CRISIS CARE MOBILE UNITS PROGRAM

Crisis Care Mobile Units

Final Action Plan – Due Feb 14, 2023

Introduction

Introduction: To move from the CCMU planning stage to its implementation phase, you must submit an Action Plan. Below is a guiding document for you to use to write your Plan. You do not have to use this document. You are free to create your own format as long as you address the elements in this guiding document.

Your Action Plan will have three major sections: stakeholder involvement and coordination, an assessment, and an implementation plan. Each of these (and their component parts) is addressed below. As you enter responses in the tables below, the boxes in which you type will expand as needed. You may also use this template as a guide to complete your Action Plan document.

Contracted Agency Name	**County of Del Norte Department of Health and Human Services**
Name of Planning Project Contractor	The Indigo Project

Stakeholder Involvement and Coordination: Methodology for Action Plan Development

Methodology. Please describe how you went about developing your Action Plan. For example, did you hire a consultant? Hold stakeholder meetings? If so, how many? How many people attended? Did you consult partners? Did you involve consumers? Did you do any research into best practices? Consult other CCMU grantees?

Include the names of your stakeholders/partners in the *next* section.

To develop a feasible, data-driven Action Plan that leverages the expertise of the County's active and informed stakeholder community, Del Norte County Department of Health and Human Services Behavioral Health Branch (DNBHB) contracted with the Indigo Project (Indigo) to form a Collaborative composed of 22 members— including county partners, service providers, family, and peers — facilitated by the Indigo Project. The Collaborative informed the development of the Crisis Care Mobile Unit (CCMU) Needs Assessment and the subsequent Action Plan. The following six Collaborative meetings were held:

- CCMU Planning Collaborative Launch – September 2
- Needs Assessment Findings and Discussion – October 6
- Crisis Response Model Design: Services and Partnerships – October 24
- Crisis Response Model Design: Staffing and Resources – November 17
- Action Planning – December 15
- Action Planning – January 12

Indigo also held a remote community meeting. Twenty-four community members attended, including system stakeholders and peers, among others, to gather information for the assessment and vet emerging themes, and to provide feedback about what if anything, would be useful information to gather as the County moves towards implementation.

In addition to these meetings, Indigo conducted literature reviews, benchmarking research, key informant interviews, and a consumer focus group, each described in more detail below in the *Assessment* section, to inform the development of this Action Plan.

In the table below, please list your stakeholders and partners along with their affiliations and their contributions to the process. Please insert extra rows as needed.

Stakeholders/Partners	Affiliation	Contribution
Ranell Brown	Health and Human Services (HHS) Director	Collaborative Member
Shiann Hogan	Behavioral Health Branch Program Manager	Collaborative Member
Karena Crowell	Behavioral Health Branch Supervisor	Collaborative Member
Devin Azevedo	Behavioral Health Branch Specialist	Collaborative Member
Maria Coats	Behavioral Health Branch Specialist	Collaborative Member
Patti Austin	Behavioral Health Branch Specialist	Collaborative Member
Nancy McClaflin	Behavioral Health Branch Fiscal Manager	Collaborative Member
Valerie Starkey	Board of Supervisors and Local Behavioral Health Board	Collaborative Member
Jodi Nerell	Sutter Health Director of Local Mental Health Engagement	Collaborative Member
Teresa Bertolini	Sutter Coast Hospital Emergency Department Manager	Collaborative Member
Garrett Scott	Sheriff's Office, Sheriff	Collaborative Member
Richard Griffin	Crescent City Police, Police Chief	Collaborative Member
Bessie Shorty	Yurok Tribal Court's Youth At-Risk Manager	Collaborative Member
Lori Nesbitt	Yurok Tribe Opioid Program Manager	Collaborative Member
Jeri Robertson	Tolowa Dee-ni' Nation Housing Manager	Collaborative Member

Matt Ulm	The SmithWaters Group Patients Rights Activist, Administrative and AOD Director, and Peer	Collaborative Member
Hilda Contreras	Open Door Site Director	Collaborative Member
Maria Durazo	Open Door Clinic Manager	Collaborative Member
Dulce Gomez	Remi Vista Program Manager	Collaborative Member
Becky Bohanon	Remi Vista Office Supervisor	Collaborative Member
Daphne Cortese-Lambert	Mission Possible, Director of Homeless Services	Collaborative Member
Lisa Buitrago-Freitas	Consumer Family Member	Collaborative Member
Roy Jackson	HHS Housing Services Manager	Key Informant
Chief Lonnie Reyman	Probation Department, Chief Probation Officer	Key Informant
Larry Depee	California Highway Patrol, Commander	Key Informant
John Pritchett	Del Norte Ambulance, General Manager	Key Informant
Charles Tweed	Del Norte Ambulance, Operations	Key Informant
Pam Wilder	Del Norte Unified School District, Director of Foster/Homeless Youth Services	Key Informant
Frank SmithWaters	The SmithWaters Group, Director	Key Informant
Bill SmithWaters	The SmithWaters Group, Program Director	Key Informant
William Bowers	Yurok Tribe, Judge	Key Informant
Heather Snow	Open Door Director of Behavioral Health	Key Informant
Elizabeth Austen	Board member of Del Norte Healthcare District	Key Informant

Behavioral Health Consumers (n=12)	Consumers	Focus Group Members
Miguel Rodriguez	Shasta County HHS Children's Services Branch Director and Acting Adult Services Branch Director	Shasta County Benchmarking Research
Laura Stapp	Shasta County Mobile Crisis Outreach Team Representative	Shasta County Benchmarking Research
Karen Larsen	Executive Director of Steinberg Institute and former HHSA Director of Yolo County	Yolo County Benchmarking Research
Kristen Love	Placer County Behavioral Health Client Services Program Supervisor	Placer County Benchmarking Research
Stephanie Lewis	Alameda County Behavioral Health Crisis Services Directors	Alameda County Benchmarking Research

Assessment

Introduction and Summary of Community Assessment: An Overview. **The assessment is a systematic process of gathering and examining information about your community's mental health and/or SUD crises and responses to them. This assessment has two components: a *data* assessment and a *resource* assessment.**

Community Vision and Goals.

Del Norte County and the community of stakeholders has envisioned a crisis system where people can receive immediate support throughout the County regardless of where they live; that is reasonable and feasible given the size and needs of the County; and that leverages the partnerships and collaboration across behavioral health, law enforcement and other first responders, the hospital, the tribes, and community-based providers.

The County and Behavioral Health Collaborative used the following structure to assess and plan their crisis response system:

- Someone to call,
- Someone to come, and

- Somewhere to go.[1]

These categories allowed the Collaborative to review and plan for how people reach out for crisis services, the crisis response itself, and what options might be available for someone who needs more support than can be provided where they are.

The County has a population center in Crescent City and the surrounding area as well as a number of outlying areas (i.e., Smith River, Gasquet, Hiouchi, and Klamath). The County and partners envision a crisis system where individuals are able to access urgent support during a mental health crisis. They also recognize that the crisis response in and around Crescent City may look different then the crisis system that is developed for outlying areas. Collaborative members wanted to ensure that supports could be available even during winter months when access was limited and as such require more than a singular approach.

The crisis planning process also looked at what the true needs in the County are and disregarded approaches that would not be sustainable in the County. For example, many of the programs and services that they were interested in require a higher level of utilization than is present in Del Norte County. Rather than focusing on larger scale programs, the County and partners chose to focus on approaches that were more aligned to the size and scope of the need. For example, programs such as a crisis stabilization unit paired with crisis residential treatment is fairly common across California Counties; however, Del Norte does not have enough need to support these programs. Instead, the County and stakeholders envisioned refreshing the "same-day services" towards a mental health urgent care combined with a crisis respite/peer respite. The County also considered the workforce challenges in mental health as well as in Del Norte and wanted to find ways to employ and strengthen the available workforce.

Finally, the County of Del Norte is rich with commitment and shared responsibility. In many ways, this collaborative spirit is the lens through which the Behavioral Health Collaborative approached their work, and this commitment to partnership across agencies and throughout the community is embedded in the assessment and action plan.

Data Assessment. The data assessment is designed to illustrate the problem. This section must identify what you need to know about crises and crisis services in your community.

Who is impacted by mental health and/or SUD crises in Del Norte County?

There are a substantial number of people in Del Norte County across demographic groups that experience crisis episodes each year. Notably, there were no priority populations that emerged as being the most impacted by mental health and substance use crises in Del Norte County. Instead, there are a diverse group of people being impacted by crises in need of services. Interviews conducted

[1] Somewhere to go was modified to include someone to stay as it pertains to crisis supports for children.

with stakeholders across the County indicated a need for crisis services to have the ability to be flexible in reaching broad populations that spans ages and needs.

The multiple groups that emerged in need of crisis services include:

- All ages spanning from children to older adults, including transitional age youth;
- Tribal and non-Tribal citizens;
- People who are both housed and unhoused; and
- Both one-time and high utilizers.

Additionally, stakeholders report that trauma, substance use, and untreated mental health are pervasive challenges for people in the County. Community members report there have been a lot of overdoses in the region, and individuals experiencing co-occurring substance use and mental health issues are a priority population and there is a strong need for services that can focus on supporting people who have *co-occurring mental health and substance use needs* across demographic groups.

What contributes to crisis events in Del Norte County?

Crisis events in Del Norte County are impacted, in part, due to the small population of the County and the County's geography. Del Norte County has a population under thirty thousand people and is located in the northernmost part of the state bounded by the Pacific Ocean on the West and Oregon state to the North. The main population is centered in and around Crescent City, which is the county seat and the only incorporated city in the County. People that live in outlying areas of the County often have limited access to services, and even experience unreliable internet and frequent road closures in the winter months. Due to the size of the population and geography of the County, people do not have access to services that are available in other regions. For example, crisis services that exist in other parts of the state, such as Crisis Stabilization Units (CSUs), are not sustainable in a County the size of Del Norte. For law enforcement who are often first responders in the community, this means there are few places to take people who are experiencing crises. As a result, they are typically taken to the Emergency Department or jail if they have committed a crime. Additionally, the small community creates unique challenges like limited options for people to pick up medication.

> *"People want to be on their medication, but they are having to get meds from a place they have probably been kicked out of before. [We need] someone who is able to distribute medication."*
>
> *– Key Informant*

The shortage of services to support people at different stages of crisis contributes to a wide variety of crisis events in the County. This assessment identified **a need for both prevention services to avert crises as well as intervention services when someone is experiencing a crisis.**

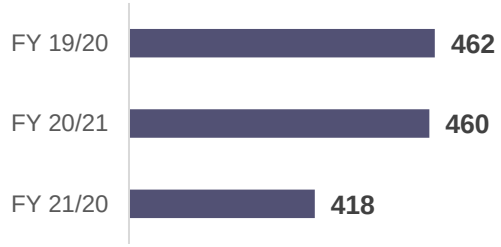
What types of calls are received in the community?

As noted in the previous section**, when a person in the community experiences a crisis, law enforcement (e.g., Sheriff's Office Deputies, Crescent City Police, or California Highway Patrol) is often the first responder.** Since 2019, **law enforcement (i.e., Sheriff's Office Deputies or Crescent City Police) has responded to over 200 calls for service each year** for individuals experiencing a crisis in the community. In 2021, law enforcement responded to 361 calls. However, there is broad agreement that law enforcement does not need to be involved in many crises that do not include threats to public safety, and there is a strong need to have trained behavioral health staff who can meet people in the community along with or instead of law enforcement.

Figures 1 and 2 below show the number of crisis episodes responded to by DNBHB each fiscal year, and the number of individuals experiencing a crisis episode each fiscal year, respectively**.** These data demonstrate that **DNBHB responded to approximately two crisis episodes per day,** in many cases after law enforcement had responded in the community and taken them to the Emergency Department. **Over 400 individuals experienced a crisis each year of the assessment as well.** Between FY19/20 and FY21/22, the County responded to between 720 and 828 episodes each year, representing between 418 and 462 individuals experiencing crises.

Figure 1. Crises Episodes, by Fiscal Year

Figure 2. Individuals Experiencing Crises, by Fiscal Year



Among individuals who are experiencing crisis episodes in Del Norte County, there are many people who only experience one event as well as a substantial group of higher utilizers. As indicated in the table below, **each year there were between 288 and 354 individuals who experienced one crisis episode, and over 50 unique individuals who experienced three or more crisis episode each year.**

Table 1. Individuals Experiencing Crises, by Fiscal Year

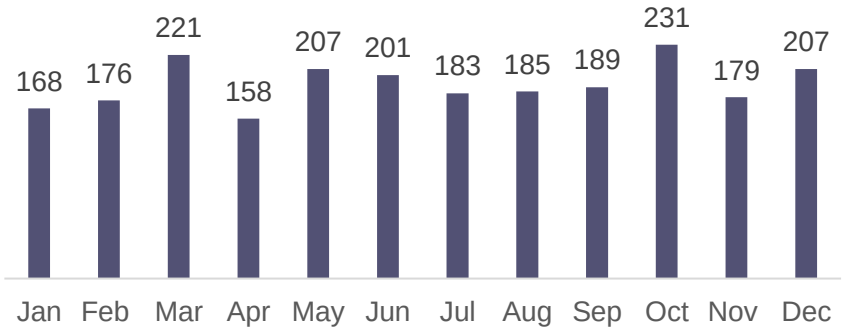
Number of Crisis Episodes	Individuals Experiencing Crisis Episode		
	FY 19-20	**FY 20-21**	**FY 21-22**
1 Crisis	354	313	288
2 Crises	57	75	73
3 Crises	14	31	23
4 or more Crises	37	41	35
Total	462	460	418

While fewer individuals experienced multiple crisis events each year, over the course of the three year assessment period, **nearly 200 individuals experienced three or more crisis episodes, and 119 individuals experienced four or more crisis episodes.**

When are crises occurring?

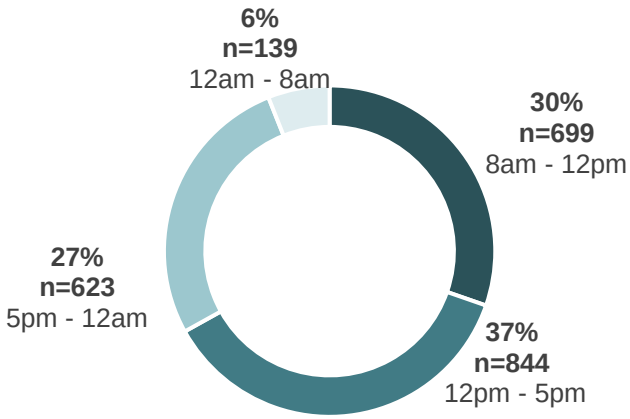
Figure 3 shows the number of crisis episodes responded to by DNBHB each month over the three year assessment period (each month in the chart is aggregated over the three-year period). There is some fluctuation in when crisis episodes occur, however there appears to be an **uptick in crisis episodes during spring and fall months**. Aggregated over the three-year period of the assessment, March and October saw the largest number of crisis episodes with 221 and 231 respectively.

Figure 3. Crisis Episodes, by Month (aggregated over three-year period)



As shown in Figure 4, crisis episodes were fairly evenly split across morning, afternoon, and after business hours. Approximately one-third of crisis responses were after hours, between 5pm and 8am, while two-thirds of crisis responses were during business hours. These data indicate a need for crisis response that extends into evenings. Because DNBHB only responded to crises between 12am – 8am for one year during the year assessment period, these data likely underrepresent the need for treatment options available during the evening and early morning hours.

Figure 4. Time of Crisis Response (aggregated over three-year period)



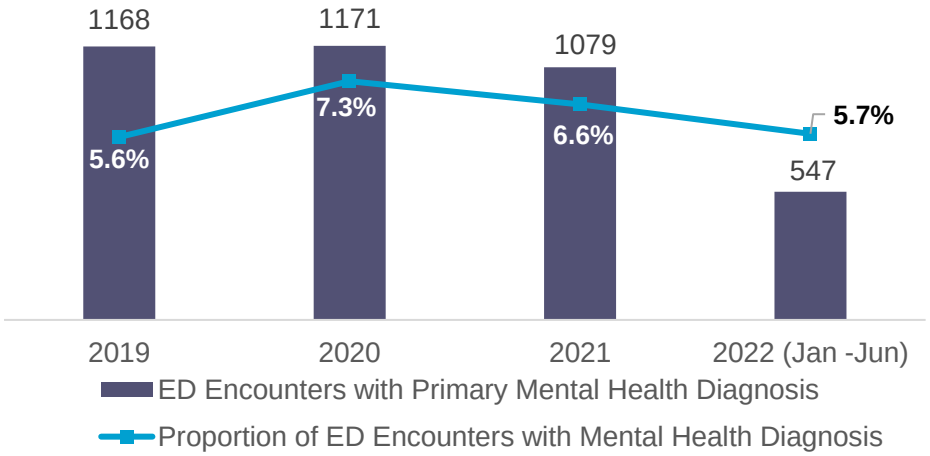
What are the consequences of unmet crisis needs in the County?

The over-reliance on law enforcement to respond to individuals suffering from a mental health crisis coupled with limited service options for people in crisis contribute to a revolving door in jail and large utilization of the emergency department for mental health and substance use related crises.

As shown in Figure 5 below, between 2019 and 2021, there were over one thousand emergency department encounters each year where there was a primary mental health diagnosis. This represented between 5.6% and 7.3% of total emergency department encounters.

> *"We need first responders trained in crisis response: tribal police, County Sheriff, ambulance, volunteer firefighters."*
>
> *– Key Informant*

Figure 5. Emergency Department Encounters with Primary Mental Health Diagnosis



As shown in Table 2 below, **the Emergency Department is the primary location for people experiencing crisis, regardless of whether or not they are on a 5150 hold**. Across the assessment period, there were almost four thousand emergency department encounters where there was a primary mental health diagnosis. However, only 11% (437) of encounters resulted in a 5150 hold; in contrast, there were 3,528 individuals who had an emergency department encounter, with a primary mental health diagnosis, and did not have a 5150 hold. **These data indicate a substantial number of people who might be able to receive crisis services in the community, were the services available, that would avert the need to go to the emergency department.** Stakeholders reported taking people to the emergency department because there are no other drop-in options. This included parents taking children to the emergency room when they were unclear where to find support. This indicates a need for other alternatives for both children and adults.

> *"We need a place for people to go that don't need a 5150, where we can take them, and we can provide services for them and their family – that would solve so much."*
>
> *– Key Informant*

For those individuals who were placed on a 5150 hold, the majority (61%) were discharged while approximately one in three were transferred to a psychiatric hospital. Notably, the average length of emergency department encounters greatly increases for those individuals with continuing holds, in part because it can take a long time to find an available bed in a psychiatric hospital, indicating a need for additional resources to support people with more severe mental health needs.

Table 2. Emergency Department Encounters with Primary Mental Health or Alcohol Withdrawal

Number of Emergency Department (ED) encounters with a primary mental health diagnosis	• **3,965 ED encounters with primary mental health diagnosis** ○ **437 (11%) ED encounters resulted in 5150 hold** ○ **369 (84%) individuals placed on 5150 hold lived in Del Norte County, almost all in Crescent City (n=348)** ○ **46 (11%) children placed on 5150 hold**
Number of 5150 Holds and related outcomes	❖ 437 Involuntary 5150 Holds ○ 147 (34%) transferred to psychiatric hospital ○ 267 (61%) discharged ○ 23 (5%) admitted to hospital or some other outcome (expired-pending, elopement, transfer)
Average length of ED encounter with a primary mental health diagnosis	❖ Average length of ED encounter with a primary MH diagnosis was 8.5 and 11 hours in 2021 and 2022 (through June), respectively ○ For those with a continuing hold, the average length of the encounter was 45.8 and 36.6 hours respectively
Number of alcohol withdrawal encounters	○ There was an average of 4.6 alcohol withdrawal encounters per month

For those that were transferred to a psychiatric hospital, stakeholders reported long travel times and minimal options for people upon release. For example, the Del Norte Ambulance, who provides transport to psychiatric hospitals, reported they often need to bring people to the Restpadd in Red Bluff to find an available bed, which is a five-hour drive from Crescent City. This situation pulls ambulance resources from the County for extended times, while also transporting people far away from their home and support systems. In a focus group of consumers conducted at the Del Norte Service Center, people spoke of the challenge of having nowhere to go and no housing after being released from a psychiatric hospital. The need for both higher levels of services for people as well as transition and step-down services was a theme across this assessment.

What resources are expected to be available as referral sources for those in crisis?

As mentioned above, there are limited options to take people in crisis aside from the emergency department and the jail, indicating a need and opportunity to use Action Planning to explore infrastructure projects that provide alternatives. There are many people that would likely go to another setting if there were alternatives to the emergency room. Similarly, there is a need for alternatives for police to take someone who does not need to go to the ED or Jail. There is also a need to have places for people to go who need a higher level of care to be released from the ED.

As of now, there is an agreement between law enforcement and behavioral health that behavioral health can assist with mental health crises in the community when called by law enforcement. At this time, this resource has been underutilized and both County behavioral health and law enforcement are renewing efforts to use this resource as other options are being designed and implemented.

> *"What if there was a 24-hour support place for any type of crisis…where people could stay and stabilize and get all the services they need; get people out of the elements."*
>
> *– Key Informant*

Additionally, there are a number of services for people in the County, but none are specifically designed for behavioral health crises. For example, the County has a Service Center that provides classes for behavioral health clients, but it is not a drop-in center and is only available for behavioral health clients served through the county. For children and youth, Remi Vista, the children's provider, does deliver walk-in services for children and youth in crisis during their open hours, but focuses on existing clients. Coastal Connections is a teen drop-in center for youth 16 to 24 that can be accessed by any youth needing services; however, this center was closed during the pandemic (currently open again) and is not designed or staffed to serve youth experiencing a mental health crisis.

What are other contributing factors in Del Norte County that may impact Action Planning?

Despite being a smaller, more rural County, Del Norte's population size is also an asset when it comes to collaboration and communication. **Stakeholders in the County work closely together and collaborate to meet the needs of individuals in the community.** This strength is evident in the CCMU planning process. Stakeholders across the County have been actively involved in all aspects of the project and are ready to find common ground and explore creative ways to address the needs of the County.

> *"The future of medicine is not four walls anymore; it's to get out where people are at."*
>
> *– Key Informant*

Many stakeholders mentioned the high utilizer meeting which brings together a multi-disciplinary team to discuss getting services for people who frequently need assistance. This meeting is already a venue to collaborate across groups to meet the needs of people in crisis.

Additionally, the County has recently strengthened services for people in need that can be leveraged. The County has been working over recent years to strengthen housing services and support for people who are unhoused. Del Norte Mission Possible provides outreach to the homeless population, which most stakeholders reported as being a strong asset in the community because the Mission Possible outreach workers are adept at building trust and providing "boots on the ground" going into encampments and connecting people to services. Additionally, Mission Possible has set up an informal ambassador program where point people in encampments take on leadership roles and check on each other; however, this program has not been able to provide any formal support or incentives. The Open Door Clinic provides primary care, including access to behavioral health and psychiatry services, to the community. In the last few years, Mission Possible and Open Door, as well as other service agencies, have begun to collaborate to provide more services:

> *"I believe in empowering the community we serve. We are so rural, that our homeless, you don't see them…Outreach has built a relationship with those people."*
>
> *– Key Informant*

- The Department of Health of Human Services, in partnership with the Del Norte Senior Center and Mission Possible offer a mobile shower set up in the Open Door parking lot. During the time mobile showers are available, the Mission Impossible team tries to engage with the community and connect them to services, such as CalWORKs.
- Open Door has set up a clinic outpost that brings medical services out to encampments and has expressed interest in broadening their work to reach other regions and bring in more behavioral health support.

Finding avenues to build off of existing services may be especially helpful as **there are many people who are struggling in the County that may benefit from proactive services to remain stable before escalating to a crisis.** Stakeholders interviewed repeatedly spoke of individuals that are known to service providers and law enforcement that may benefit from ongoing support that can prevent crisis events. For example, logistic challenges and stigma can create obstacles for individuals with mental health and substance use needs in obtaining a steady supply of medications. For some, having a person check up on them, and help ensure they are getting and taking their medication may stabilize and support people to avert crisis events. There is also a lot of stakeholder interest in broadening the ways people can get medications and exploring options for mobile services to bring medications out to people.

There is an ongoing need to provide services that meet people where they are at culturally, linguistically, and in hours and locations that are accessible. As mentioned above, Del Norte is a rural County with a small population. Additionally, the County has

four tribes that provide varying levels of services to their tribal citizens. The Yurok tribe, for example, has an array of support services primarily for Yurok citizens, while other tribes have fewer services.

The unique landscape of Del Norte necessitates creative solutions that are feasible in a County of its size. For example, the County needs more mobile crisis support, but that may not be sustainable in the outlying areas. Additionally, while Tribal citizens typically receive services through United Indian Health Services (UIHS), it is imperative that they are aware of what services they can obtain through County behavioral health. Stakeholders have reported that some tribal citizens would prefer to obtain services through the County to maintain confidentiality, however they have been turned away because there is a perception that they should go to UIHS or that they are not eligible for County services.

Additionally, for all members of the County, there is a need for flexible service options that can provide services in the community that are welcoming and reduce stigma, and provide options outside of traditional business hours.

There is also a need to work with the Tribes in the County to ensure culturally appropriate options are available. As one example, Native American youth are disproportionately represented in the County's juvenile hall. They make up about 10% of the Del Norte population but are 30% of the juvenile hall bookings suggesting there should be efforts to divert these youth to appropriate services when possible.

> *"People can't navigate the system to access the services…There is confusion or miscommunication about what Native citizens are eligible for."*
>
> *– Key Informant*

It has been a strength that there has been tribal representation in the CCMU planning process, and it is important to recognize that tribes may have needs separate from County Behavioral Health that may be addressed through BHCIP. The Yurok tribe, for example, was very recently awarded a BHCIP Round 4 Grant for Children and Youth services, and there are additional needs that may benefit from BHCIP funding, such as a tribal detox center described below.

> "In the words of Yurok Tribe Police Chief O'Rourke, the need for access to 24-hour, 7-days a week, mental health facilities could be hugely preventative*:*
>
> *I would love to see the tribe actually have its own detox center. So instead of bringing somebody to jail, who's under the influence, unable to care for themselves, we bring them to a detox center….We can take a proactive, immediate response to help our own people."*
>
> - Yurok Tribe, 3-Year Report, pg. 83

Staffing is an ongoing challenge across the County. While counties across the state struggle with staffing, these issues are especially pervasive in Del Norte County that often cannot attract staff for positions, especially when specific clinical credentials are required.

Challenges with staffing impact all County departments and services. This means that staffing needs to be an explicit consideration for any ideas in an Action Plan. As one example, many stakeholders expressed interest in pairing an officer with a clinician as a mobile response model seen in other counties. However, given the number of crisis events and the challenges in recruiting for both law enforcement and behavioral health, this model may not be the most efficient for Del Norte County highlighting a need to explore creative solutions that are feasible given staffing constraints.

> *"Recruiting for all jobs is difficult. Don't have a lot of facilities, but even if you build a facility if you can't staff it, that is a problem."*
>
> *– Key Informant*

There is stakeholder interest and opportunities to build out the role of community health workers, family, and people with lived experience to provide a larger role in crisis support. As a few examples:

- The County has just begun to hire peers in positions within behavioral health and housing services and there is ongoing interest in supporting the role of people with lived experience.
- The County has a volunteer fire department, and stakeholders have suggested they could be a resource to support crisis response.
- While the County currently does not have a National Alliance on Mental Health (NAMI) Chapter, there are stakeholders that are actively collaborating with Humboldt NAMI and working to bring that support to Del Norte County.

In order to make these valuable efforts possible, there is an ongoing need to build out the infrastructure, such as training, resources, and support, to support a more robust network of community workers, peers, and families to be engaged in providing services. Additionally, there is a need to invest in the peer and family member communities to support advocacy efforts and build the workforce of people with lived experience.

Crisis Resources and Linkages

Currently, there are limited options for crisis response. The only mobile or field-based services available are through existing first responders, primarily law enforcement. If a person requires immediate intervention, they are transported to the Emergency Department for further assessment. If they require inpatient services, they are transported to an out-of-county facility for these services.

If they do not require ED services or they do not meet medical necessity criteria for hospitalization, they are given the number for the Behavioral Health Branch and can call the access line to schedule an appointment or access drop-in services through the same-day service team. Within the Behavioral Health Branch, there are a number of outpatient services as well as a wellness center for individuals enrolled in the Full Service Partnership (FSP) program. There are no in-County residential or Board and Care facilities for people with mental health issues, but there are three County-supported residences that provide shared housing for individuals enrolled in FSP and who are on an LPS conservatorship. There are also a handful of community based organizations that can support individuals pre and post crisis, including:

- Open Door - operates a federally qualified health center (FQHC), an outpost clinic one day per week, and support the County's mobile showers. They serve a number of individuals experiencing homelessness as well as those who have a behavioral health issue and may experience crisis. They also support individuals to reconnect to health and mental health services if they have fallen out of care.
- Mission Possible - provides an outreach and engagement team to people experiencing homelessness as well as informal peer mentoring. They currently are able to provide pre-crisis engagement as well as follow-up following crisis in order to continue to engage individuals in services.
- Remi Vista - provides children, youth, and family mental health services, including a drop-in clinic for children and families in need of more immediate support as well as In-home Behavioral Supports for children with significant, ongoing support needs.

Program Models and Best Practices

Crisis Program Model Overview

During the assessment process, the County and Behavioral Health Collaborative received information about the types of locked and unlocked mental health services as well as substance use services that one might expect to see in a crisis system, including:

- Field-based services that provide crisis prevention and/or crisis intervention services. Crisis prevention services are those that prevent the likelihood of a crisis occurring, and crisis intervention services are those that respond in the moment of crisis or emergency.
- Crisis Receiving Centers where one can go in the moment of crisis to receive support, including the Emergency Department, LPS-designated and voluntary Crisis Stabilization Units, and Sobering Centers.
- Short-term Behavioral Health Services for a short-term intervention typically ranging from a few days to a week or two, including inpatient psychiatric services, crisis residential and peer respite models, and withdrawal management/detoxification.
- Longer Term Behavioral Health Services where someone might stay for a period of months or years, including locked Mental Health Rehabilitation Centers and Skilled Nursing Facility/Special Treatment Programs; unlocked Adult Residential Treatment,

FSPs, and other outpatient services; and Housing ranging from emergency, supervised, and supported/independent living options.

The proceeding tables provide this information at-a-glance as well as the definitions of each of the behavioral health programs, including average length of stay, legal status, and program description.

Table 3. Crisis Prevention, Intervention, and Treatment At-A-Glance

<table>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Field Based Services</td></tr>
<tr><td colspan="2">Crisis Prevention
Ex. Law enforcement liaisons
Ex. Multi-disciplinary forensic teams
Ex. Embedded mental health staff
Ex. Outreach and engagement teams</td><td>Crisis Intervention
Ex. community health workers/peers
Ex. Mental health and law enforcement joint response
Ex. Mental health and EMS response</td></tr>
<tr><td colspan="3">Receiving Centers</td></tr>
<tr><td>5150 Receiving Centers:
Emergency Department
Crisis Stabilization Unit, if LPS Designated</td><td>Unlocked Crisis Settings:
Crisis Stabilization Unit, not LPS designated
Mental Health Urgent Care
Other Settings (i.e., living room)</td><td>Substance Use/Misuse:
Sobering Center</td></tr>
<tr><td colspan="3">Short-Term</td></tr>
<tr><td>Secure Treatment:
Acute Psychiatric Hospital
Psychiatric Health Facility</td><td>Voluntary Treatment:
Crisis Residential Treatment
Peer Respite</td><td>Substance Use/Misuse:
Withdrawal management/ detoxification</td></tr>
</table>

Longer Term		
Secure Treatment: • Mental Health Rehabilitation Center • Skilled Nursing Facility/Special Treatment Program	Voluntary Treatment: • Adult Residential Treatment/Social Rehabilitation Facility • Full Service Partnerships • Other outpatient services	Substance Use/Misuse: • Residential treatment • Intensive outpatient and outpatient services
Housing		
Emergency: • Hotel/motel • Shelter	Supervised: • Licensed Board and Care facility (ARF/RCFE) • Unlicensed Room and Board • Recovery Residence/ Sober Living Environment	Supported/Independent: • Shared housing • Permanent supportive housing

Table 4. Behavioral Health Crisis Continuum - Program Descriptions

Facility Type	ALOS	Legal Status	Description
Crisis Stabilization Unit (CSU)	23 hour 59 minute	Individuals can be served on a voluntary basis or on a 5150 hold if LPS designated.	24 hour non-medical facility providing evaluation and treatment for individuals experiencing crisis. Can be hospital affiliated as psychiatric emergency services (i.e., CSU/PES) or can be freestanding.
Mental Health Urgent Care	N/A	Unlocked, voluntary	Outpatient, drop-in clinic where individuals can receive crisis or same-day services
Sobering Center	4-24 hours	Unlocked, does not serve individuals who are otherwise detained	24 hour non-medical facility where individuals can go or be dropped off in order to safely sober and be connected to ongoing recovery services.

Acute Psychiatric Hospital (AP)	As long as medically necessary	Locked, requires a 5150, 5250, or other hold for admission	24-hour hospital facility for individuals requiring inpatient services
Psychiatric Health Facility (PHF)	Approximately 7-14 days	Locked, requires a 5150, 5250, or other hold for admission	24-hour locked facility for individuals requiring inpatient services
Crisis Residential Treatment (CRT)	5-14 days with option to stay up to 30 days	Unlocked, voluntary	24 hour short term social rehabilitation facility that serves in a voluntary alternative to psychiatric hospitalization for those who do not require services in a locked setting.
Peer Respite	Typically 5-14 days	Unlocked, voluntary	A 24 hour peer led residential environment where people experiencing crisis can access peer supports to resolve their crisis and work on their recovery.
Withdrawal Management	1-3 days	Unlocked, voluntary	24 hour setting where individuals can safely detox from substances and be connected to longer term treatment. Can be social model, with incidental medical service, or medically monitored or supervised.
Mental Health Rehabilitation Center (MHRC)	As long as necessary	Locked, requires placement on conservatorship	24 hour secure treatment setting for those who require longer term services in a locked setting.
Skilled Nursing Facility/ Special Treatment Program (SNF/STP)	As long as necessary	Locked, requires placement on conservatorship	24 hour secure treatment setting for those who require more intensive health and mental health services in a locked setting.
Adult Residential Treatment (ART)	6-18 months	Unlocked, voluntary	24 hour transitional social rehabilitation facility that serves in a voluntary alternative to MHRC placement for those who do not require services in a locked setting.
Adult Residential Facility (ARF)	Generally long term	Unlocked, can be voluntary or can be on conservatorship	A licensed “Board and Care” facility serving individuals ages 18-59, does not provide mental health treatment
Residential Care Facility for the Elderly (RCFE)	Generally long term	Unlocked, can be voluntary or can be on conservatorship	A licensed “Board and Care” facility serving individuals age 60 and over, does not provide mental health treatment

Crisis Services Benchmarking Research

During the assessment process, the County and Behavioral Health Collaborative also participated in a panel discussion with leaders from other Counties, including:

- Karen Larsen, Executive Director of the Steinberg Institute and former Yolo County HHS Director.
- Kristen Love, Crisis Services Director, Placer County Health and Human Services
- Stephanie Lewis, Crisis System of Care Director, Alameda County Behavioral Health

Each panelist was invited because they had a unique perspective to share with the Del Norte collaborative.

Alameda County was invited because they operate multiple mobile crisis teams using a number of different models, as demonstrated in the table below. Alameda County also partners with some cities who operate their own mobile crisis response. This includes the newer MACRO program, led by the Oakland Fire Department as part of a larger effort to minimize law enforcement's role in mental health response where public safety is not at risk.

Table 5. Alameda County Crisis Team Models

Team	Staff	# of Units	Hours	Geography	Dispatch
Mobile Crisis Team (MCT)	2 Licensed Clinicians	2 Teams	10am-8pm Mon-Fri	Countywide	• 911 • Team Cell • On-Duty Clinician • Crisis Support Services
Mobile Evaluation Team (MET)	1 Licensed Clinician and 1 Police Officer	2 Teams	8am-3pm Mon-Thurs	Oakland	
			8am-4pm Mon-Fri	Fremont	• 911
Community Assessment &Transport Team (CATT)	1 Licensed Clinician and 1 EMT	6	7am-11pm, everyday	• Oakland • San Leandro • Hayward • Fremont	• 911

Placer County was invited to participate because they have overcome some similar challenges as the ones facing Del Norte in that they a population center in Roseville and some outlying areas heading up the mountain where mobile response in not practical during certain times of the year. Placer County, as a smaller County, has clear and well established guidance for what mobile crisis teams are expected to do when they are not actively responding to a crisis, including stakeholder outreach and education about mobile crisis services, as well as post crisis follow-up care.

Yolo County was highlighted because they have piloted and re-worked a number of different models, including successfully encouraging police departments to fund some mental health/homeless liaison staff. They shared their experience in starting a mobile crisis co-responder model with police and a mental health urgent care as well as how they considered the feasibility of a CSU which they ultimately decided was not sustainable given their projected utilization.

Shasta County and their Mobile Crisis Outreach Team (MCOTT) were also of interest to Del Norte. Shasta County was not able to participate in the panel but did participate in an interview, of which the results were shared back to the Behavioral Health Collaborative. The information shared included:

There are two mobile crisis programs, the Crisis Response Team (CRT) and the MCOTT. The MCOTT provides mobile services out of a van seven days per week between 8:30 am and 7:30 pm. It is operated by a community based organization and is connected to an FQHC. They take calls directly from community and responds independently with a team of clinician and case manager; they are not able to place 5150 holds. The CRT is a joint response model operated by County Behavioral Health in partnership with the Redding Police Department. The CRT is dispatched through the 911 system, and a clinician and law enforcement officer respond together. The CRT provides services four days per week from 8:00 am through 6:00 pm. Both programs provide services that are limited to the Redding area and provide follow-up services when not actively responding to a crisis.

Table 6. Shasta County Mobile Crisis Programs

	Mobile Crisis Outreach Team	Crisis Response Team
Operator	Community Based Agency	Shasta HHS and Redding PD
Transportation	Mobile Van	Law Enforcement Car
Calls	Directly from Community	911 dispatch
Staff	Clinician + Case Manager	Clinician + LEO
5150 privileges	No	Yes
Hours of Ops	8:30am - 7:30pm M - Su	8a - 6p T - F
Funding	MHSA INN	Shasta HHS funds clinician and 50% LEO
Service Connection	Connected to FQHC	Connected to Shasta HHS
Ages	Adults	All ages
Geography	Redding	Redding
Downtime	May do follow-up or case management	
Telehealth	No	

Overall, Shasta County representatives shared that MCOTT and the CRT have provided real benefit to residents in need of mental health crisis support.

Lessons Learned

Overall, the other counties shared the following insights for Del Norte to consider:

- There are a lot of different models of how to structure mobile crisis teams, including ways to respond with and without law enforcement.
- In smaller communities, find ways to layer on activities so that staff have other duties when not actively on a call, like outreach and follow-up.
- Consider a mixture of field-based and site-based interventions.
- You don't have to do everything at once. It will evolve over time. Just keep trying to figure it out.
- Be a team of yes. Find ways to say yes, offer help, screen people in.
- Keep it simple. Try not to impose limits or complications. Stay focused on the helping part.
- It's okay to have one approach for the population center and another approach for the outlying areas.

- ❖ Follow-up is a really important component of lessening the number of crisis episodes happening.
- ❖ Engage your partners, engage your community. Tell people about what you're doing.

Sources for data – In the table below, list the *quantitative data* sources you accessed and what you learned from those sources. Please add rows as needed.

Quantitative Data Sources	What you learned
Del Norte County Behavioral Health Branch	• Crisis Responses ○ Date and Time • Presumptive transfers (proxy for youth in foster care)
Del Nore County Sheriff's Office	• Calls for Services coded as 5150
Del Norte County Probation Department	• Juvenile Hall Bookings, by Year and Race • Juvenile Placements in Foster Care or STRTP • Adults on Probation with Mental Health Needs
Sutter Coast Hospital	• ED Encounters with Primary Mental Health Diagnoses, by Date • 5150 Holds and Disposition, by Age and City • Sobering Encounters, by Date
Ambulance	• Transports from Hospital

***Qualitative assessment* – In the table below, provide information about the qualitative data you collected.**

Questions	Your Responses
If you conducted key informant interviews, whom did you interview? What did you learn from them?	Indigo conducted interviews with county leadership, behavioral health leadership and staff; justice system partners; tribal representatives; community based service providers; and peers to learn about their experiences and perspectives regarding the County's current crisis response system, as well as their hopes and concerns about the project and future implementation of a crisis system in Del Norte County. Findings are aggregated in the needs assessment to ensure anonymity.

If you held focus groups, describe the participants, how many participated, and what you learned from them.	Indigo facilitated a focus group with consumers to understand their experiences receiving mental health services, including crisis response services, in the County, and to identify what programs or services were most helpful and which were unhelpful, or unavailable to them. From this focus group Indigo also learned what consumers consider to be the key programmatic elements that help make them feel safe when they start to experience a crisis, as well as the services that should be available in the community so that they do not continue to experience crises.
If you held town hall meetings, how many people participated? What did you learn from them?	Indigo Project facilitated a community meeting with 24 community members to gather information for the assessment and vet emerging themes, and to receive feedback about what, if anything, would be useful information to gather as the County moves towards implementation.
If you collected any other type of qualitative data, please describe it, and tell us what you learned from it.	Indigo Project conducted a literature review to describe the array of crisis prevention, intervention, and treatment options, as well as research on Evidence Based Practices (EBPs) and a gap analysis that have been incorporated into the planning meetings. For example, in each planning meeting, the team has presented on information from literature and EBPs that can be considered for future Action Planning The Indigo Project team, along with County staff, conducted benchmarking research by interviewing representatives from four other counties: Alameda, Placer, Yolo, and Shasta. Each county was specifically selected because there were components of their mobile crisis models that were of interest to Del Norte. Alameda, Placer, and Yolo representatives presented as a panel in the first planning meeting. Each presented mobile crisis in their county and lessons learned. Shasta was unable to attend but participated in a benchmarking call where they described their mobile models that were shared back to the group in the second planning meeting. Indigo also connected DNBHB with La Familia for a benchmarking call to learn more about their implementation of Crisis Respite Centers.

Resource Assessment – **In the table below, describe the resources you already *have* to address the behavioral health crises you've identified. (Resources you need are addressed in the next table.)**

What do you already have?	Your Responses
People are the staff, trainers, consultants, volunteers, stakeholders, partners, community leaders/champions. Who are the people and agencies involved in crisis response that are already available to you? (You don't need to name stakeholders and partners that you've already named.)	In addition to all of the individuals, partner agencies, and community based organizations who came together for this assessment and action plan, Del Norte has developed a sustainable structure for how this group can work together to progress this action plan, as well as other crisis system improvements that go beyond the CCMU funding. Specifically, the Behavioral Health Collaborative worked together to on this assessment and action plan. The Collaborative has already submitted a request for funding to the CareStar Foundation to support our continued work and added additional members from other organizations for this next phase of implementation.
Funding are grants and allocations. Funding is also the things that money buys – office space, vans, desks, computer hardware/software, etc. What funding do you already have to address mobile crisis response?	Del Norte has some unspent MHSA funds that may be used to support elements of this plan as well as the other crisis system enhancements identified through this assessment and action plan.
Community is the people you live, play and work with. Are there community-based groups that already respond to mental health and/or SUD crises? How knowledgeable is your community about mental health and SUD issues? Does your community support the idea of mobile crisis response?	Del Norte has a relative strength with the kind and compassionate communities that exist within the County. There are also a number of community based organizations and partners described above that will continue to be a tremendous resource as the County continues to build out their crisis system, including the CCMU programming.
Organizations are the structures we work in. Consider the following: a. How would mobile crisis response align with existing county mission, vision and values? b. How would mobile crisis response operate within county organizational policies and practices? c. Are there any policy obstacles or nay-sayers?	Many of the organizations that participate in crisis services were members of the Behavioral Health Collaborative, including the hospital Emergency Department and law enforcement. The crisis services identified are based on the shared vision and values of the collective group, and they have identified the areas where additional policy or procedural work will be necessary, including creating a new job classification for mobile crisis staff that work outside of business hours as well as MOUs between dispatch, law enforcement, and the CCMU programs that outline their procedural agreements in terms of cross-training, responding jointly and separately, and safety protocols.

In the table below, describe the additional resources you *need* to address the behavioral health challenges you've identified.

What do you need?	Your Responses
People – Do you need more staff? More volunteers? Better training for staff? Do you need to learn more about best practices in mobile crisis response? Do you need more engaged stakeholders/partners? Other?	The primary resource need for staff is training around mobile crisis response and community crisis response. There will also be a need to hire staff to provide mobile crisis services and determine clinical supervisor protocols given that the team may not always include licensed clinical staff.
Funding – includes the things that money buys. Do you need computers, software, vans, office space, promotion and publicity of programs? Other?	Del Norte will use the entirety of the base allocation to purchase the mobile crisis vehicle and obtain training for staff and community members in mobile crisis and community crisis response. The County has already applied for funding from the CareStar Foundation to continue the collaborative workgroup through the implementation phase. The County is also planning to apply for BHCIP funds in order to develop a Mental Health Urgent Care and is considering applying for funds for a crisis respite, as well.
Community – On a 1-10 scale, with 1 being "the community is largely in denial," and 10 being "the community enthusiastically supports the development of mobile crisis response" where is your community? How can you "move" people "up" the scale? Do you have community champions?	The community appears to wholeheartedly support the vision that all people deserve mobile crisis services wherever they are in a way that promotes recovery and protects public safety. The challenge that this action plan seeks to address is to engage community in being a part of the solution by becoming mental health aid first responders or community crisis responders. To this end, the action plan outlines the outreach and engagement, available trainings, and supports and incentives to encourage people to take an active role in supporting their friends and neighbors who may experience a mental health crisis. This is in addition to the formal mobile crisis unit detailed in the proceeding action plan.
Organizations – how could you address mismatches between aims of mobile crisis response and existing county mission, vision, and values – if there are any mismatches? How can you help nay-sayers become yeah-sayers?	There are not any opponents to the mobile crisis services and supports planned through this process. Rather, there are some organizations that have not yet been fully engaged in the process, such as the volunteer firefighters or crisis response teams. We anticipate their cooperation and participation, and we understand that outreach, engagement, and education take time; continuing to nurture those relationships is a part of the action plan itself.

Findings – At the end of your resource assessment through gathering of quantitative and qualitative data, you must synthesize data to describe the need for mobile crisis service in your community. These findings should identify models and best practices that are relevant and applicable in your community, needs and resources for mobile crisis services in your community, consideration of how mobile crisis response will fit into other crisis or non-crisis services within your community, and how mobile crisis will link with other system transformations currently underway.

The findings from this Needs Assessment led to Del Norte County in collaboration with the behavioral health collaborative to make a series of recommendations to address the need for crisis services in the region.

There were a few overarching findings in the Needs Assessment that highlighted that the County has needs that fall both within CCMU planning as well as those that should be planned and funded separately. Specifically,

- This assessment identified **a need for both prevention services to avert crises as well as intervention services when someone is experiencing a crisis.**
- There is an overreliance on the jail and emergency department because of a shortage of other options to take people in crisis. **Needs Assessment data indicate a substantial number of people who might be able to receive crisis services in the community, were the services available, that would avert the need to go to the emergency department.**

As a response to these findings, the collaborative defined a series of recommendations for services that would be explored outside of CCMU. As shown in the Table below, these include exploring options that include places to go such as a mental health urgent care and crisis respite; in-home crisis respite for children and families; and a Short Term Residential Therapeutic Program (STRTP) for youth with higher level needs.

Recommendations Outside of CCMU Planning

Adults		
Mental Health Urgent Care	Re-define same day service team and clinic space to create a mental health urgent care	Del Norte is working internally on exploring options.
Crisis Respite	Open a non-licensed place to go after hours until mental health urgent care opens up	HHS staff to meet with respite provider from another County

Youth		
In Home Crisis Respite	Train crisis staff to provide in-home support after hours until the crisis more fully resolves or until business hours.	Del Norte exploring the possibility of expanding behavioral health services
STRTP/CCRP	Create a STRTP with a small number of Children's Crisis Residential beds.	HHS is doing preliminary outreach to Child Welfare and Juvenile Probation to see if there may be interest in partnering

Within CCMU planning, the Needs Assessment led to the collaborative establishing three goals for crisis services and related objectives.

Goal 1: Reduce the number of people experiencing crisis

Objective 1.1: Partner with Open Door to augment existing "outpost clinic" currently serving people at high risk for crisis.
Objective 1.2: Partner with community organizations to formalize peer mentor crisis prevention services.

Goal 2: Provide crisis services to individuals wherever they are

Objective 2.1: Provide mobile crisis services to individuals in the Greater Crescent City area.
Objective 2.2: Partner with Crisis Response Teams and other first responders to become mental health first aid responders.

Goal 3: Build community capacity to respond to crises.

Objective 3.1: Train community leaders to support crisis response, with a focus in outlying areas.
Objective 3.2: Blanket outlying communities with community crisis response training, with a focus in outlying areas.

These form the basis for the subsequent work planning in the final collaborative meetings where the collaborative team built out progress measure, action steps, and a timeframe for each objective.

Implementation Plan

To create your Implementation Plan, consider first creating a planning group. This group will advise you, help you define your goals and objectives, and help you prioritize needs and services. Good members of a planning group are similar to the stakeholders and key informants you already interviewed in your assessment. Your planning group should also include some of the staff you work with as well as those who will be implementing the services you hope to fund.

An Implementation Plan should include

- **An introduction and summary of the assessment (overview)**
- **A detailed implementation plan with goals, objectives, progress measures, timeframes and action steps**
- **A dissemination plan**
- **A sustainability plan**
- **A deliverable schedule**

Implementation Plan Overview

The mission of this work is to provide crisis support where people already are in the moments when they most need them from people who they trust in a way that promotes recovery and protects public safety and is a prudent use of resources. This is grounded in the belief that all services should facilitate access and promote equity, including ensuring the capacity to serve individuals who are experiencing a co-occurring substance use disorder and/or homelessness.

The Del Norte CCMU Action Plan includes three primary components:

1. **Crisis Prevention Services** that seek to engage individuals who are at high risk for experiencing a crisis in services and reduce the likelihood that they will experience a crisis.
2. **Mobile Crisis Services** that can respond in and around Crescent City as well as leveraging the network of existing crisis responders in outlying areas to equip them to respond within their home communities.

3. **Build community capacity** to become mental health first aid responders within their own communities and reduce the avoidable use of emergency services when community support would suffice.

The purpose of these programs is to ensure that formal supports are available for those that need them and also strengthen communities to support their friends and neighbors when access to outlying communities is limited.

Goals and Objectives

The goals and objectives of the CCMU Project are grounded in the mission, values, and rationale described in the preceding section.

Goal 1: Reduce the number of people experiencing crisis

- Objective 1.1: Partner with Open Door to augment existing "outpost clinic" currently serving people at high risk for crisis.
- Objective 1.2: Partner with community organizations to formalize peer mentor crisis prevention services.

Goal 2: Provide crisis services to individuals wherever they are

- Objective 2.1: Provide mobile crisis services to individuals in the Greater Crescent City area.
- Objective 2.2: Partner with Crisis Response Team and other first responders to become mental health first aid responders.

Goal 3: Build community capacity to respond to crises.

- Objective 3.1: Train community leaders to support crisis response, with a focus in outlying areas.
- Objective 3.2: Blanket outlying communities with community crisis response training, with a focus in outlying areas.

The progress measures, action steps, and timeframe for each goal and associated objectives immediately follow.

Goal 1: Reduce the number of people experiencing crisis

In order to prevent people from experiencing crises whenever possible, the Collaborative wants to ensure crisis prevention measures are developed alongside crisis intervention services. To that end, the Behavioral Health Department is collaborating with Open Door to augment their existing outpost health clinic that currently serves people at high risk for crisis. Each entity is committed to expanding the reach of the outpost clinic, and the details of what is feasible are to be worked out. The goal is to increase the number of days of operation and bring in a behavioral health specialist to the existing Sunday clinic. Once each party has identified what is feasible for their organization, they will work together to develop an MOU that includes detailed information on the services that will be offered, as well as the staffing, workflow, and reimbursement model. This work should be complete by the end of September 2023.

The County of Del Norte also plans to partner with community organizations to formalize peer mentor services. Existing providers such as Mission Possible, provide informal peer support through an informal ambassador program where point people in encampments take on leadership roles and check on each other; however, this program has not been able to provide any formal support or incentives. The County intends to build on these opportunities and bring together an initial cohort of peer mentors who can provide support in the community, including homeless encampments, to people most at risk of experiencing crisis.

Objectives	Progress Measures	Action Steps	Timeframe
Objective 1.1: Partner with Open Door to augment existing outpost health clinic currently serving people at high risk for crisis - Additional day(s) of service - Mental health services at existing clinic	- Final decision about what expansion will look like. - Inclusion of crisis prevention efforts in MHSA plan. - Executed MOU for augmented clinic.	Open Door to explore if expanding the days of operation would be financially viable with Partnership Health Plan billing	3/31/23
		Del Norte County to explore feasibility of providing behavioral health specialist to existing Sunday clinic	3/31/23
		Del Norte County to consider funding outreach and engagement position during the MHSA CPP process	6/30/23
		Negotiate MOU, including services, staffing, workflow, and reimbursement model	9/30/23
Objective 1.2: Partner with community organizations to formalize peer mentor crisis prevention services.	- Fully developed concept for pilot project - Formation of initial cohort of peer mentors - Executed MOU for pilot project	Meet with existing providers to flush out concept, design, and resource needs	3/31/23
		Identify a small cohort of initial crisis ambassadors	6/30/23
		Negotiate MOU, including services, staffing support, and resource needs	9/30/23

Goal 2: Provide crisis services to individuals wherever they are

To support crisis service availability across the county, Del Norte will utilize a two pronged approach. For the Greater Crescent City area, the County is pursuing a traditional mobile crisis response model in collaboration with the Sheriff's Office and Crescent City Police. These partners are fully committed to the collaborative effort and will meet over the next six months to develop an MOU, which will include policies and procedures to follow for deploying crisis response, including when one agency responds alone, as well as when and how they will respond jointly. In addition to the more traditional mobile crisis response model, the County also plans to partner with their Crisis Response Teams and other first responders to become mental health first aid responders. These trained individuals will provide frontline support for people experiencing mental health crises in the Greater Crescent City area and in outlying areas where it would take longer for the mobile crisis van to travel and provide support. Details of this work, including how mental health first aid responders will coordinate with mobile crisis, are to be determined over the course of the year.

Objectives	Progress Measures	Action Steps	Timeframe
Objective 2.1: Provide mobile crisis services to individuals in the Greater Crescent City area.	- Vehicle - Vendor selection - Vehicle purchase - Vehicle modifications complete - Executed MOU - Draft and final written guidance - Collateral materials available - Staffing - Approved job descriptions - Staff hired - Staff trained	**Vehicle:** Finalize specifications, identify vendor for vehicle and modifications, stock with needed supplies and materials.	9/30/23
		MOU: Meet with LEAs, dispatch, and other first responders to collectively design the MOU, negotiate specific details of the agreement, draft and execute MOU between HHS and LEAs.	7/31/23
		Policy, Procedure, and Protocol Development: Draft and finalize written guidance for deploying crisis response when any agency responds alone and for when and how to respond jointly.	9/30/23
		Materials Development: Develop education and outreach materials to share with partners, community members, and other stakeholders about mobile crisis services, including print and electronic versions as well as press releases and talking points for earned media.	8/31/23
		Staffing: Draft job descriptions; engage in county process to recruit, hire, and onboard mobile crisis staff; onboard and train staff to mobile crisis	9/30/23

Objective 2.2: Partner with Crisis Response Team and other first responders to become mental health first aid responders	- Ongoing meetings with CRT and other first responders - Executed MOU - Training - Final MH First Aid Responder curriculum - Training event plan and schedule - Training event(s) occur	**Initial Partnership:** Meet with Crisis Response Team to explore partnership.	3/31/23
		MOU: Meet with CRT and any other participating first responder groups to collectively design the MOU, negotiate specific details of the agreement, draft and execute MOU.	6/30/23
		Training: Finalize training curriculum to include Mental Health First Aid and Community Crisis Response, plan training event(s), recruit participants, provide training to participating first responders.	9/30/23
		Ongoing Partnership: Explore potential for fire to participate after program is established.	12/31/23

Goal 3: Build community capacity to respond to crises

In addition to the two pronged crisis response approach outlined in Goal 2, the Collaborative identified a need to have dedicated response tailored to the needs of outlying areas in Del Norte County. To this end, the County intends to identify, recruit, and train community leaders to support crisis response, especially in outlying areas, and to blanket outlying communities with community crisis response trainings. The Behavioral Health Branch, with support from Collaborative partners, will develop an outreach and engagement plan for identifying and recruiting community leaders to support crisis response, as well as plan, schedule, and implement trainings, and develop ongoing communication and support mechanisms to support Goal 3.

Objectives	Progress Measures	Action Steps	Timeframe
Objective 3.1: Train community leaders to support crisis response, with a focus in outlying areas	- Identification of first cohort of participating community leaders - Finalized training curriculum and training plan - Collateral materials	**Partnership Development:** Develop outreach and engagement plan, including list of potential participants; outreach to potential participants; solidify commitments.	6/30/23
		Training and Coordination: Plan, schedule, and implement trainings; plan and implement ongoing communication and support mechanisms, including recognition; engage in data collection for trainings.	9/30/23
		Materials Development: Develop outreach materials, resource guide, partnership agreement form, other training materials.	6/30/23
Objective 3.2: Blanket outlying communities with community crisis response training.	- Identification of first cohort of participating community members	**Community Building:** Support community leaders to expand their reach by inviting more community to participate; outreach to additional community members.	9/30/23
		Training and Coordination: Plan, schedule, and implement trainings for community members; plan and implement ongoing communication and support mechanisms, including recognition; engage in data collection for trainings.	12/31/23

Dissemination Plan

Many counties, cities, tribes, agencies and community groups do great work, but don't typically toot their own horns. If you want to build a sustainable program (see the next section), it's helpful to let your community and funders know what you're doing. In the table below, describe steps you will take to disseminate news about your mobile crisis response. Consider traditional as well as social media. Include a timeframe and the responsible party. You can make your dissemination plan as detailed as you like, but it's also OK to just list the major steps along the way.

The County's overarching mobile crisis program is grounded in community engagement and capacity building, and envisions dissemination as one element of a larger community outreach and education campaign to build the capacity of communities to 1) better understand mental health crisis, 2) more easily access available resources, and 3) increase the number of individuals who are willing and able to serve as mental health first aid responders. The below activities represent a multi-purpose, multi-pronged approach that outreaches, educates, and engages community members through:

- Direct contact with formal and informal presentations with existing meetings and community groups (i.e., schools and parent organizations, faith-based organizations, other health and social service organizations, other first responders)
- Print and television media through press releases, articles, and filmed interviews
- Social media campaign

The County has not allocated funds to purchase airtime and is planning to leverage earned media for the CCMU dissemination activities.

Steps for Dissemination	Timeframe	Party Responsible
Develop outreach and engagement plan	6/30/23	DHHS
Develop collateral materials re: mobile crisis services	6/30/23	DHHS
Develop outreach materials (invitations, flyers, welcome packets, social media posts)	6/30/23	DHHS
Develop educational materials (PPTs, handouts, resource guide, social media posts)	6/3023	DHHS
Draft media materials (interview guide, talking points, press release, social media posts)	6/30/23	DHHS

Schedule interviews and presentations (community groups, print and tv media outlets)	Ongoing	DHHS
Engage in dissemination activities	Ongoing	DHHS and all Partners

Sustainability Plan

The truth about grant funding is that it eventually ends. If you want your mobile crisis response to outlive its funding, you have to plan for sustainability, and the time to start planning for sustainability is when you're in the planning stage. The key to sustaining programs is that the more your community supports what you're doing, the louder their collective voice grows to keep your programs going. Aside from applying for additional funding, here are ways that can help build a sustainable mobile crisis response:

- **Engaging stakeholders at every step in the planning and implementation stages**
- **Promoting public awareness**
- **Cultivating community champions and partners**
- **Recruiting new partners**
- **Training stakeholders and community members**
- **Institutionalizing services**

In the table below, please describe your sustainability plan. List steps you plan to take to build a sustainable program along with a timeframe for implementing those steps and the party responsible for doing so. Please add more rows as needed

The Behavioral Health Collaborative, convened by Del Norte Department of Health and Human Services, has already applied for funding from the CareStar Foundation. Sutter Coast Hospital submitted the Letter of Intent in December of 2022 requesting funds to support the ongoing work of the Collaborative and continue the workgroup meetings to support action plan implementation. Through the funding development process, the Local Emergency Medical Services Agency (LEMSA) and Del Norte Ambulance signed on as new ongoing members of the collaborative, if the CareStar application is approved.

Steps toward Sustainability	Party responsible	Timeframe
Continue Behavioral Health Collaborative meetings to support implementation	Convener: Sutter/DHHS Participants: All Members	Ongoing
Build community capacity to participate (See Goal #3)	Lead: DHHS	Ongoing
MHSA Funding • Include CCMU action plan in MHSA three year CPP process • Engage MHSA Stakeholders in CCMU implementation and ongoing development • Engage MHSOAC for technical assistance in INN project development	DHHS	3/30/2023
BHCIP Funding • Submit request for additional base allocation funding • Consider application for Round 6 to support Mental Health Urgent Care and Crisis Respite facility development	DHHS	4/15/23
Continue to engage other jurisdictions and first responders in this process • City and town leadership • Fire departments • Other local law enforcement agencies (Fire Department, CHP and other local law enforcement agencies)	DHHS, Crescent City PD, Sheriff	Ongoing

Benchmarks

In the table below, please indicate the next steps you need to take before beginning to implement your mobile crisis response plan. What needs to happen for you to move forward? Include a timeframe and party responsible. Please add rows as needed.

Next steps	Timeframe	Party Responsible
Meet with CRT Liaison	3/30/23	Shiann Hogan, DHHS
Present Action Plan to Board of Supervisors with Additional CCMU Allocation Request	04/25/2023	Ranell Brown, DHHS Shiann Hogan, DHHS
Identify DHHS Analyst to coordinate CCMU plan implementation	3/30/23	Shiann Hogan, DHHS