Sacramento County
Wellness Crisis Call Center and Response Team

Community Stakeholder Input

Context and Purpose

The County of Sacramento engaged community members to hear input to inform the initial approach and development of the Wellness Crisis Call Center and Response Team (formerly alternatives to 911 for a behavioral health or quality of life crisis) in October and November of 2020. The report of those findings is available here:
https://dhs.saccounty.net/BHS/Documents/Virtual-Meetings/Alt-to-911-community-response/RT-BHS-Community-Input-on-Mental-Health-and-Quality-of-Life.pdf

In August 2021, Behavioral Health Services (BHS) virtually hosted four additional community stakeholder workgroup meetings to gather more detailed input about the following content areas to inform the development of the Wellness Crisis Call Center and Response Team (WCCCRT): community marketing and advertising; training; community resources; implementation; and evaluation. To be as inclusive as possible, Real Time Captioning (RTC) was provided for all events, and interpretation was available upon request.

Overall, 155 individuals participated in one or more community stakeholder workgroup meetings and/or surveys, including 36 County staff. Fewer than half (29%) of listening session participants also completed a demographic survey. Given this low response rate, demographic data are not presented in this report.

The next steps are for Sacramento County Behavioral Health Services, County Counsel, Risk Management, and Labor Organizations to review the input in this report and incorporate recommendations as appropriate and feasible into the WCCCRT program design. The Mental Health Board will review the Advisory Committee recommendations to inform their development of and appointments to the Advisory Committee.

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Terminology note

"Behavioral health" is a broad term that includes the promotion of health and wellness; resilience, wellbeing, and healing from traumatic experiences; prevention, support, and treatment for mental health and/or substance use challenges; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

1. Community Marketing and Advertising

Context
Participants responded to the following questions via breakout groups and a follow up survey:

1. How should the Wellness Crisis Call Center and Response Team be promoted? How do we spread the word about this program (e.g., flyers, specific radio stations, websites, print, emails, trusted messengers)?
    a. Where should the Wellness Crisis Call Center and Response Team be promoted? (e.g., busses, billboards in specific neighborhoods, community leaders, locations such as library)
    b. Consider specific marketing strategies and advertising locations that would be most effective to reach specific cultural communities.
    c. What partners should we reach out to help advertise?

2. We would like to develop specific marketing for different cultural communities. How should we describe the program to attract your community and underserved communities? Please specify the communities you are referring to.
    a. How can we help your community understand how to use the Wellness Crisis Call Center and Response Team?
    b. Are there specific images you think should be included on the advertising?

Findings
Participants provided thoughtful recommendations regarding ways in which the Wellness Crisis Call Center and Response Team could be promoted, including the locations where advertising could be placed and types of groups that could advertise, how to best reach specific ethnic/cultural communities, and specific images and phrases that should be included or avoided on the advertising materials.

Ideas for promoting the Wellness Crisis Call Center and Response Team

- **Social media**, especially referenced as an effective method to engage youth and to de-stigmatize getting help with behavioral health needs.
    - Social media platforms mentioned included: TikTok®, YouTube® and Instagram® (which were mentioned multiple times), in addition to Facebook®, Twitter®, Next Door®, LinkedIn®, dating sites, Meet Up®, Snap Chat®, social media geared to people of color, etc.
    - A participant also suggested that the WCCCRT should have its own social media account.
- **Provide presentations** on the WCCCRT at various locations, including schools and colleges, community-based organizations and events, community centers, businesses, crisis and respite centers, hospitals, farmer’s markets, and other places where

community members tend to gather (see complete list of ideas on page 4).

Participants offered the following specific recommendations for presentations:

- The **recommended frequency** of presentations ranged from bi-weekly to quarterly.
- One recommended presentation **method** is the SacPort model, in which video scenarios are used to help train and educate programs and communities about the resource.
- Host **an event**, or several events within various communities, to **launch the program** and share information about resources. Include speakers and time for the community to ask questions.
- Ensure that **peer specialists** who can attest to the importance and effectiveness of programs like the WCCCRT participate in presentations.
- Present information in a fun yet respectful manner that helps to reduce stigma and takes seriously the needs of communities.

- **Website presence** is critical. Participants stated that WCCCRT should have its own website with contact information, and every Sacramento County website should include a link to WCCCRT as a resource.
- **Traditional media**, including television (TV), newspapers, and radio stations, is another important method for advertising. Some participants noted that TV commercials and public service announcements are visible by many viewers, and that the media outlets should be diverse to make sure diverse communities are reached.
  - A participant suggested that WCCCRT staff could appear as guest speakers on various TV and radio programs. Some media outlets and programs that participants mentioned included local television news, NPR®, 101, 97.5 (KDEE), and IHeartRadio®.
- **Flyers** about the WCCCRT could be shared in a wide variety of public locations, including outside jails and hospitals, various homeless encampment sites, bars, restrooms, restaurants, grocery stores, etc. Additionally, some participants also recommended using promotional materials or "swag" such as fridge magnets that list website and contact information.
- **Billboards,** including both print and digital billboards with images and in multiple languages, were noted as another potential advertising method. Participants noted the content should be clear, culturally/linguistically relevant, fun, and relatable by using personal stories.

Ideas about types of locations and groups which could support advertising

- **Community-Based Organizations and Neighborhood Associations**, including community centers, behavioral health organizations (e.g., NAMI), Community Incubator Lead organizations with the Black Child Legacy Campaign, affordable housing and homeless advocates (e.g., Sacramento Homeless Union, Sacramento SOUP), and grassroots community groups (e.g., Sacramento Sister Circle, Anti-Police Terror Project, Decarcerate Sacramento, Black Woman on Political Action)
- **Faith-based, religious organizations and ethical value communities** (e.g., Hmong Family Community Alliance church, Sikh Coalitions, American Sikh Public Affairs Association, MAS-SSF)
- **Medical institutions and behavioral health facilities**, including hospitals and emergency rooms, mental health hospitals and clinics, doctor's offices, urgent care clinics, Federally Qualified Health Centers (FQHCs), and substance use and prevention treatment centers, programs, and recovery groups (e.g., Alcoholics Anonymous and Narcotics Anonymous)
- **Law Enforcement**, including the Sheriff, Police, and Probation, and providing the WCCCRT phone number and program information on law enforcement websites so individuals can choose to divert calls from 911 as appropriate
- **Services for people experiencing homelessness,** including shelters, respite centers, and crisis centers
- **Professional Organizations**, including the local chapters of the National Association of Social Workers, the Association of Marriage Family Therapists, the Sacramento Valley Psychologist Association, and the Black Psychologists Association
- **Support groups** (e.g., for a variety of topics ranging from LGBTQIA+ to aging and dementia)
- **Libraries and educational institutions** from pre-kindergarten to colleges (including college clubs, fraternities and sororities, etc.), with specific outreach to students, parents, teachers, and counselors
- **County and City departments**, including communication channels used for ongoing communications and previous health related campaigns (e.g., Stop Stigma campaign and Well-Baby campaign)
- **Employment agencies** including Sacramento Employment and Training Agency (SETA), Sacramento Works, the Sacramento Urban League, and temporary work agencies
- **Jails and prisons**
- **Public transportation stations**
- **Supermarkets, marketplaces, and swap meets** (e.g., the Florin Square African marketplace, Little Saigon, farmer's markets)
- **Cafes, parks, and recreational venues,** including concert halls, sports venues and events (e.g., Sacramento Kings, River Cats, Sacramento Republic), public parks (e.g., Cesar Chavez Park and Southside Park) movie theaters, and **community festivals** (e.g., state fair, art walk)
- **Beauty and nail salons and barber shops**
- **Adult day care centers for seniors**

Participants also noted several recommendations about how to best reach specific **ethnic/cultural communities**:

- Advertise in **community-based, culturally specific newsletters** (i.e., Native News by Sacramento Native American Health Center, Expert Pool – Cal Voices, MAS-SSF, Sacramento Observer) and **cultural/ethnic fraternity and sorority group councils** (e.g., National Pan-Hellenic Council).
- Outreach to impacted neighborhoods via "**word of mouth**" and **"pop up events"** as the reputation of the program among trusted community members is important. A participant suggested determining where the highest call volumes for behavioral health are being received in order to advertise and direct **community leader** outreach and rapport-building in those neighborhoods (e.g., potentially South Sacramento, Oak Park, North Sacramento, North Highlands, Downtown Sacramento, Elk Grove, West Sacramento, Orangevale, Rancho Cordova).
- Participate in collaborative events, with emphasis on in person or Zoom presentations to **community and neighborhood organizations**, prioritizing those of Black, Indigenous, People of Color (BIPOC) and Asian-American Pacific Islander (AAPI).
- Use **celebrities and social media influencers** (local and beyond, representing the different cultural communities of Sacramento), as well as **music and videos** to advertise. Including **case studies** and visuals that illustrate **representation and diversity** within WCCCRT and individuals served is very important.

Recommendations for images and phrases to include or avoid on advertising materials

- Use **graphics** that look inviting and **affirming symbols** (e.g., rainbows).
- Images should include persons **representing the community/people of color/marginalized communities** (including people with turbans and beards, men and fathers, inter-racial families, and same gender families).
- Use **community friendly** language that provides a clear understanding of this service, including when to access it and what response people can expect when they call.
- Use a **memorable image** that people can remember and associate with the WCCCRT (consider a mascot or a character).
- Images should be inclusive across socioeconomic statuses.
- Do not use any law enforcement personnel or imagery associated with law enforcement.
- Do not use doctors' coats or imagery associated with medical institutions.
- Use safe symbols and words that convey "we are there to help, not harm."
- For some communities, it may help to convey behavioral health as a health issue, and ensure the framing is broad enough to include situations ranging from alcoholism to domestic conflicts.

2. Training

Context
Participants responded to the following questions via breakout groups and a follow up survey:

1) What types of training would you recommend the Wellness Crisis Call Center and Response Team receive? See below list for ideas and please add any topics as needed.

    12 Broad categories of training (from the Reach Out Response Network report on International Crisis Response Team Trainings)

    - Mental health-related (ex. Mental Health First Aid)
    - Substance use-related (ex. harm reduction training)
    - Working with specific marginalized populations (ex. street-involved individuals); equity/diversity
    - Clinical skills (ex. motivational interviewing training, trauma-informed care training, professional boundaries training)
    - Crisis de-escalation and suicide intervention (ex. ASIST)
    - Situational awareness/personal safety (ex. non-violent crisis intervention, self-defense training)
    - First aid and basic medical training (ex. CPR, tourniquet training, naloxone training)
    - Vehicle operations
    - Operational/logistics (ex. organizational policies, report writing, use of police radios)
    - Privacy (ex. Health Insurance Portability and Accountability Act (HIPPA) compliance) and relevant
      legislation (ex. laws about involuntary commitment and duty to report)
    - Community resources (ex. learning about various resources; referrals) and field training

2) Are there specific trainings and/or trainers you recommend for any of the topics above?

Findings
Participants recommended that the Wellness Crisis Call Center and Response Teams (WCCCRT) receive the following categories of trainings. Training resource recommendations noted by participants are also included.

- **Mental Health, Substance Use-Related, and Clinical Skills**
    - Many participants recommended and emphasized **trauma informed care** (TIC) and vicarious trauma training including specific TIC topics such as **Adverse Childhood Experiences (ACEs)** and **complex trauma.**

- **Mental Health First Aid** was recommended including Youth Mental Health First Aid training.
- A few participants indicated **Assisted Outpatient Treatment (AOT)** and **Laura's Law resources** training should be provided.
- Many participants recommended and emphasized **substance use and abuse** trainings. They mentioned specific topics in this area:
  - Prevention and treatment.
  - Co-occurring mental health and substance abuse conditions, drug induced psychosis.
  - Substance use screenings such as Screening, Brief Intervention and Referral to Treatment (SBIRT) and assessments such as American Society of Addiction Medicine Criteria (ASAM).
  - Harm Reduction approaches were indicated by many participants. Approaches such as Medication Assisted Treatment (MAT), overdose responses and detox interventions were also mentioned.
- Several participants recommended **ethics, boundary and co-dependency training.**
- A few participants mentioned **Motivational Interviewing and Dialectical Behavioral Therapy**.
- A participant mentioned the importance of learning **communication skills** while delivering program and follow-up services. Another participant stated the importance of understanding **body language**. Another participant stated that team members should be trained on how to **support family members and other support persons** who are with individuals being served. Another participant suggested role-playing as a training method.

- **Crisis De-escalation and Suicide Intervention**
  - Many participants suggested **crisis de-escalation** as a training topic, no-force approaches, and **de-escalation approaches specific to diverse communities served**. Pro-Act was suggested as a de-escalation approach.
  - A participant mentioned **risk assessments, suicide risk assessments, safety planning, and 5150 process**.
  - **Suicide intervention and prevention** were indicated by many participants.
  - Specific crisis de-escalation and suicide prevention trainings and resources were suggested by many participants and include: Mental Health First Aid (MHFA), National Council for Behavioral Health, Sacramento County Office of Education, Mental Health First, Crisis Text line, CAHOOTS, Crisis Intervention Team, LivingWorks Suicide Prevention Trainings, safeTALK and Applied Suicide Intervention Skills Training (ASIST).

- **Peer Training**
  - Many participants recognized the need to include individuals with lived experience on the WCCCRT. They recommended providing **mental health, substance use, self-care training to peers** providing support through this program.

- A few participants suggested the following resources for peer training: Cal Voices, NAMI, and WISE University.

- **Working with specific populations**
    - Many participants supported **training on cultural competence and cultural responsiveness as it relates to the impact of racialized trauma on the individual experiencing a crisis**. Some participants also noted the need for training on biases.
    - A participant also included the topic of **faith-based cultures**.
    - **Unique needs of specific age ranges** was also mentioned, specifically youth, transition age youth and older adults.
    - Participants indicated a focus on working with **marginalized populations such as immigrant and refugees, commercially sexually exploited children and youth, individuals who experience human trafficking, sexual harassment, and cyberbullying** was important. A participant stated that **veterans** was another population with specific needs. Many participants highlighted that training for working with individuals experiencing **domestic violence** was needed.
    - **LGBTQ populations** were noted by many participants, who highlighted the importance of understanding and being culturally responsive to a spectrum of sexual orientations and gender identities.
    - Several participants stated that training for the WCCCRT on **how to work with interpreters** as well as **training for interpreters on how to best assist callers experiencing a crisis** was needed. Several participants emphasized ensuring that interpretation services, including the use of video relay service, are available for callers.
    - A few participants stated training should be provided on **how to work with individuals living with disabilities,** such as individuals living with a hearing or visual disability or intellectual or developmental disability.
    - Participants listed training resources such as Sacramento County Behavioral Health Services, Safe Space, OnTrack, Muslim American Society, WEAVE, My Sister's House, Sacramento LGBT Center, Gender Health Center, PESI Inc., University of Minnesota, and California Health Care Interpreter Association.

- **Program Operations**
    - Participants listed protocols and situational procedures that the team should understand such as **decision trees** for knowing how and what to manage verses when to obtain support from a supervisor or law enforcement; **non-violent responses; providing warm hand-offs; when to close-out the service.**
    - Participants also listed training topics relating to informing and protecting individuals served such as how to obtain **informed** consent and release of information while assisting an individual experiencing a crisis; **required mandated reporting** of known or suspected child abuse and neglect and elder and dependent adult abuse; knowing and providing information about the **grievance process;** understanding **legal rights of individuals with disabilities**

(Disability Rights) and individuals receiving mental health services (Patients' Rights).
    - Vehicle operations was mentioned by a few participants relating to **safety and defensive driving** and knowing when not to transport an individual in crisis.
    - A participant mentioned the need for training on **situational awareness** relating to personal safety.
    - A few participants recommended understanding **medications and side effects** as well as **reactions from combining medication and substances.**
    - A few participants mentioned the importance of WCCCRT understanding **program outcomes** and **program evaluations measures.**
    - Several participants emphasized the importance of **including and coordinating with local law enforcement in developing safety and deployment protocols and procedures, defining roles, establishing coordination and communication protocols.**
    - Participants did not have specific recommendations for first aid/basic medical and privacy (e.g. Health Insurance Portability and Accountability Act compliance) trainings.
    - Participants listed the following relevant resources: California Commission of Peace Officer Standards and Training (POST), Therapeutic Options Training, Sacramento County Mobile Crisis Support Team (MCST), local law enforcement agencies and other local first responders, Sacramento County Office of Compliance, Sacramento County Public Health, McGeorge School of Law, 911.gov trainings.

- **Community Resources**
    - Many participants emphasized the importance of WCCCRT's **familiarity with existing community resources and ability to access and/or conduct warm hand-offs to them.** Participants highlighted the following relevant resources: Sacramento County Behavioral Health, including Mental Health and Substance Use, Prevention and Treatment services, Mental Health Services Act funded services, other substance use related services; detox facilities and services; housing resources; benefits; mutual assistance programs, and the child welfare system.

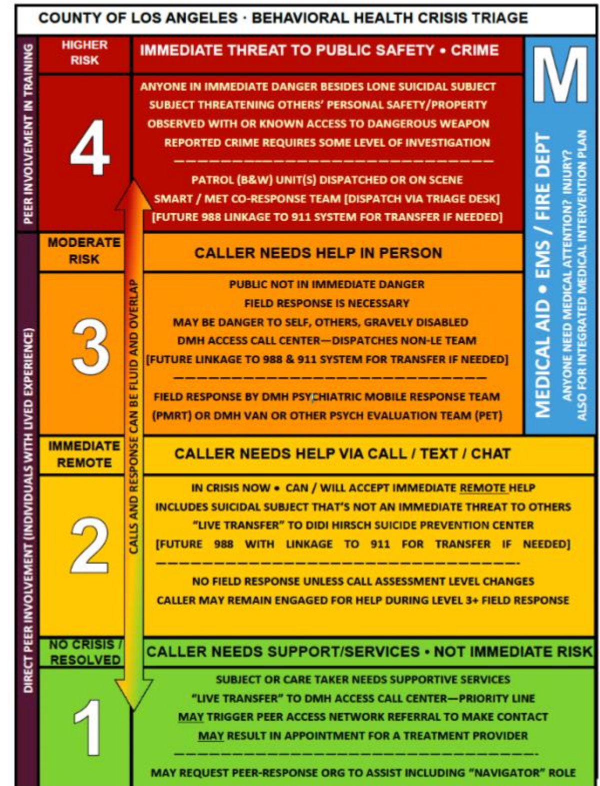
- **Other notes and considerations**
    - A participant recommended job shadowing for new staff, and providing continuing education to WCCCRT.
    - Another participant suggested providing family members and other support persons education and tips for how they can best support their loved ones.
    - A participant noted the need to provide information to the community about the WCCCRT's mission and purpose.

3. Implementation

Context

Participants responded to the following questions via breakout groups and a follow up survey:

1. Do you agree with the 4 levels of risk and criteria that define the levels of risk (in Los Angeles' crisis triage framework at right), or do you recommend any changes?



2. At what point do you think the Call Center staff should initiate a call to 911 (aside from the circumstances that mandate a call to 911 such as health emergency, fire, and danger to others)?

   Definition of Danger to Others: If the client has communicated a serious threat of physical violence against a reasonably identifiable victim or victims, a clinician discharges their duty to protect by making reasonable efforts to communicate the threat to the intended victim or victims and to a law enforcement agency.

3. For what types of calls would you recommend a co-response with other agencies?

   a. Under what conditions would you recommend a co-response between Wellness Crisis Response teams and paramedics?

   b. Under what conditions would you recommend a co-response between Wellness Crisis Response teams and law enforcement?

4. Under what conditions would you recommend diverting calls from 911 to the Wellness Crisis Call Center and Response Team?

5. What do you think the role of peers (individuals with lived experience) should be at the various levels of risk?

   a. What types of supports for peers may be needed?

Findings

Risk Levels and Law Enforcement Involvement

Overall, many participants indicated that mental health and substance use concerns and crises should not be handled by law enforcement, but instead should be referred to Behavioral Health (as described in the previous community stakeholder input report). Participants addressed different considerations and perspectives regarding the assessment of risk and the role of law enforcement within the WCCCRT model.

- **Limiting Law Enforcement:** Many participants indicated that law enforcement involvement was not appropriate, as their intent for the WCCCRT is to separate behavioral health from law enforcement responses. They noted that community callers to the WCCCRT are seeking behavioral health teams "trained in harm reduction and de-escalation" as an alternative to law enforcement responses. Some participants stated that the WCCCRT would be able to de-escalate many crises most effectively without the presence of law enforcement and expressed concern that "people of color and members of the LGBTQI+ community" would be most negatively impacted by law enforcement involvement.

- **Behavioral Health as Response Lead**: Many participants indicated interest in "changing the current culture" to ensure that the behavioral health team can take lead in their area of expertise during crisis responses. They described situations in which they recommended (a) both law enforcement and behavioral health be sent concurrently (co-response), or (b) when law enforcement is on standby for urgent response as needed. They recommended centering behavioral health within these responses.

    a) Co-response: Many participants indicated that there are certain instances where a co-response would make sense. Participants expressed different opinions about the criteria for these situations (discussed in the "high risk" section below), the order of coordination, and the referral pathway between law enforcement and behavioral health. Many participants indicated a need for strong communication and coordination within this model. One situation a participant described is if "someone is threatening to jump into traffic or off of an overpass," then it would be best for law enforcement to block and direct traffic as needed while the behavioral health team is working with a client.

    b) Law enforcement on standby: Some participants indicated situations that may pose some risk which the solo WCCCRT may be able to de-escalate sooner, with law enforcement available for an urgent response if the WCCCRT determines that is needed; otherwise, they can be dismissed and respond to other calls.

- **Defining risk levels**: Many participants articulated "high risk" situations as involving immediate danger/threats to others (with consideration to severity of the

threat and ability to carry it out) and situations in which law enforcement dispatch is legally required. A few participants agreed with the levels of risk and criteria provided in Los Angeles' crisis triage framework and stated that the levels of risk outlined are standard protocol that many counties and states use. Other participants recommended reviewing the CAHOOTS and MH First models' risk factors and triage framework. Participants highlighted several considerations regarding risk determination and mitigation:

- Early referrals to behavioral health assessments: Some participants focused on opportunities to prevent escalation of risk and safety threats by first recognizing behavioral health crises and risk factors, and then referring individuals for behavioral health assessments. One participant suggested that repeat 911 calls be evaluated to identify those that may benefit from behavioral health assessments.

- Safety: Participants expressed consideration of the safety of staff and of people experiencing crises. Many participants indicated the need for risk to be assessed early and often with appropriate behavioral health expertise to ensure safety is a priority to the personnel responding. Many participants indicated that law enforcement involvement should only be triggered if situations escalate into serious, immediate danger.

- Threat of danger to property: Some participants considered this as high risk, whereas others indicated this should be labeled as moderate risk.

- Firearms: Some participants indicated that in the presence of firearms, law enforcement may be the best to call. Other participants focused on the type of risk and differentiated between whether an individual is endangering themselves or others. For example, a participant noted that if a caller "is in immediate risk of harming themselves, they might be best helped by behavior health specialist," and another stated that if a caller is "holding a gun to someone, a co-response may be needed."

- Criminal activity: Participants expressed different perspectives regarding the labelling and treatment of criminal activity. Some participants expressed that "mental health providers should respond to mental health calls while law enforcement should respond to criminal activity," and that "mental health providers may be unable to respond in person when there is a criminal intent and a weapon." Other participants described a need to evaluate the context of the behavior, and as one participant recommended, be "mindful about criminalizing callers/clients, such as those that are under the influence." Another participant described a "lower level of mental health criminal behavior," for example if a "client grabs a knife and is off mental health medications with family in the house," and suggested for the response that the family vacate the premises and the WCCCRT provide behavioral health

intervention to the client.

    - Nuanced Approach: Many participants indicated that determining if law enforcement is needed can be complex, particularly with cases of domestic violence and public safety threats.

- **911:** Many participants indicated a concern about the WCCCRT referring to 911 and indicated it will be important for 911 to be able to divert calls as appropriate to the WCCCRT. One participant explained this is important, as it will take time to build community awareness about the WCCCRT as a response option.

- **Bias:** A participant indicated concern around the framework and the potential of risk assessments to reinforce biases.

Community Resources

Many participants indicated the need for additional community resources for prevention and warm hand offs as a critical part of the crisis response and risk mitigation. Many participants indicated there are systemic gaps that need to be addressed such as support for persons experiencing homelessness, basic essential needs, ongoing case management, post-crisis needs, and other community resources (see more detail in section 6) Community resources).

Medical and Psychiatric Emergencies

Many participants recognized the need for an ambulance and/or EMS if there is a health or medical emergency such as a community member experiencing life-threatening withdrawals or suicidality. They indicated the specific need for some staff, such as behavioral health, to know CPR and be prepared for the possibility of a medical emergency. Many participants emphasized the need for a strong process that would assess and divert situations with an emergency medical component. A few participants asked whether the WCCCRT could include a street medic or EMT to provide basic medical care as needed (as described in the previous community stakeholder input report). Some participants also indicated it may be helpful for the WCCCRT to be able to place 5150 holds and expressed uncertainty about which entity would transport the client in those situations.

Peers

While one participant indicated that peers should only respond when there is not imminent danger, most participants agreed on the importance of including peers on the response team at any level of risk. They stated the response approach should be a non-hierarchical team effort aligned with each team member's strengths. Some participants also indicated that peers have critical skill sets for serving as cultural brokers and de-escalators during crises, in addition to supporting the process of navigating resources and services, acting as life coaches, and assisting follow-up after crises. They also noted the importance of supporting peers after they address crises to help process residual trauma.

4. Evaluation

Context
Participants responded to the following questions about recommended outcomes to evaluate the Wellness Crisis Call Center and Response Team via breakout groups and a follow up survey:

1) If you were a recipient of this service, how would you like to give feedback? For example - follow up via online link, phone call, etc.?

2) What metrics would you recommend be tracked to evaluate the Wellness Crisis Call Center and Response Team?

Performance metric ideas below are from SAMHSA National Guidelines on Behavioral Health Crisis Services.

- Crisis Call Center Services:
    - Descriptive call metrics: Call volume, average speed of answer, average delay, average length of call, caller hang up rate, percentage of calls resolved by phone
    - Number of response teams dispatched
    - Number of individuals connected to a crisis or hospital bed
    - Number of first responder-initiated calls connected to care

- Crisis Response Team Services:
    - Number served per 8-hour shift
    - Average response time
    - Percentage of calls responded to within 1hour...2hours
    - Longest response time
    - Percentage of responses resolved in the community

Findings
Participants discussed conducting surveys and/or conversations to gather feedback about experiences to understand how the program is operating and the impacts of the program. They recommended the following **methods of gathering feedback about the program:**

- Many participants stated that a **phone call** is a good option for obtaining feedback because it is more personal and conversational. Some participants suggested that the WCCCRT offer a follow-up call to ask how the caller is doing and for **feedback.**
- A few participants suggested creating an option to take **an online survey** at the end of a call or in person service and noted this was an ideal method for obtaining feedback. A **link** to this survey could be texted or emailed to individuals. Another participant suggested **creating an app** as another avenue of obtaining feedback.
- Several participants stated that having different options available, such as phone call, survey on-line, texting and emailing link to on-line survey, QR codes.
- Another participant suggested having **quarterly listening sessions**.

Participants recommended gathering feedback from the following groups:

- Recipients of program services.
- Family members and support persons, especially those who were with the individual receiving program services.
- A participant suggested obtaining feedback from providers linked to the caller.

Other notes and considerations that participants shared included:

- Several participants recommended **incentivizing** individuals to provide feedback or take a survey by offering gift cards or through community based organizations.
- A few participants indicated being mindful of **culturally and linguistically responsive** ways of obtaining feedback.
- A participant stated that callers should be informed of the **grievance process**.

Participants suggested obtaining the following information from individuals served:

Demographics

- Level of satisfaction
- Part(s) of service that was most important
- Were needs met
- How did services work
- Was there coordination with other resources
- What more could be done
- How can services improve

Participants recommended tracking the following metrics to evaluate the WCCCRT:

- **Crisis Call Center Services:**
    - Descriptive call metrics: Call volume, average speed of answer, average delay, average length of call, caller hang up rate, percentage of calls resolved by phone
    - Number of response teams dispatched
    - Number of individuals connected to a crisis or hospital bed
    - Number of first responder-initiated calls connected to care

- **Crisis Response Team Services:**
    - Number served per 8-hour shift
    - Average response time
    - Percentage of calls responded to within time increments (e.g., 1 hour, 2 hours)
    - Longest response time
    - Percentage of responses resolved in the community

- **Both Crisis Call Center and Crisis Response Services:**
    - Service was easy to access
    - Community feels safe with this alternative approach
    - Services are responsive to the community's defined needs
    - Reduction in law enforcement calls related to behavioral health needs
    - Reduction in hospitalization and incarcerations
    - Successful navigation to behavioral health services

5. Advisory Committee

Context
The introductory presentation to the community noted that the Advisory Committee for the Wellness Crisis Call Center and Response Team would be a sub-committee of the Mental Health Board (MHB), that its membership would be broader than existing MHB members, and that its function would be to review outcomes and make program recommendations.

Participants responded to the following questions via breakout groups and a follow up survey:

1. What types of experiences and backgrounds would you recommend be included on the Advisory Committee?

2. What other important considerations should be factored in the selection of the Advisory Committee members (e.g., demographics reflect the diversity of Sacramento County)?

Findings
Participants recommended that the following types of experiences and backgrounds be included on the Advisory Committee:

Lived Experiences

Note that participants indicated that it is important to consider the timeframe of the lived experiences, and to seek people who, for example, have these experiences within the last 10 years or so (time frame flexible).

1. People with the **behavioral health lived experience.** This refers to individuals who have directly experienced mental health and/or substance use needs, also known as peers.

2. People who have been involved with the criminal justice system. This refers to individuals who have been **arrested and/or formerly incarcerated**, and especially for individuals who have been arrested or incarcerated while they were experiencing a behavioral health crisis/illness.

3. People who have previously or are currently **experiencing homelessness**.

4. People who are **living with disabilities**, including individuals with developmentally disabilities (e.g., intellectual, physical), cerebral palsy, deafness, blindness, etc. Some people specifically recommended including deaf community members and community members with other disabilities who have experienced police encounters and who have experienced homelessness.

5. **Survivors** of intimate partner violence. Some participants also mentioned including people who have experienced human trafficking or elder abuse, and/or have been commercially sexually exploited children.

Family Members

6. **Family members and caregivers of people who have lived experience** with behavioral health and/or incarceration. Some participants also mentioned loved ones of people who have experienced homelessness or elder abuse.

Work Experience

Participants recommended representation from people with the following types of work experience (either paid or volunteer).

7. **Advocacy organizations** (e.g. related to homelessness, behavioral health, racial equity, and public health)

8. **Behavioral health providers** (e.g., psychiatrist, lead from respite center, provider that operates a support line, specialist in de-escalation)

9. **Alternative Crisis Services and Disaster Relief**

10. **Medical organizations** (e.g., emergency department, or other point of entry into behavioral health services)

In addition to the above, other types of work experience that at least one participant noted include behavioral health policy and business.

Most participant groups indicated that they did not recommend including individuals involved in law enforcement or criminal justice (e.g., sheriff, police, probation). Some participants cited concerns regarding biases and a desire for people who are thinking outside of the cultural status quo. One participant noted that if an individual has former law enforcement background, they should have not served within the last 7-10 years. Another participant noted that law enforcement could be involved to help identify areas that could be diverted to an alternative response.

Representatives from other Commissions and Advisory Boards

1. Adult and Aging commission
2. Alcohol and Drug Advisory Board
3. Disability Advisory Commission
4. First Five or Children’s Coalition
5. Human Services Coordinating Council
6. In-Home Supportive Services Coordinating Council
7. Mental Health Board
8. Public Health Advisory Board
9. Youth Commission
10. A Commission or Board that addresses housing and outreach

Demographics and Backgrounds

Participants expressed that it was important that the demographics of the Advisory Committee mirror the demographics of Sacramento County.
They recommended specific efforts to reflect the diversity of Sacramento County for the demographics below. Some participants expressed that specific demographics who have been the most impacted by law enforcement responses to mental health and substance use situations should be represented or overrepresented.

- **Age groups**, including transition age youth (e.g. ages 14 -24), adults, and older adults. A participant noted that youth with current or former experience in the foster system could be included.
- **Gender**, including individuals who identify as transgender and a diversity of gender identities.
- **Sexual orientation**, including lesbian, gay, bisexual, and/or queer identified individuals.
- **Race, ethnicity, and culture**, including Asian American and Pacific Islander, Black, Indigenous, and Latinx/Hispanic/Latino communities.
- **Language.** A few participants specifically noted including people who speak Spanish and American Sign Language (ASL).

In addition, some participants recommended ensuring representation in the following areas:

- **Geographic representation** from across the County of Sacramento, including underserved areas.
- **Immigrant and refugee communities**
- **Faith communities**

Participants also posed questions and shared other comments, which are compiled below.

Questions from Community Stakeholders

1. How will the Advisory Committee members be selected?
2. Are there any expectations of the Advisory Committee aside from making recommendations?
3. What is the maximum number of members on the Advisory Committee?
4. How can we reach out to people to engage them in this process in a culturally appropriate way?
5. What are the compositions of other similar advisory bodies, and does that match what this community has been advocating for?

Other Community Input

Some participants shared the following comments and recommendations:

- Recruitment should be proactive and intentional to ensure representation from the key groups described earlier.
    - Question: How will we get representation from people with lower socio-economic status on this committee? "Barriers include working late and other barriers to get to the committee and provide feedback. Belief now is that they can't say anything

due to the price they will have to pay. Help these individuals have a voice and show them they are valued and get to use it."

- Make meetings as accessible as possible.
    - Maintain the option to join meetings virtually (e.g., via Zoom).
    - Offer compensation for members' time and energy.

- Use a survey to screen Advisory Committee candidates and include the following questions:
    - Professional backgrounds and job title, and lived experiences. A participant noted the importance of diversity in education levels.
    - What is your purpose on being on the committee/why would you like to be on the committee? What are your overall outcomes/hopes/interests of being on this committee?
    - What are your thoughts around equity/inclusion and how it applies to the work of this committee?

- Provide trainings/education for Advisory Committee members, to include:
    - An overview of the Behavioral Health Services system, existing services, challenges (e.g., policies, practices, barriers) and any relevant upcoming plans.
    - Implicit bias training.
    - Legal rights and rules for Committee members.
    - Training on decision making and reaching consensus.

- Committee Operations
    - Encourage County Behavioral Health Services to attend and listen, and ensure the Advisory Board recommendations reach decision makers.
    - "The County and this committee can work on making this a partnership rather than a hierarchy. This will hopefully help build trust and allow clients to voice their voices without intimidation."
    - "Ensure Members feel like their voices are being heard and valued. One way to ensure voices are being heard is to include a bylaw or procedure regarding recommendations being considered within a certain amount of time."
    - "Make sure that what happens in this committee is taken back to the already established commission and relevant bodies so they stay informed about the decisions being made and allow everyone to work collaboratively."

- Ensure voting ability for all Advisory Committee members. Ensure committee decisions are honored; there is concern about whether this committee's recommendation need approval from the broader MHB.
    - "Look at model from the respite model collaborative for help about how to inform these processes."

6. Community Resources

Context
Participants responded to the following questions via breakout groups and a follow up survey:

1. Here are the categories of resources in SacMAP, which CalVoices developed. Are any resource categories missing? In other words, are there any additional types of services that you would like the Wellness Crisis Call Center and Response Team to be able to refer people to and/or provide warm hand offs to?
    - A. Assistance with Medi-Cal Enrollment
    - B. Counseling
    - C. Crisis Services
    - D. Housing
    - E. Linkage to Services
    - F. Mental Health Respite Services
    - G. Peer Support
    - H. Phone Services
    - I. Substance Abuse Treatment
    - J. Suicide Bereavement Support
    - K. Suicide Prevention
    - L. Support Groups/Training
    - M. System Navigation

2. Within each category, are any resources missing? We are interested in compiling a comprehensive list, including resources that focus on a specific population/community.

3. Are there any other additional specific populations missing from the list on SacMAP? In other words, do any of the new services listed above focus on serving specific populations in addition to the list below? (Languages are a separate category)

Findings
Below are the specific resources that at least one participant recommended including in each pre-existing category, followed by new categories and specific populations that participants suggested including in the resource directory. Please note that this is the original list as brainstormed by community members, and this information has not been verified. As applicable, notes and considerations shared by participants are included as well.

Additional Community Resources in Existing Categories

A. <u>Assistance with Medi-Cal Enrollment</u>
Participants recommended including assistance for SSI/SDI enrollment as well as Medi-Cal enrollment in the resource directory.

- Sacramento Covered
- Covered California
- Department of Human Assistance (DHA)

- County Substance Use Prevention Treatment (SUPT)
- Wellness Recovery Center – North and South
- One Community Health
- Crossroads
- Bay Area Community Services (BACS) Crisis Navigation Program (after an Emergency Department visit/Inpatient stay)
- Elica Health Center
- Peach Tree Health
- El Hogar's Sacramento Multiple Advocate Resource Team's (SMART)- Homeless services
- Capitol Health Network
- Veteran's Administration and VOA
- Resources for Independent Living

Notes and considerations

- All outpatient providers in the Mental Health Plan will help clients with Medi-Cal Enrollment.
- All federal health centers are supposed to accept everyone and have a process to link them to Medi-Cal and other health programs in Sacramento County.
- Participants were unsure about whether The Source and TLCS/Hope Cooperative provide this service. They also noted a law firm, Aullsup,that charges individuals to assist with SSI, SSDI, and other types of enrollment.

B. Counseling

- Adoptive Families Respite at Capital Adoptive Families Alliance (CAFA)
- Bay Area Community Services (BACS) Programs (locally)
- Genesis at Loaves & Fishes
- Peer Counseling/Ripple Effect Respite at A Church For All
- Veterans Administration and VOA
- Center for Fathers and Families
- Family Resource Centers
- Roberts Family Development Center
- Oak Park Community Center
- Meadowview Community Center
- Sacramento Urban League
- College Mental Health Resources
    - Los Rios Community College District Student Services
    - Sacramento State University Student Health and Counseling Services
- Genesis Mental Health at Loaves and Fishes
- Federally Qualified Health Centers (FQHC) – Capitol Health Network
- Alta California Regional Services (contracts out for mental health services)
- Black Indigenous People Of Color (BIPOC) Mental Health Providers: Sacramento County Collectives
- African American Mental Health Provider (AAMHP)
- All providers in Mental Health Plan

C. Crisis Services

Participants recommended indicating which services require and do not require individuals to provide identification, as well as the types of crises that organizations may focus on serving (e.g., homeless, domestic violence, trauma, LGBTQ).

- Mental Health First
- Loaves and Fishes
- WEAVE
- CSU (ISU and Dignity CSU)

- Mary’s House
- Crisis Residential (Turning Point and STAR)
- MHP Community for Peace – DV, trauma, LGBTQ
- Chicks in Crisis
- Community Against Sexual Harm (CASH)
- City of Refuge
- Veterans Administration and VOA
- Adult Protective Services
- Child Protective Services
- SURE Program (no self-referral)
- Ifeatu (supports black families; community crisis intervention for families engaged in child welfare)
- Living Room (24 crisis phone line)
- WellSpace Health Suicide Crisis Line

Notes and considerations

- A respondent noted that there is a need for “refugee crisis services that are culturally competent and linguistically relevant; not just translators but people with training in peer support; and bi-lingual staff trained in peer support. Staff need to have enough experience in the US to understand the rules and regulations in the US to address what things are shared or not based on cultural shame.”

D. Housing, Shelter & Resources

Community stakeholders recommended organizing housing resources by the type of housing and suggested the following categories: Emergency Shelter; Transitional Housing; Other Housing.

Emergency Shelter

- Loaves and Fishes
- WEAVE
- WIND Youth Services
- Common Ground
- Wellness Recovery Center
- Project Roomkey
- Sacramento Self Help Housing
- Next Move
- Salvation Army
- SHELTER, Inc.

Transitional Housing

- Islamic Circle of North America (ICNA) Sacramento
- Sakina House (focuses on the middle Eastern/ South Asian community)
- SHRA Vouchers and Prevention
- Sacramento Steps Forward
- Department of Human Assistance
- Housing support through BHS programs
- 211 Resources

Other Housing

- Room & Boards (e.g., Senior Connections referrals from hospital placement – not just for seniors)
- Board & Cares
- Veterans Administration and VOA

Notes and considerations:

- All community programs in MHP can support with housing if the client is linked to services.
- A few participants expressed frustration with a lack of shelter beds during a crisis. One participant noted a need for effective coordinated entry that is easy to access.
- A participant asked if it was possible to prioritize access to County shelters for this program.

E. Linkage to Services

Participants did not share additional resources in this category.

F. Mental Health Respite Services

- Mental Health First Sacramento (crisis line on the weekend evenings)
- A Community for Peace (survivors of domestic violence and sexual assault crisis line)
- Youth Help Network (ages 16-25)
- AL-MISBAH (food distribution community support focusing on the Middle Eastern/South Asian community)
- WEAVE
- Chicks in Crisis (focused on pregnant and parenting moms)
- First 5
- Francis House
- Danelle's Place – Gender Health Center
- LGBT Center Adult/Youth Respite
- Hope Cooperative (23 hour Crisis Respite program)
- Wellspring Women's Center
- Hope Cooperative
- Sacramento Children's Home Crisis Nursery
- MaryHouse
- Genesis – Loaves and Fishes
- HART (Homeless Assistance Response Team)

G. Peer Support

- Cal Voices
- Sac Homeless Organizing Committee
- Homeless Union
- Sac SOUP (Solidarity of Unhoused People)
- Sacramento Children's Home: The Source (youth peer mentors and family partners and foster youth; mobile response or text/talk 24/7)
- Sac Kids First Coalition
- Capital Star TAY Navigator Program (Youth Help Network)
- Capital Star Commercially Sexually Exploited Children
- Opening Doors
- My Sisters House
- WEAVE
- Daughters of Zion (providing clothes and supports to youth & women)
- Francis House
- Free Support Groups in the community (Apathtorecovery.com)
- Refugees Enrichment Development Association
- Sutter Center for Psychiatry
- African American Healing Network – Robertson Family Development Center
- La Familia (for Spanish speaking individuals)
- Self-awareness Recovery Program – Fruitridge
- LGBT Center (13-27 age youth group)

- PFLAG (for family members of LGBT community)
- NAMI (groups for family members)

Notes and considerations:

- Participants noted a need for peer support for parents and families; support groups focused on adults with disabilities and youth with disabilities (e.g., autism); people who are newly disabled; youth and/or family empowerment (e.g., Rose Family for families in South Sacramento); and for people who have been formerly incarcerated.

H. Phone Services

- Warmline Family Resource Center
- CalHOPE
- Sacramento Children's Home - Cal FURS (Foster Urgent Response System) (available 24/7)
- Sacramento County Mental Health 24-Hour Crisis Line
- Sacramento SOUP and Sacramento Homeless Union

I. Substance Abuse Treatment

Participants recommended renaming this category to "Substance Use Prevention, Treatment, and Harm Reduction Services" in order to be more inclusive and reflect current terminology. They also suggested indicating types of services available, including detoxification/withdrawal
management, methadone clinic, harm reduction services, and overdose support.

- Harm Reduction Services of Sacramento (HRS)
- Safer Alternatives through Networking and Education (SANE)
- Transitions Clinic
- American Homeless Veterans
- Union Gospel Mission
- Behavioral Health Services – Substance Use Prevention Treatment (SUPT) System of Care (24/7 phone number)
- SURE Center
- Mental Health Urgent Care Clinic
- WellSpace
- Gender Health Center
- Methadone Clinics such as MedMark Treatment Center and others in the County
- FQHCs
- Mather Community Campus
- BAART
- Al-ANON
- STARS Behavioral Health (recovery services and SUPT peer support for youth ages 12-26

Notes and considerations:

- The SUPT provider Community Resource List may be helpful for the Wellness Crisis Call Center and Response Team: https://dhs.saccounty.net/BHS/Documents/SUPT/GI-BHS-SUPT-Community-Resource-List.pdf
- Reference the Sacramento County Resource List for Assessment Process and Treatment Facilities.

J. Suicide Bereavement Support

Several participants recommended that "Suicide" be removed from this category title, so that "Bereavement Support" encompasses other types of loss as well.

- Hospitals
- Yolo Hospice of Yolo County (offers bereavement, 1:1 services, LGBTQ Specific Services)
- Widowed Persons Association of California, Sacramento
- Friends For Survival (Suicide Bereavement Support)

K. Suicide Prevention

- Supporting Community Connections (SCC) Sacramento County providers

L. Support Groups/Training

Some participants recommended including "Mental Health and Substance Use Education Classes" as a subcategory of Support Groups/Training.

- NAMI
- SNAHC
- Mental Health First Aid
- Youth Mental health First Aid
- Safe Black Space

M. System Navigation

- APS
- Powerhouse Ministries (in Folsom and near Fulton Ave.)
- St. John's Program for Real Change
- Community Support Team

Notes and considerations:

- Some participants indicated that re-entry services and navigators for people who have been formerly incarceration should be included in this list.

New Resource Categories and Additional Community Resources

Participants recommended that the following categories of community resources be included in the directory of resources that the Wellness Crisis Call Center and Response Team refers people to and/or provides warm hand offs to. Specific suggestions for resources within categories are included as applicable.

- Assistance with benefit enrollment (e.g., CalFRESH, CalWORKs)
- Employment Services
    - Pride
    - Sacramento Works
    - Sacramento Urban League
- Elderly Services/Resources (e.g., to support elders who are isolated, need transportation to appointments)
    - Cal Voices – Senior Support
- Food, water & other survival needs (e.g., blankets, tents, tarps, clothing, wound care, hygiene and feminine hygiene items, diapers)
    - Street Sheet

- Halal food (Al Misbah)
  - Ar-Razzaq Food Bank (via Mosque)
  - Sac SOUP/Sac Homeless Union
- Medical care: Participants recommended including a subcategory of "Low cost healthcare services" (community clinics, public hospitals and other facilities that take Medi-Medi or uninsured – for physical health)
  - One Community Health
  - SNAHC (Sacramento Native American Health Center)
  - Wellspace
  - All FQHCs – Elica and Peach Tree
  - Sac SOUP/Sac Homeless Union – Sacramento Street Medicine
  - Low cost healthcare services (community clinics, public hospitals and other facilities that take Medi-Medi or uninsured – for physical health)
- Medication: Participants noted a need for resources to support with providing medication and refills for individuals without insurance or Medi-Cal.
- Warming/Cooling Centers and Cleaner Air Centers
- Resources for Pets (for those that are experiencing homelessness)
- Transportation (including transportation to shelter)
- Interim Care Access
- Community Based Conflict Management
  - Sac SOUP/Sac Homeless Union
  - Mental Health First
- Technology (e.g., emergency use phones, Go cards)
- Legal Services
  - Loaves and Fishes Legal Clinic
  - Capital Probono (Volunteer Services Legal Program)
- Childcare
  - DHA Stage 1 program
- COVID-19 Resources/ COVID-19 Bereavement
- Stress management
  - DHS Resources on Website Re: Managing Stress
- Financial Services – Help with applying for rental assistance and paying bills, SSI, SSDI Enrollment
- Cultural Brokerage (i.e., any agencies that protect and provide advocacy for special populations)
  - Sierra Health Foundation (SHF) / African American TIWP
  - CPS
- Black, Indigenous, and other People of Color (BIPOC)
  - Sierra Health Foundation/ African American TIWP
  - Supporting Community Connections – A Church For All
  - Safe Black Space
- Immigration
  - La Familia
  - Sacramento Welcome Center
- Resources for people with disabilities that require special accommodations (e.g. hearing impaired, mobility impaired)

    - Resources for Independent Living, Sacramento
- Services for Disabled Parents with able bodied children (e.g., transportation for children to school; assistance with daily living, cooking for children)
- Respite for Caregivers
- Services for Adult/Senior Day Care during the day (e.g., another type of respite care)
- LGBTQIA+ Specific Services and Navigation (e.g. hormone clinics, respite and housing services, gender affirming services, adoption resources for same-sex couples)
    - Gender Health Center
    - LBTQ Center (includes youth respite)
    - Shelter on P Street
    - Danelle's Place (Respite for Transgender individuals)
    - Capital STAR (for transition age youth)
    - LGBT Center Spring 2022 (will have housing program for adult/aging population)
- Human Trafficking
    - Opening Doors
    - My Sisters House
    - International Rescue Committee IRC
    - WEAVE
- Interpretation/ translation services
- Justice system involved
    - Juvenile Justice Diversion and Treatment Program
    - Conditional Release Program (CONREP)
    - Mental Health Court, Sacramento County Public Guardian/ Conservator, Public Defender
- Veterans Services
    - Nation's Finest
    - VA Hospital (Mather)
    - VFW
    - Elks

Notes and Considerations

- The Treatment Center resource packet has additional relevant resources to reference.
- A participant recommended that "when making a referral or providing a warm hand off to callers, ensure that staffing/programs are reflective of BIPOC/LGBTQ and culturally, linguistically and ethnically diverse communities and that the community is aware these diverse resources are available to them. Knowing that they can connect with someone who looks like and understands them and can speak to them in their native language will help with engaging them in times of crisis."
- A participant noted the need to ensure resources have availability prior to referring individuals to them, and another highlighted the need for shelter and housing resources for people experiencing homelessness to support their ability to stabilize from crises.
- One participant noted that ensuring resources are current will be important and require dedicated resources.

Additional Specific Populations of Focus

Participants recommended some new categories and revisions to the existing categories, as noted below.

- Racial/Ethnic/Linguistic Populations
  - Asian American/Native Hawaiian/Pacific Islander
  - Black/African American/Of African decent
  - East Asian populations (including Hmong)
  - Latinx/Latina/Latino
  - Middle Eastern/North African/South Asian
  - Middle Eastern or Arabic Speaking
  - Native Americans and Indigenous Communities
  - Russian Speaking/Slavic Community
  - Afghan
  - Iranian
  - Indian
  - American Sign Language

- Age-specific Populations
  - Children
  - Youth / Transition Age Youth (TAY)
  - Adults

- Populations Based on Specific Experiences
  - Deaf or hard of hearing
  - Faith-based (may include religious and cultural groups, e.g., Muslim)
  - Families and/or Caregivers
    - Parents/Caregivers of Youth
    - Youth who are parents
    - New parents
    - Caregivers of Disabled and/or Older Adults
  - Current and Former foster care youth
  - Formerly incarcerated individuals
  - Incarcerated youth and adults
  - Immigrants/DACA and Refugee populations
  - LGBTQ
  - People experiencing homelessness (individuals and families)
  - People living with disabilities and/or cognitive/developmental delays
  - Perinatal
  - Survivors of Abuse (including intimate partner violence, domestic violence, elder abuse, etc.)
  - Veterans