatch system so communities can feel safe to call it during crisis, and not fear potential interaction with law enforcement."*

D) Mental Health and Quality of Life Response Team

Response Team Composition

The majority of participants recommended the following composition for a multi-disciplinary response team:

1. **Mental health clinicians** with psychiatric expertise to assess mental health, access mental health records, to connect individuals to providers within the system of care.
2. **Peers** with lived experience who can build rapport and support the individual experiencing crises.

3. **Social workers** who are knowledgeable about community resources and can conduct warm hand-offs, case management, and support access to benefits and housing.
4. **Medical clinicians** who can conduct medical assessments as well as provide emergency psychiatric medications with a doctor's order. Some participants noted a clinical health background helps address physical health issues that may accompany or underlie mental health crises.

Response Team Role	Participant Quote
1. Mental health clinicians	"Someone who is qualified to interview or have a conversation with the person to 'listen' and 'hear' them. Only a qualified therapist/ counselor/psychiatrist can really understand what a person in distress is trying to communicate or what type of mental health issue is causing adverse behavior." "…clinical skills and access to [mental health records] to be able to see if part of the system – can reach out to outpatient provider if linked and quickly connect to help avoid having to send to the emergency rooms. Able to connect to services in the community. Clinically, be able to know what we're looking at – assess what's happening (psychosis, depression, etc). Ability to demonstrate empathy and engagement." "Trained mental health professionals and social workers are able to recognize how a person is behaving and are more skilled in judging if someone is likely to hurt themselves or others, or if they just need resources, care, or advice in their time of crisis."
2. Peers	"In this team there needs to be some peer support and lived experience. Need to be trained and attuned to the system they are responding to and the dynamics of the family system and community system." "It's incredibly important that the people who show up on these calls, look like normal people and talk like normal people. Having that peer support person with lived experience is important." "Increase role of peers and community health workers specifically communities that are underrepresented, those impacted by socio-economic status, and racial and cultural stressors, and systemic oppression and interpersonal violence. Those with these experiences can take the lead as peers and community workers to deliver these services in a way that meets people where they are at."
3. Social worker	"Social workers who know the community's resources well and are not going to give them a piece of paper." "They need social workers! They need people that are able to understand their behavior and not respond with deadly force when it's unnecessary. They need people trained to LISTEN FIRST. They need people flush with knowledge of local community agencies to

Response Team Role	Participant Quote
3. Social worker (ctd.)	assist them with mental health care, housing needs, medical problems, financial resources such as assistance with SSI, etc."
4.Medical providers	"Able to have live remote access to a physician in case pharmaceutical intervention is needed." "They need trained mental health professionals; EMS personnel who can assess for and administer field care for things like substance overdose; and non-triggering supportive administrative staff (e.g., those who can get them access to needed services)."

Response Team Skills and Expertise

Participants most commonly cited the following skills and expertise as important for the response team to possess:

1. **De-escalation**. This refers to the ability to keep people calm and safe without the use of force.

2. **Trauma-informed.** Participants described this as being compassionate, listening without judgment, validating feelings, and respecting individual's choice and control. This skill helps to stabilize the crisis situation while avoiding potential triggers and minimizing additional trauma. Some people also mentioned the need to be aware of different types of trauma (e.g., complex, historical, and intergenerational traumas) and how they affect mental health crises.

3. **Background in behavioral health.** This refers to knowledge, experience, and training in mental health and substance use to recognize symptoms, assess their severity, and provide the appropriate response.

4. **Responsive to race, culture, gender and disability.** This includes multicultural and multilingual response teams that understand implicit bias and are able to respond to specific needs related to race, culture, and gender with humility. Some participants also described the importance of ensuring the response team is equipped to identify and meet the needs of specific populations, including people with disabilities (e.g., intellectual and developmental disabilities), youth, and older adults.

Skill/Expertise	Participant Quote
1. De-escalation	"The response team should be made of professionals who are trained and skilled in providing de-escalation tactics, calming the situation, and providing supportive mental assistance. This first step may be the difference between life and death, and great care, at any expense, is worthwhile to get it right the first time. After that, the appropriate post-crisis services can be provided." "They probably want to know that someone cares about them and that they aren't only perceived as a threat. They need someone who will help them feel safe and be able to get to a safe place."

Skill/Expertise	Participant Quote
1. De-escalation (ctd.)	"Someone who is calm, approachable, knowledgeable about MH crises and empathetic. I worked in one of the most intensive outpatient settings in Sac County and deescalated everything under the sun with no harm done. I am a LCSW."
2. Trauma-informed	"I really think that the most important skill is being nonjudgmental. I'm here to listen. I'm still going to treat you with some respect and dignity. Allow the person time to communicate their needs and wants during the crisis." "Training that includes being trauma-informed […] maintaining a holistic approach to offering a person culturally sensitive emotional, mental and physical safety with dignity, compassion, care and choice that reflects their path toward recovery. This can mean a faster, more complete recovery, especially with early intervention." "People in these situations are often met with judgement and treated less humanely than other members of our community. Responders should have trauma training as well to avoid re-traumatizing people while attempting to provide assistance." "Trauma informed response team, and one that understands the unique needs of the population. Efforts made to reduce law enforcement involvement to reduce fear of punishment and additional triggers that may escalate the situation."
3.Background in Behavioral Health	"They need expertise and compassion - someone level-headed and familiar with common symptoms of mental distress with knowledge of how to best respond. Likely medical professionals / mental health experts." "Need people trained in mental health, addiction, and compounded trauma response. Persons on a crisis team need to be aware of Spectrum of Intervention for Mental Health Problems to measure and assess how best to assist with dual diagnosis and co-morbidities."
4.Responsive to race, culture, gender and disability	"Having folks from diverse backgrounds are important. Race, gender, sexuality, languages." "Our county is large and has large cultural population groups – make sure we are responding to trauma and cultural and linguistic needs of different populations and subpopulations." "People responding […] who understand racial bias deeply and have done their own work, and who work to make a genuine connection with the individual."

E) Crisis Services

The most frequently described services that participants indicated the response team should be able to provide are:

1. **Housing and shelter** suitable to individual's needs and utilizing a housing first approach.
2. **Mental health assessment/evaluation and services** that individuals may be referred to after an evaluation. Some people described the importance of transportation assistance and peer accompaniment to mental health and substance use treatment services.
3. **Food, water, and other survival needs.** This includes providing a meal, water, and other items needed for survival to respond to an individual experiencing mental health and/or quality of life crises.
4. **Medical care and medication.** This includes immediate medical services for urgent needs, connection to ongoing physical health care, and assistance accessing medication.
5. **Crisis stabilization and respite centers**. This includes 24/7 drop-in centers where people can access mental health care and safety while intoxicated or under the influence of substances.

Service	Participant Quote
1. Housing and shelter	"Homeless: Great if there was availability to help homeless individuals resources they need to get them housed (i.e., access to shelters, temporary housing). Access to immediate resources" "Meet people where they're at with relevant and safe housing and services. They need to be non-punitive and without coercion to be successful." "We need more affordable housing, employment training programs, and robust mental health and substance abuse programs. The lack of inventory of housing and services available is what leads to the issues needing alternatives to calls to 911." "The obvious answer is a home. In the event of a crises they need medical attention, social work, a safe place to store belongings and shelter for pets. When people living on the streets need medical attention, they have to worry about what will happen to their belongings."
2. Mental health assessment and services	"Immediate access to counseling and wellness services." "Consistent availability of support services, i.e., regular counseling available weekly to address mental health factor and reduce the likelihood returning to crisis functioning (once a month does not cut it, nor does a 15-minute check in), Psychiatric assessment of mental health/meds assessment. Assessment of life issues contributing to the crisis instability (inconsistent availability of housing, food, social support system, etc.)."

Service	Participant Quote
3. Food, water, and other survival needs	"Provide food, water, on the spot health care, and an assessment of their support system, social contacts. Connect with those people and work with them for support, survival, coupons to fast food, etc." "Give people a bottle of water, a sandwich. The first moments will dictate how the situation will go." "For me, as an outreach worker, it's really important to have concrete things to offer people (car ride, etc) and to have flexibility." "Many do not believe they are mentally ill, so we need to offer other support services like shelter and food or money to bring them along to a place of trust where they will accept medication and therapy and coaching. Contact family members or friends if possible."
4. Medical care and medication	"See if they have any urgent medical issues or have alcohol or other drug issues that need attention." "I don't think every mobile team would need a health professional, but there should be one to access when needed. That way people wouldn't need to go the ED for medical clearance [before accessing the Mental Health Treatment Center]."
5. Crisis stabilization and respite centers	"A safe place to go like local 'urgent care clinics' that only specialize in behavioral health issues that are easily accessible when you have an immediate need for this type of help and where people that are trained in behavioral health can see patients to more easily follow up with after a crisis. Hopefully having better support would prevent some of the crisis situations. I have just in the last 36 hours taken my husband to a local hospital for his 2nd 5150. There are no beds available. He is now in crisis sitting in the busy emergency room where it is noisy and a lot of people coming and going. Literally the last place I want to take my already physically health compromised husband with an added mental health crisis needs during a pandemic to get treatment, i.e., drugs, to help control his mania. We sat in the ER waiting room from 10 PM to 4 AM until there was even a bed available in the ER and then other than taking his blood pressure, no one came to see him until another 6+ hours later. We can do better for all health issues, not just behavioral health issues."

F) Follow Up Support After the Crisis

The majority of participants indicated that **ongoing follow up and case management** is needed to ensure individuals are **connected to support networks and services** and to prevent mental health and quality of life crises from reoccurring. Many participants also recommended **providing transportation and financial assistance** to help individuals access needed services. Other specific types of follow up that participants described included support **rebuilding social support systems** and including family and loved ones in the follow up plan; **wraparound services**; **needs assessments for people experiencing homelessness;** and **job support** services.

Quotes that illustrate these key themes include:

> "*Safe, rapid response with comprehensive follow-up care and case management to prevent future crises."*
>
> *"Given the limited availability of housing/program openings, consistent case management is needed for providers to stay in touch with individuals and help them get through the process, such as applying for social security and Medi-Cal, etc."*
>
> *"Follow up should include mental health service coordinator and someone who facilitates the bridge between short term and long term care (options for housing, access to rehab, job services – whatever that definition of stability is to them). Mindfulness and coping has everything to do with long-term care."*
>
> *"Help with treatment of ongoing medical and mental health issues; help with integrating into the community, staying housed, job training, transportation, healthy food, help with obtaining documents, bank accounts, child care- rebuilding the support structure that enables one to successfully navigate life."*
>
> *"Mental health resources must remain in place indefinitely; these are often conditions that may require a lifetime of treatment and access to medication. Without ongoing support individuals will be unsuccessful in their recovery."*
>
> *"Crisis is over but the underlying reasons are still there. A follow up in person or by phone directing the individuals and family members involved to community resources that can help to alleviate the root causes of their mental health incident, such as financial assistance, healthcare access, medication management, employment aid, counseling services, childcare services, and outpatient services."*
>
> *"This is the reason for case management: someone to check back in. People easily slip back into isolation and need resources. Asking them what type of support they need or connections they want in the community."*
>
> *"Assistance getting to pharmacy to get meds, getting to appt, ability to get to Urgent care if needed. Pts need to feel they have options to get the resources they need, they often feel 'alone' to figure out the next steps of stability after short hospital intervention"*
>
> *"Feeling a sense of being connected to the process-even a card given to the person who was in crisis or an email, text message, letter in the mail. Follow up communication to let people know that they were seen and it is important that their issues are heard and hopefully solved. The person can choose the level of follow up (are you good or do you want us to continue to reach out a few days later, then a week to 14 days later, then a month later?) so they do not feel like they have been forgotten."*

Appendix A: Community Listening Sessions and Input Survey

The Listening Sessions events consisted of a welcome and overview by Jenine Spotnitz, a Program Planner from the Department of Health Services; introductory framing by Bruce Wagstaff, the Deputy County Executive for Social Services, and Dr. Ryan Quist, the Director of Behavioral Health; followed by breakout group discussions with community members (see page 1 for the questions discussed during the breakout groups).

Process Measures	October 29, 2020 Event	November 4, 2020 Event	TOTAL
Number of participants	80	112	192
Number of staff	30	38	50
Number of breakout groups	12	22	34

The Listening Sessions and Community Input Survey were publicized via the Behavioral Health website, County's social media accounts (i.e., Facebook, Twitter, NextDoor), Public Health Twitter, Countywide Event Calendar, Behavioral Health website, Continuum of Care listserv, MHSA listserv, Cultural Competence Committee and Supporting Community Connections mailing lists.

[1] Be Healthy Sacramento. 2020 Demographics. http://www.behealthysacramento.org/index.php?module=DemographicData&controller=index&action=index