County of Inyo

2022-25 MHSA THREE-YEAR PLAN – ANNUAL UPDATE FY 2024-25

Draft – June 16, 2024

MHSA THREE-YEAR PLAN 2022-25
ANNUAL UPDATE FY 2024-25

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THREE YEAR PLAN
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County Demographics and Description

Inyo County is the second largest county in California encompassing 10,192 square miles and is the second most sparsely populated, with 1.8 people per square mile. According to the 2020 census, the population of Inyo County was 19,016 citizens. The population is concentrated in Bishop, (population 3,879) West Bishop (population 2,607), Lone Pine, (population 2,035), Big Pine (population 1,756) and The Bishop Paiute Tribal Community (population 1,588). All of these communities are located along the Owens Valley beneath the Eastern crest of the Sierra Nevada. Inyo County has the highest point in the contiguous United States; Tumanguya (Mt. Whitney) at 14,505 ft., and the lowest point in the contiguous United States at Badwater in Death Valley at 282 feet below sea level.

Recovery from the pandemic and multiple local natural weather-related events has extended issues for those experiencing medical problems, mental health problems associated with isolation, loss of employment, lack of financial resources, and families struggling to acclimate to children being back in the school setting.

At this time, Inyo County Behavioral Health Services is working to understand the new direction of Behavioral Health services in the CalAIM initiative and how to make it work in our small rural community with limited resources. Health and Human Services, as a department, has provided Trama Informed Care (TIC) training to all staff and implemented a JEDI (justice, equity, diversity and inclusion) work group to ensure department wide education and review of plans to encompass a JEDI approach to client services.

The majority of Inyo County's population identify as Euro-American, with next largest segment identifying as LatinX or Mexican, and the next largest, Indigenous tribal members. Based on the 2020 census, 66% identify as white; 19% identify as Hispanic or of Latino origin. Given the LatinX population which has grown 3.7% since the last census, Spanish is a threshold language for Inyo County, and we are challenged to find ways to meet our Spanish-Speaking client's needs in behavioral health and substance use disorders services.

The federally- recognized "Native American" (Indigenous) nations in Inyo County are the Bishop Paiute Tribe, Big Pine Paiute Tribe of the Owens Valley, Fort Independence Reservation, Lone Pine Paiute Shoshone Reservation, and Timbisha Shoshone Tribe. The Timbisha Shoshone Tribe, located in Death Valley National Park, is the only tribe located inside a national park in the US.

Settlement within Inyo County by Euro-Americans within the past one hundred fifty years has had significant consequences for the Indigenous tribes of Inyo County. Most significant of these are the impact on the physical, spiritual, and mental health,[1] and for whom historical trauma is strongly correlated with higher incidences of

[1] Spillane, N. S., Schick, M. R., Kirk-Provencher, K. T., Nalven, T., Goldstein, S. C., Crawford, M. C., & Weiss, N. H. (2022). Trauma

addiction-related health problems, mental health problems related to trauma, and disproportionate numbers of justice-involved individuals. [2]The combination of multi-generational trauma compounded by substance use disorders is often stigmatized in ways that prevent people from feeling welcome or safe in seeking recovery or healing services. Seeking culturally relevant healing services is particularly challenging when our State and County governed behavioral health systems are grounded in a Western medical paradigm and allow no room for practices and methods that fall outside of the Western medical model.

The health issues experienced by people of color and particularly Indigenous people include diabetes, hypertension, heart disease, obesity, and increased rates of colon cancer, which are related to diets high in salt, sugar, and fat. Immune-related disorders and inflammatory conditions are also related to acute and chronic trauma. The effects on mental and spiritual health are correlated with transgenerational and historical trauma, the symptoms of which manifest in substance use and dependence, depression, anxiety, bipolar disorders, and post-traumatic stress disorder among other illnesses that occur disproportionately among Indigenous People and people of color.

Finally, we have a disproportionate number of Indigenous people and people of color in jail who need rehabilitative and recovery services. As it is, Inyo County, like most other rural counties, lacks the infrastructure to provide safe, secure housing for justice-involved clients who require a higher level of behavioral health care. The jail serves as the "de facto" psychiatric hospital which is true for many rural counties where resources are few for individual who are substance-involved, mentally ill, and experience chronic homelessness. We are striving to build out services in the jail and to make our re-entry services more robust.

The Toiyabe Indian Health Project established in 1968 serves eight tribes along the eastern slope of the Sierra Nevada and Death Valley. Services available for tribal members include medical, dental, dialysis, optometry, behavioral and substance use disorders services, and pharmacy services.

Inyo County Behavioral Health Services works collaboratively in serving clients who need Intensive Outpatient Treatment groups and who may qualify for supportive services such as case management and specific groups for improving life skills and improving physical well-being. These services are located at Wellness Centers in Bishop and Lone Pine and will be funded by MHSA Community Services and Supports (CSS).

Economic conditions in Inyo County may impose hardships on many families and individuals due to the combination of a high cost of living and limited work availability. Inyo County relies heavily on tourism and government services to support the economy. Many available jobs are in the service industry or are seasonal. It is difficult to find entry level jobs for persons with a disability. The median family income in Inyo County is slightly below the 60% marker of the median family income for California as a whole.

Substance Use among Indigenous Peoples of the United States and Canada: A Scoping Review. Trauma, Violence, & Abuse, 0(0). https://doi.org/10.1177/15248380221126184

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Statistics and Demographics on Number of Medi-Cal beneficiaries served in Calendar year 2022:

Source: BHC MHP QRO Final Report – FY 22-23

The Statewide Penetration Rate (PR) is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the Mental Health Plan (MHP), the MHP's PR of 6.84 percent was 57.6 percent greater than the statewide rate, and the average claim amount of $5,896 was 21.1 percent less than the statewide average.

Table 1: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	6,300	431	6.84%	$2,541,371	$5,896
CY 2020	5,835	412	7.06%	$2,302,022	$5,587
CY 2019	5,493	356	6.48%	$1,256,009	$3,528

*Total annual eligibles may differ in Tables 3, 4, and 7 due to rounding of different variables in calculating the annual number of eligibles based upon average of the monthly eligibles.

- Annual eligibles, beneficiaries served and AACB increased each year from CY 2019 to CY 2021. The PR declined from CY 2020 to CY 2021 (7.06 percent vs. 6.94 percent.)

Table 2: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	720	-	-	1.71%	1.96%
Ages 6-17	1,478	134	9.07%	8.65%	5.93%
Ages 18-20	286	<11	-	7.76%	4.41%
Ages 21-64	3,157	220	6.97%	8.00%	4.56%
Ages 65+	660	43	6.52%	3.73%	1.95%
Total	**6,301**	**431**	**6.84%**	**7.08%**	**4.34%**

- PRs exceeded statewide rates for all ages except those ages 18-20. PRs exceeded similar sized county rates for those aged 0-5, 6-17, and 65 and over.

Table 3: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	25	5.80%
Threshold language source: Open Data per BHIN 20-070		

The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access specialty mental health services (SMHS) through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served. Table 7 and Figures 1–9 compare the MHP's data with MHPs of similar size and the statewide average.

Table 4: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	38	<11	-	7.64%
Asian/Pacific Islander	49	<11	-	2.08%
Hispanic/Latino	1,995	81	4.06%	3.74%
Native American	1,160	59	5.09%	6.33%
Other	428	37	8.64%	4.25%
White	2,632	251	9.54%	5.96%
Total	**6,302**	**431**	**6.84%**	**7.64%**

Inyo served 431 unique beneficiaries in CY 2021 with 251 White beneficiaries served and 81 Hispanic/Latino beneficiaries served. The MHP's White penetration rate was 60.1 percent greater than the statewide rate (9.54 percent vs. 5.96 percent) and the Hispanic/Latino penetration rate was 8.6 percent greater than the statewide rate (4.06 percent vs. 3.74 percent.)

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021

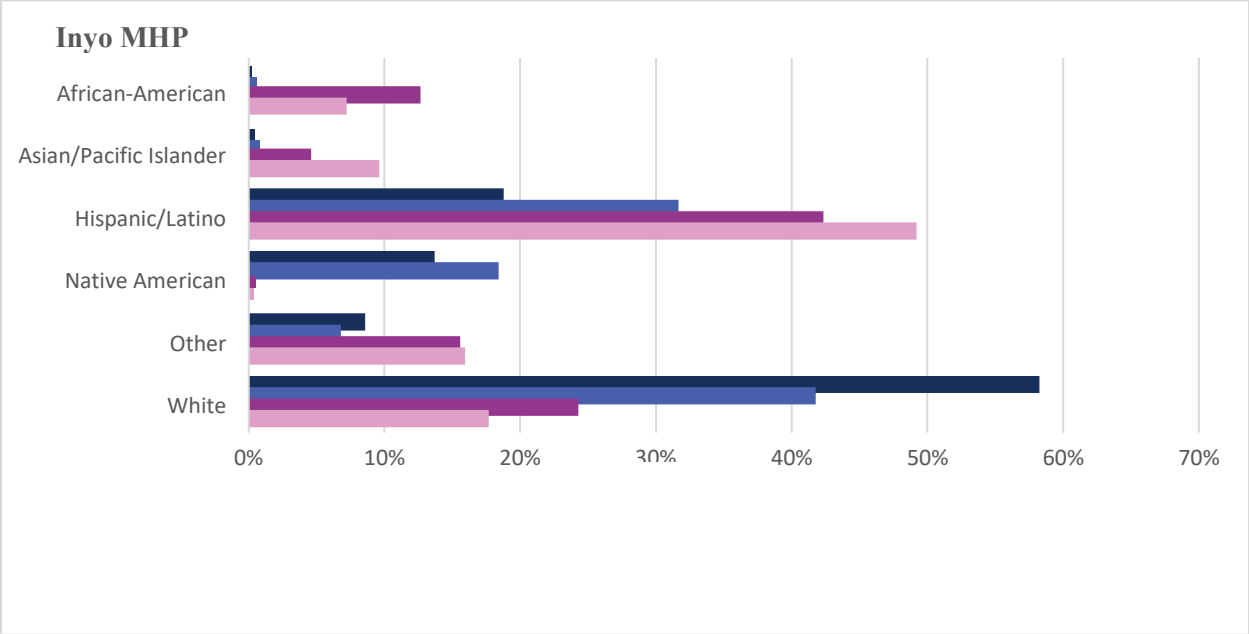
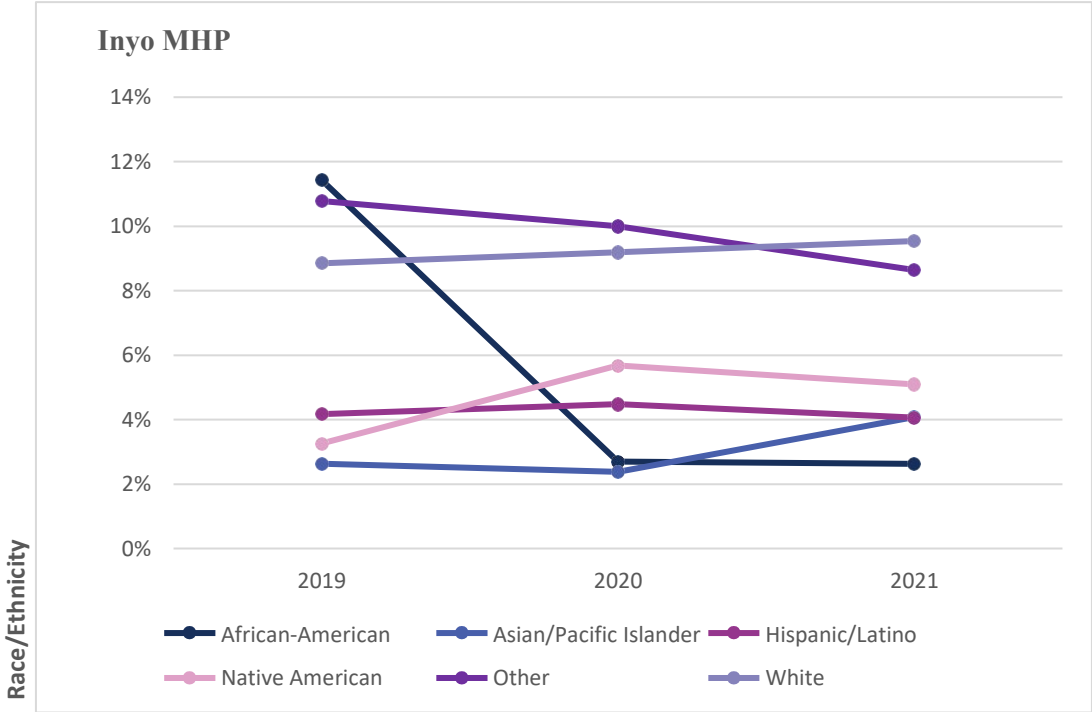


Figure 2: Race/Ethnicity for MHP Compared to State CY 2021



From CY 2019 to CY 2021, Asian/Pacific Islander, Native American and Hispanic/Latino PRs were consistently lowest while White and Other had the highest PRs. It should be noted that African-American and Asian Pacific Islander race/ethnicity groups each served <11 beneficiaries, and lower beneficiary counts can cause greater year over year variations in the data.

Table 6: Foster Care PR CY 2019-21

	2019	2020	2021
MHP	47.06%	52.38%	60.61%
Small-Rural	45.51%	44.98%	42.49%
State	51.91%	51.00%	49.15%

The Foster Care PR increased each year from CY 2019 to CY 2021 and in CY 2021 exceeded both the small-rural and statewide rates.

Source: BHC MHP EQR Final Report FY 22-23

INYO COUNTY'S STRENGTHS AND VULNERABILITIES:

Strengths:

- Community members care for one another.
- Connection through events and rituals
- Knowledge and concern for the land and water issues
- Awareness and concern for increasing substance use
- Multi-generational connection
- Appreciation of cultural differences
- Desire to help and to find solutions to disparities in access to culturally appropriate addiction services, healthcare, and mental health therapy; housing, and healthy food.

Vulnerabilities:

- Lack of recovery resources for adolescents and adults
- Lack of recovery resources for residential drug and alcohol treatment
- Developmental trauma as a root cause for substance use disorders and mental health challenges
- Few resources for Spanish-speaking community members
- No housing resources for individuals experiencing homelessness
- Marginalization of Indigenous people (overrepresentation in jail and disproportionate numbers experiencing post-traumatic stress related symptoms, mental illness, substance use, and health problems typically associated with developmental trauma.)
- Fear of seeking services

Inyo County's Division of Behavioral Health has prioritized awareness and education to staff members around trans-generational, race-related, and historical trauma and how families have struggled to manage the myriad ways in which trauma manifests. There is more potential for community members to be more involved in prevention and support as volunteers or paid staff.

We are rebuilding and revisiting how best to collaborate with our community partners which include regular multi-disciplinary team meetings with Probation, Northern Inyo Healthcare District, Inyo County Sheriff's Department, Bishop Police, Toiyabe Family Services, and other divisions within Inyo County Health and

Human Services (HHS).
We are invested in training and education in trauma awareness and cultural humility and will continue to offer Trauma Informed Care training and ongoing training and education in Justice, Equity, Diversity, and Inclusion (JEDI). Our mission is to bring those principles into all aspects of services.

Mental Health Services Act – Foundational Precepts
Inyo County Behavioral Health Services is committed to following the California Code of Regulations to ensure that MHSA services are in keeping with its foundational precepts of being

- Client Centered
- Family Centered
- Community-Based and Collaborative
- Culturally Competent
- Outcomes driven

RESOURCES:
CA Code of Regulations - Title 9 - Rehabilitative and Developmental Services, Division 1 - Department of Mental Health
Chapter 14 - Mental Health Services Act
Article 2 - Definitions
Sections 3200.050, 3200.120, 3200.060, 3200.070, 3200.100

Definitions:

MHSA – Mental Health Services Act
ICBHS – Inyo County Behavioral Health Services

Services will be client driven: "Client Driven" means that the client has the primary decision-making role in identifying his/her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for him/her. Client driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

Services will be Family Driven: "Family Driven" means that families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

Services will be Community-Based and Collaborative: "Community Collaboration" means a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals.

ICBHS will ensure that services are culturally competent: "Cultural Competence" means incorporating and working to achieve each of the goals listed below into all aspects of policy-making, program design, administration and service delivery. Each system and program is assessed for the strengths and weaknesses of its

proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocol and procedure are developed, as necessary to achieve these goals.

(1) Equal access to services of equal quality is provided, without disparities among racial/ethnic, cultural, and linguistic populations or communities.
(2) Treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.
(3) Disparities in services are identified and measured, strategies and programs are developed and implemented, and adjustments are made to existing programs to eliminate these disparities.
(4) An understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups is incorporated into policy, program planning, and service delivery.
(5) An understanding of the impact historical bias, racism, and other forms of discrimination have upon each racial/ethnic, cultural, and linguistic population or community is incorporated into policy, program planning, and service delivery.
(6) An understanding of the impact bias, racism, and other forms of discrimination have on the mental health of each individual served is incorporated into service delivery.
(7) Services and supports utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.
(8) Staff, contractors, and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and/or linguistic population or community that they serve.
(9) Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community.

CORE PRACTICES:

Ensuring services are Client Centered: ICBHS clinical staff will work with each client to identify strengths in seven Life Domains pursuant to CalAIM documentation standards (DHCS-BHIN 22-019). ICBHS will work with clients on identifying barriers to optimizing strengths and will engage client's natural supports (family, friends, colleagues, teachers, spiritual guides, and other providers) to create a service plan based upon client's stated needs and goals.

Ensuring Services are Family Driven: Services for children and adolescents will involve the child's parents or caregivers when safe and appropriate, extended family, and others whom the children and family consider part of their kinship system. Planning will be driven by the family's values and needs, and that care plans are established to optimize the children's overall well-being and build on the family's strengths.

Ensuring services and supports are community-based and collaborative:

ICBHS will conduct stakeholder meetings each month in the planning process. "Stakeholder" means individuals or entities with an interest in mental health services, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families, (CA CCR 3200.270).
ICBHS will ask for community feedback and input by conducting surveys intended to identify needs and gaps in services each year which will also inform the planning process.

Ensuring services and programs are outcomes driven:

- ICBHS will invite each client and family enrolled in Full Services Partnerships to provide feedback in Team Meetings as to their progress as they define it;
- Community partners will provide quantitative data on enrollment in services and completion of services on a quarterly basis
- ICBHS will track data by service category at the Wellness Centers.

Community Program Planning

The Inyo County Health and Human Services-Behavioral Health (ICHHS-BH) Community Program Planning (CPP) process for the development of the MHSA FY 2022-2025 Three- Year Plan built upon the planning process for the previous MHSA Three-Year Plan and the most recent Annual Update.

UPDATES FOR FY 2024-25 for the Behavioral Health Division:

- We will continue building the participation in our monthly Behavioral Health Advisory Board meetings which are held monthly on the second Wednesday from 2:30-4:00.
- Hire Behavioral Health Director - Identify and appoint a highly qualified Behavioral Health Director who possesses the necessary expertise, experience, and leadership skills to oversee and enhance the delivery of behavioral health services, ensuring the highest standards of care and effective program management.
- This year we will be attending State provided training and coordination of the change to Behavioral Health Services Act (BHSA) and the Proposition 1 changes.
- Finalize and Implement a Crisis Care Mobilization Unit - The Crisis Mobilization Unit has been under development and is on schedule to launch in July 2024. The goal is to ensure it is equipped with trained personnel, appropriate resources, and effective protocols. The unit will provide immediate, on-site mental health crisis intervention and support, enhancing the community's ability to respond swiftly and effectively to mental health emergencies.
- Successfully launch CARE Court by December 2024 - Establish and operationalize the CARE Court system by the end of 2024, ensuring all necessary infrastructure, personnel, and protocols are in place. This includes training staff, coordinating with mental health and legal professionals, and creating streamlined processes for identifying, evaluating, and providing care to individuals in need, thereby enhancing access to comprehensive mental health support within the community.

As part of our monthly Advisory Board meetings, the Deputy Director and MHSA Coordinator will inform the Behavioral Health Advisory Board and other participants of each of the programs' statistics and accomplishments. We will discuss ongoing challenges and potential solutions, including the following:

- Capacity and staffing issues,
- Crisis response and how to partner with law enforcement and emergency departments
- Access issues for clients who live in remote parts of the County,
- Program statics of CCMU responses
- Updates on the operationalization of Care Court
- Provide a Continuum of Care and HHS Housing program update
- Program updates on MHSA activities
- Community-based solutions for mentally ill and/or substance-involved clients who are chronically incarcerated and/or presenting in the emergency departments
- Mental health awareness and stigma within the community.

Ideally, the Community Planning Process occurs on an ongoing basis in response to needs and outcomes that are data-driven. In keeping with MHSA principles and the California Codes that inform MHSA services, services are community-based, needs based, family driven, and outcomes driven. In service of making services relevant, we will be asking clients for feedback on an ongoing basis via surveys and questionnaires.

The draft of the annual workplan for 2024-25 was shared with Inyo County's Health and Human Services leadership team from Social and Placement Services, Public Health and Prevention, Public Assistance and Aging, Fiscal Oversight and Special Operations, and Departmental Administration. It is shared with the Behavioral Health Division staff and is made available on Inyo County's website.

What are the service components of the Mental Health Services Act?

1) **Full Services Partnership** (FSP) – Clients and providers identify strengths and needs for clients and provide a full spectrum of services to optimize potential for achieving mental, physical, and spiritual well-being.

2) **Prevention and Early Intervention (PEI) –** "The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties prevent negative outcomes by intervening early in the onset of mental health needs with timely access to services and support. The MHSA requires collaboration with consumers and family members in the development of PEI projects and programs.," (MHSOAC).

3) **Innovation (INN)-** The MHSA's Innovation component aims to explore and develop new mental health models that improve the quality of services, promote collaboration, and increase access to services. Counties propose Innovation plans to the Commission, which selects candidates for funding.

4) **Workforce Education and Training** (WET) - The Workforce Education & Training component supports the building of diverse mental healthcare workforces to include the viewpoints and expertise of clients and their families/caregivers and provide services that are linguistically and culturally competent.

5) **Capital Facilities and Technologies Needs** (CFTN) - The Capital Facilities & Technological Needs (CFTN) component supports the development of facilities and technologies used for administrative services or delivery of mental health services. Counties may use these funds to underwrite peer-support and consumer-run facilities, develop community-based settings, and build technological systems to deliver services.

The MHSA FY 2024-25 Annual Plan was approved by the Behavioral Health Advisory Board after reviewing data on our current programs; analyzing community needs based on stakeholder input; and determining the most effective way to further meet the needs of our unserved/underserved populations. In addition, it was shared at staff meetings to obtain additional input and feedback on services. All stakeholder groups are in full support of this annual plan.

Stakeholder Participation

Coordination with Local and Regional Organizations

2023-24 Stakeholder, Community Partner, and Consumer meetings

Coordination with Local and Regional Organizations (specifying number of stakeholder meetings and stakeholders present)

- Weekly:
    - Staff meetings to discuss staffing changes, hiring updates, program activities, State regulation changes and trainings
- Bi-Weekly:
    - Jail multidisciplinary team (MDT) meetings – Behavioral health, SUD program staff, Jail nurse, re-entry staff, Probation – Purpose: case planning and access to Wellness Center and progress House Programs
- Monthly:
    - Behavioral Health Advisory Board Meetings – Agenda items include public comment and addition of suggestions for improvements in services including MHSA CSS at the Wellness Centers
    - Northern Inyo Hospital Emergency Room staff to determine data on psychiatric emergencies, follow-up care, 5150 hospitalizations, and substance-related emergencies. Coordination of care and access to Wellness Center and Progress House programs.
    - Program Planning on the CalAIM Justice Involved initative with Inyo County Sheriff, Inyo County Probation, and other Health and Human Services divisions.
    - Meeting with Mono County Behavioral Health Director and Program Manager to discuss collaboration opportunities for mentally ill and unhoused individuals in Mono County and proposed solutions for housing for individuals in Mono and Inyo Counties.
    - Meetings with the two MediCal Managed Care plans to discuss Enhanced Care Management, Community Supports and required Memorandum of Understandings for several programs in our HHS Department.
    - Eastern Sierra Continuum of Care meetings to engage in the Coordinated Entry System and to remain apprised of housing initiatives

Challenges or barriers ICBHS has encountered in our planning processes and the resolutions to overcoming these barriers:

It is challenging to engage community partners primarily because most feel there are no clear solutions to the main issues identified in surveys and meetings. Many first responders including law enforcement, emergency room staff, probation officers, child protective services social workers, behavioral health staff, and substance use disorders staff are experiencing varying degrees of post-secondary trauma or "compassion fatigue," as defined by Charles Figley, in his1995 book, and Ron M. Walls, M.D. (2018). Many express frustration that no clear solutions exist in Inyo County for the escalating need for behavioral health and crisis services, often complicated by substance-related problems such as brain injury and chronic health problems. Stakeholder and partners correctly identify that we have very few resources to meet a significant need and no real or sustainable solutions available in the near future for such issues as housing for people without shelter, availability of secure supervised living for severely mentally ill and/or substance-involved consumers, and lack of availability of adolescent or adult residential treatment for substance use disorders.

In FY 2023/24, the HHS Department underwent a reorganization to move the Lanterman-Petris-Short (LPS) Act Conservator program into the HHS Social and Placement Services division. We have seen a significant increase in clients who have been conserved and requiring placement in qualified institutions. Most of these clients have been clients of our Wellness Centers.

Community Needs Assessment (CAN)
Inyo County Behavioral Health Services distributed Community Needs Assessment (CNA) surveys in English and Spanish to community partners, consumers and stakeholders.

The results of the CNA surveys indicated that:

- The majority of respondents are more likely to seek support and care from family members than from friends, a therapist, a school counselor, or clergy.[3]

Why this is significant:

- If community members are in distress and they would prefer to seek support and help from a family member, it suggests that we need to provide training in basis suicide awareness, skills for prevention, and education as to resources in Inyo County. It also suggests that we need to provide services that involve family members.

How MHSA services can meet this need:

- Offering Mental Health First Aid and ASIST training to community partners, consumers and their families, and stakeholders
- Full services partnerships – comprehensive services for consumers and their families or legal guardians

Performance Outcomes and Quality Improvement (POQI)
Inyo County Behavioral Health also distributed POQI surveys to clients, in English and Spanish, which are intended to measure satisfaction with mental health services and to identify needs

[3] See Attachment A – Community Needs Assessment Summary – July 2022

The results of the POQI surveys indicated that:

1.) Most respondents reported that substance use disorders are Inyo County's biggest problem. Trauma is Inyo County's next most significant problem, contributing to chronic or terminal illness, death, divorce, and mental illness.

Why this is significant:

- A disproportionate number of individuals struggling with addiction are BIPOC (Indigenous people and people of color).
- Our community is aware of trauma and that trauma is a root cause of mental illness, alcoholism, and drug addiction particularly for Indigenous and LatinX community members.

How MHSA services can meet these needs:

- Partnering and cross-referrals with Inyo County Substance Use Disorders or Toiyabe Family Services to increase our capacity for outpatient recovery services
- Educating staff and community members in trauma as it relates to family events, discrimination and its effects on our BIPOC population.
- Collaboration with our re-entry program for incarcerated individuals including engagement in Wellness Center services and groups, full services partnerships, and linkage with appropriate resources
- Educate staff, stakeholders, community members, and community partners on racial and historical trauma and provide access to trainings and learning materials
- Continue to use Prevention and Early Intervention funding to provide therapeutic and case management services in schools, to elder community members, and to young adults experiencing First Episode Psychosis.
- Continue to implement Trauma Informed Care (TIC) and extend its core principles out into the community.
- Use CSS funding to continue providing welcoming and culturally relevant groups at the Wellness Centers

School Mental Health and Early Intervention Services:

While Behavioral Health provides services in each of the schools within the county, the services focus on youth with severe emotional disturbance and their families. School partners have long expressed a need for early intervention services to fill a gap between the support that can be provided by the school counselors and those services provided by Behavioral Health. While services were provided for several years through statewide PEI funds used to support North Star Counseling Services, there was a need expressed to restructure these services and to work to increase mental health awareness and reduce stigma. Counseling services were identified as well as the need for training around suicide prevention, LGBTQIA+ issues, and stigma reduction.

LOCAL REVIEW PROCESS

30-Day Posting Period and Circulation Methods

This proposed MHSA FY 2024-25 Annual Update was posted for a 30-day public review and comment period from July 1- through August 9, 2024. An electronic copy of the final Plan is available online on the Inyo County website (http://www.inyocounty.us/MHSA). Hard copies of the document are available in the Bishop Behavioral Health Clinic; Bishop Wellness Center, Lone Pine Wellness Center, and at all county libraries, including the Bishop, Big Pine, Independence, Lone Pine, Furnace Creek, and Tecopa branches. In addition, a hard copy of the proposed Annual Update has been distributed to all members of the Behavioral Health Advisory Board.

Public Hearing Information for 2024-25 Annual Update:

A public hearing was conducted on August XXX, 2023 at 1:00 p.m. at 1360 N. Main St – Rm 103., Bishop California, 93514 as a special meeting of the Behavioral Health Advisory Board.

Substantive Recommendations and Changes

Input on the Annual Update will be reviewed prior to submitting to the County Board of Supervisors and the California Mental Health Services Oversight and Accountability Commission (MHSOAC). Substantive changes will be submitted prior to Board approval.

COMMUNITY SERVICES AND SUPPORTS
All Ages/Populations

Community Services and Support (CSS) Program Description and Outcomes

REFERENCES:
CA WIC Division 5, Chapter 1, Sections 5600-5610
9 CCR 3620.05
9 CCR 3200.140

POLICY

Inyo County Behavioral Health Services recognizes and abides by WIC Division 5, Community Mental Health Services, Chapter 1. Section 5600-5610, and 9 CCR 3620.05, as follows:

(a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.

(b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated, and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.

(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.

(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.

(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health. This program

combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

(f) By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.

(g) To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars ($1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars ($1,000,000). They have an average pre-tax income of nearly five million dollars ($5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multi-million-dollar homes in other states.

9 CCR, Section 3200.080: "Community Services and Supports (CSS) is the section of the Three-Year Program and Expenditure Plans that refers to service delivery systems for mental health services and supports for children and youth, transition age youth, adults, and older adults. These services and supports are similar to those found in Welfare and Institutions Code sections 5800 et. seq. (Adult and Older Adult Systems of Care) and 5850 et. seq. (Children's System of Care).

9 CCR Section 3200.140: "Full Service Partnership Service Category" means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plans, under which the County, in collaboration with the client, and when appropriate the client's family, plans for and provides the full spectrum of community services so that children and youth, transition age youth, adults and older adults can achieve the identified goals.

The Full Services Partnership component of the Mental Health Services Act offers clients the best opportunity to restore and sustain full functioning in seven life-domains identified in CalAIM goals to implement a "whole person care approach," that encompasses physical, behavioral, developmental, dental, and, and long-term care needs. Contact data is entered into BHIS by MHSA staff. Data is submitted to DHCS within 90 days of collection as required by section 9 CCR 3530.30.

COMMUNITY SERVICES AND SUPPORT PROGRAMMING

The MHSA CSS programs provide services to all ages [children (ages 0- 17); transition age youth (ages 16-25); adults (ages 18-59); older adults (ages 60+)]; all genders; and all races/ethnicities.

The strategies are part of the larger system/continuum of care now implemented as part of CalAIM (California Advancing and Innovating Medi-Cal). The Mental Health Services Act's core principles and regulations are similar in that a "whatever it takes" service approach applies under both programs to meet client and family needs. This approach has allowed us the transformative flexibility to meet our clients where they are in terms of life-domain functioning and needs for strengthening and building upon natural supports. Services for all populations are intended to acknowledge that anyone can experience compromised ability to function at their best, and that our ability to partner with other agencies and to include natural supports in case planning will yield optimal outcomes. These services emphasize the principles of empowerment, self-determination, wellness, recovery, and resiliency and offer integrated services for clients of all ages and their families.

Inyo County Behavioral Health services prioritizes meeting clients' needs in a timely and culturally aware manner. We recognize that some of our community members do not recognize themselves as "mentally ill," and that we can best serve them by including them in Wellness Center groups where they may participate in groups and services according to their particular needs. To ensure easy access, our Wellness Centers are centrally located and easy to find. We offer Bilingual case management services via the language line or when we have Bilingual staff available.

CSS Programs:

1.) **Full Services Partnerships** - Includes comprehensive behavioral health and substance abuse assessments, wellness and recovery action planning, case management services, individual and group mental health services; crisis services, peer-led self-help/support groups, education and employment support, education and awareness around stigma associated with mental illness, linkage with primary care providers, and housing support and assistance.

2.) **Wellness Centers:** Our Adult and Older Adult Wellness Centers (located in Bishop and Lone Pine) provide adults and older adults with meals, showers, laundry facilities, assistance with applications for CalFresh, housing, social security disability, and Medi-Cal, domestic violence advocacy necessary services and supports in a welcoming environment. During the summer, we have a garden where clients can learn to grow vegetables and bring them home or learn to cook with Wellness Center staff.

The Wellness Centers Model that many counties in California have adopted follow the Mental Health Service's Acts core principles which are to make services needs driven, client-centered, strengths-based, and outcomes driven.

The Wellness Centers goals are:

a. De-stigmatize mental health conditions by being inclusive and respecting each client's experiences.

b. Be strengths-based in its programs and services by offering an array of services where clients may learn basic life skills, creative expression, improving nutrition awareness, opportunities for recreation and outdoors activities;

c. Build community by including clients in planning and developing groups, projects, and programs.

d. Be client-driven such that clients are the main informants of needs and gaps in programs and services.

e. Create an environment of safety by creating and committing to expectations of non-violence and non-discrimination for staff and clients.

As a community center for the purposes of serving community members experiencing homelessness, mental health challenges, and substance use disorders, the Wellness Center provides case management, assistance with accessing recovery services, therapeutic interventions, healthcare, financial assistance, housing, and resources for employment or continuing education. Wellness Centers also serve as cooling and warming centers for these community members during times of extreme heat or cold during business hours.

We provided ongoing peer-facilitated groups at the Wellness Center in Bishop, including recovery, journaling, creative expression through art, nutrition, blanket-making, and wellness walking. We may also provide groups such as money management, smoking cessation, gardening, and dialectical behavioral therapy to persons at the wellness center facilitated by Behavioral Health staff members.

Table 7: Total number of clients served at the Bishop Wellness Center from July 2023 through April 2024:

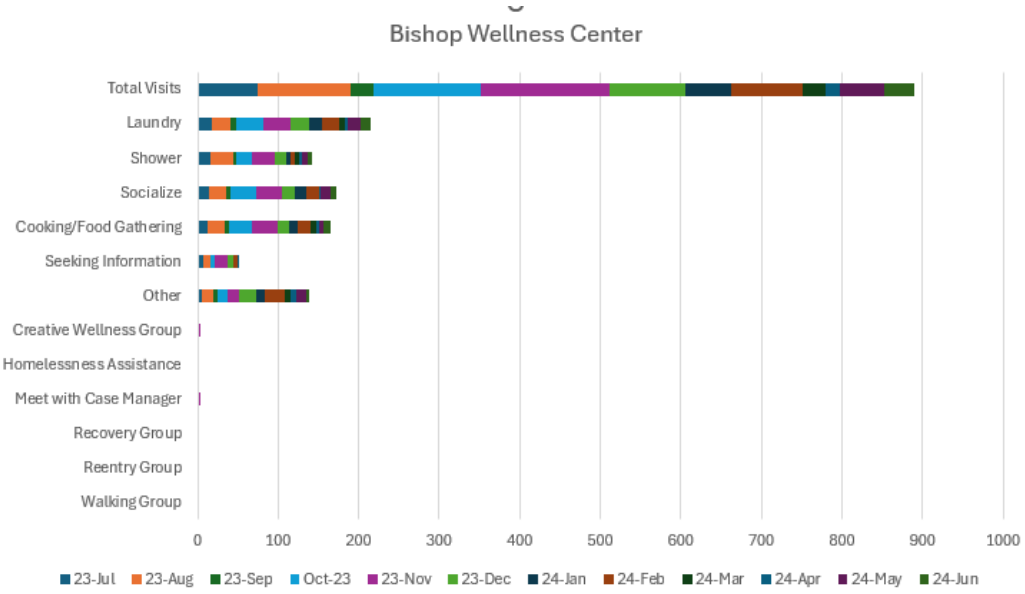
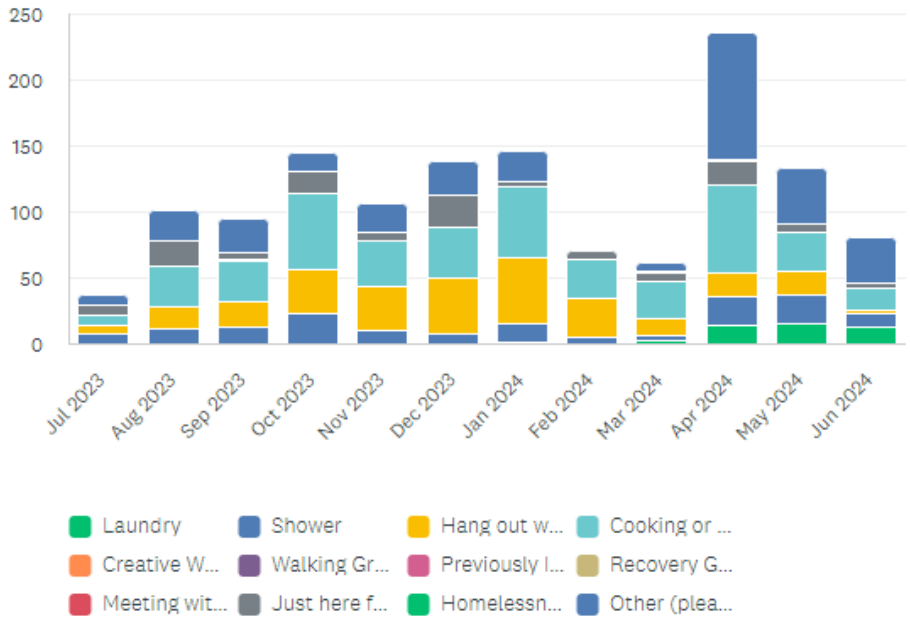


Table 8: Total number of clients served at the Lone Pine Wellness Center from July 2023 through April 2024:



This year, the three goals for the Wellness Centers are:

1. **Revise and implement the Full Service Partnership (FSP) procedure to ensure it aligns with current best practices and incorporates feedback from current staff.**

- *Assemble a Review Committee:*
  - Task: Form a committee of staff members who will be responsible for reviewing the FSP procedure.
  - Metric: Committee formed by August 1, 2024.
- *Review Existing Procedure:*
  - Task: The committee will review the current FSP procedure, identify areas that need updates, and compile a list of recommendations.
  - Metric: Complete review and compile recommendations by October 1, 2024.
- *Draft Revised Procedure:*
  - Task: Create a draft of the revised FSP procedure incorporating staff feedback and current best practices.
  - Metric: Complete the draft by November 1, 2024.
- *Staff Review and Feedback on Draft:*
  - Task: Distribute the draft to all staff for review and collect additional feedback.
  - Metric: Collect feedback from at least 50% of the staff by January 1, 2025.
- *Finalize Procedure:*
  - Task: Revise the draft based on the feedback received and finalize the FSP procedure.
  - Metric: Finalize the procedure by February 1, 2025.

- Staff Training:
    - Task: Develop and conduct training sessions for all staff on the new FSP procedure.
    - Metric: Train 100% of staff by March 31, 2025.
- Implementation:
    - Task: Implement the revised FSP procedure across all relevant departments.
    - Metric: Fully operationalize the new procedure by April 1, 2025.
- Monitor and Evaluate:
    - Task: Monitor the implementation and evaluate the effectiveness of the revised procedure through regular check-ins and performance metrics.
    - Metric: Report monthly performance metrics at the BHAB meetings and quarterly QIC meetings starting May 2025.

2. **Train staff and develop a standardized procedure to ensure that 100% of clients experiencing homelessness are entered into the Coordinated Entry System (CES).**

- *Identification of staff and Training Implementation*
    - Task: Working with the Inyo HHS Housing Program identify staff who will be trained on the use of CES.
    - Metric: Completion of training program materials and schedule by July 31, 2024.

- *Draft Revised Procedure:*
    - Task: Develop and document a standardized procedure for identifying clients experiencing homelessness and when to enter those clients into the CES.
    - Metric: Complete the draft by September 1, 2024.

- *Staff Review and Feedback on Draft:*
    - Task: Distribute the draft to all staff for review and collect additional feedback.
    - Metric: Collect feedback from at least 50% of the staff by October 15, 2025.
- *Finalize Procedure:*
    - Task: Revise the draft based on the feedback received and finalize the CES procedure.
    - Metric: Finalize the procedure by December 1, 2024.
- *Staff Training:*
    - Task: Develop and conduct training sessions for all staff on the new CES procedure.

- *Monitoring and Evaluation:*

    - Task: Monitor the implementation and evaluate the effectiveness of the revised procedure through regular check-ins and performance metrics.
    - Metric: Report monthly performance metrics at the BHAB meetings and quarterly QIC meetings starting May 2025.

3. **By December 31, 2024, ensure that 100% of staff at the Wellness Center utilize the new Electronic Health Record (EHR) system to document all services provided to clients, with an individual productivity rate of at least 75% of their time in the system**.

    - *Training:* Provide comprehensive training sessions for all staff members on how to use the new EHR system effectively.

- *Support:* Implement a process for regular monitoring and support to help staff transition to this documentation.
- *Monitoring:* Conduct monthly reviews of productivity to check the accuracy and completeness of the documentation in the EHR system.
- *Feedback:* Collect feedback from staff to address any challenges they face and make necessary adjustments.

PREVENTION AND EARLY INTERVENTION
Prevention Programs

(1) Per 9 CCR, 3705, Inyo County Behavioral Health Services will incorporate the following into its MHSA Three-Year Plan:

(2) At least one Outreach for Increasing Recognition of Early Signs of Mental Illness Program as defined in Section 3715.

(3) At least one evidence-based Prevention Program as defined in Section 3720 as follows:

(a) "a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors." The goal of this Program is to bring about mental health including reduction of the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members.
(b) "Risk factors for mental illness" means conditions or experiences that are associated with a greater than average risk of developing a potentially serious mental illness. Risk factors include, but are not limited to, biological including family history and neurological, behavioral, social/economic, and environmental.
(1) Examples of risk factors include, but are not limited to, a serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, prolonged isolation, traumatic loss (e.g. complicated, multiple, prolonged, severe), having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.
(c) Prevention Program services may include relapse prevention for individuals in recovery from a serious mental illness.
(d) Prevention Programs may include universal prevention if there is evidence to suggest that the universal prevention is an effective method for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average.

ELDER OUTREACH

Purpose:
To recognize early signs of mental illness and co-occurring substance use disorders and physical health problems

Desired Outcomes*:*
1) Decrease incidents of suicide, neglect, and increased substance abuse
2.) Educate the community on mental health and substance use recovery services on how to recognize early signs of mental illness and co-occurring substance use disorders.

To better serve Inyo County's older adult population, the Elder Outreach Program, our Prevention and Early Intervention (PEI) program is intended to serve at-risk seniors who are experiencing symptoms of depression, prescription drug abuse, isolation, and other conditions of concern for an ageing population. The Elder Outreach Program provides outreach and engagement, early mental health screening, and prevention services to older adults who had been receiving services in the community and through county resources. This program also trains agency partners to recognize the signs and symptoms of mental illness in older adults.

The Elder Outreach Program funding provides for a behavioral health nurse for screening, referral, and linkage, to services that address medical and mental health needs. Support services to prevent the exacerbation of mental health conditions. Prevention and Early Intervention services are voluntary and client-centered, strengths-based, integrating wellness and recovery principles that address both immediate and long-term needs.

Historically the role of the Behavioral Health Nurse is to provide screening, referral, and linkage, to services that address mental health needs and support services to prevent the exacerbation of mental health conditions. They can also provide the initial assessment to potential candidates for prevention services such as the Friendly Visitor Program.

The Behavioral Health Nurse collaborates closely with other agencies that provide services to this population, including In-Home Supportive Services, Adult Protective Services, Eastern Sierra Area Agency on Aging, local physicians, Public Health, nursing homes, home health agencies, and the home delivery meals program. All agencies receive training to help them recognize signs and symptoms of mental illness in older adults.

The Behavioral Health Nurse also provides services to older adults in community settings that are the natural gathering places for older adults, such as our Senior Center sites in the community sites of Bishop, Big Pine, Independence, Lone Pine, and Tecopa. Older adults who need additional services are referred to a Friendly Visitor (see below) or to Behavioral Health for ongoing treatment, as appropriate.

This year, with the change in administration and staff, we will review and update the planned activities and program purpose to meet the needs of the community.

Program Update and Implementation:

- Identify training and education activities that can be provided (i.e. depression, prescription drug abuse, isolation, and other conditions of concern for an ageing population)
    1. Working with stakeholders (In-Home Supportive Services, Adult Protective Services, Eastern Sierra Area Agency on Aging, local physicians, Public Health, nursing homes, and home health agencies) identify natural gathering places for older adults and their families to provide training and education
    2. Develop an annual schedule for training and education events

Metric: Report monthly event and attendance metrics at the BHAB meetings and quarterly QIC meetings starting January 2025.

Families Strengthening Team (FST)

Purpose: To work collaboratively with Inyo County Social Services and families to create client-driven, strengths-based Wraparound care for high-risk families

Desired outcomes: Reduce out of home placements and improve functional capacity by offering evidence-based parenting skills interventions (PC Care) and other services and supports.

This year, we are proposing to identify additional youth in need of full-service partnership (FSP) within our FST program. As part of our overall ICHHS Children's System of Care, the FST program employs a wraparound model in working with families with youth at risk of placement in a high level of out of home placement as well as families in need of intensive services as a means of building upon existing protective factors. Strengths-approaches consider several factors in developing a care plan;

1.) Developmental history including trauma and at which points in developments, trauma has occurred

2.) Functioning in life domains – We evaluate how well family members are able to manage the stressors of everyday life within family system. We look at functioning in the family in the domains of education, work, physical health, substance use, mental health history, and spiritual life.

3.) Existing resources or natural supports – What has worked for the family in terms of managing challenges, changes, and "big T traumas," and "little T traumas, which are better explained in the research into complex post-traumatic stress disorder and developmental trauma.

4.) Developing intervention strategies and measuring outcomes

FST utilizes a multi-disciplinary approach in developing a care plan which includes clinical staff, substance use disorders staff, child -protective services social workers, case managers, Parent Partners, healthcare providers, other advocates such as CASA's or coaches, teachers, and spiritual mentors. We include resources from the First Five program as well as other agencies to intensively support the families. As the result of this expansion, we serve families with younger children.

This year we will support the Behavioral Health division by training in the evidence-based PC CARES (Parenting in Challenging Contexts: Child and Adolescent Resilience and Emotional Strength) program to ensure CPS-identified children and families receive this intervention as needed.

- **Training Completion:**
  - **Target:** Train FST team members in the PC CARES program by January 1, 2025.
  - **Metric:** Percentage of team members who have completed the PC CARES training.
- **Certification:**
  - **Target:** Ensure at least 90% of trained team members achieve certification in the PC CARES program within 2 months of completing the training.
  - **Metric:** Percentage of trained team members who are certified.
- **Implementation:**
  - **Target:** Deliver the PC CARES intervention to CPS-identified children and families referred to the FST within 3 months of referral.
  - **Metric:** Percentage of referred CPS-identified children and families who receive the PC CARES intervention.
- **Follow-Up:**

- **Target:** Conduct follow-up assessments with families who received the intervention to evaluate the program's effectiveness within 6 months.
- **Metric:** Percentage of families followed up with post-intervention.

- **Outcome Evaluation:**

  - **Target:** Achieve a 75% satisfaction rate among families who received the PC CARES intervention based on post-intervention surveys.
  - **Metric:** Satisfaction rate from post-intervention family surveys.

We have addressed the need for school-based early intervention services through a contract with Inyo County Office of Education's Northstar Counseling Center. The contract provides for counseling services for children and teens who do not meet medical necessity criteria for services with Inyo County Behavioral Health where we serve children with severe mental health challenges. The contract provides for training for youth in Mental Health First Aid with the intention of developing a Youth Peer Support team.

This year:

- North Star Counseling Center will increase access to school-based mental health services by maintaining a full-time staff of qualified therapists (PEI Project #1)
- North Star Counseling Center and Inyo County Office of Education will facilitate Youth Mental Health First Aid training sessions for school staff and interested community partners throughout the school year (PEI Project #2)
- North Star will continue to facilitate activities to reduce the negative feelings, attitudes, and beliefs associated with mental illness for our youth in an effort to reduce the stigma associated with mental health illness as well as promote suicide prevention and awareness efforts county-wide (PEI Project #3

PREVENTION AND EARLY INTERVENTION
Suicide Prevention Programs

This year we will offer crisis de-escalation and suicide prevention training in the ASIST and SafeTalk models to community members, law enforcement, first responders, school counselors and staff, probation staff, SUD program staff, and case managers within the Division of Behavioral Health.

We will also develop a local media campaign for Know the Signs – disseminating information and educating Inyo County about 988 as a resource for individuals experiencing emotional distress and for the prevention of suicide.

PREVENTION AND EARLY INTERVENTION
Stigma Reduction Programs

This year, we will continue to encourage staff to attend and participate in the monthly HHS JEDI (Justice, Equity, Diversity and Inclusion) meetings. All staff are Trauma Informed Care (TIC) trained and there are annual trainings offered to staff to refresh their skills in being trauma informed when delivering services.

INNOVATIONS

We do not have an Innovative project identified for this fiscal year.

WORKFORCE EDUCATION AND TRAINING

By the end of this year, our department will have developed and implemented a comprehensive annual training plan that aligns with our strategic goals and enhances staff competencies. This plan will include:

1. **Develop list of trainings:** Work with staff to identify required and requested trainings for their specific programs.
2. **Collaboration with Learning Institutions**: Establish partnerships with UC Davis and other relevant educational institutions to provide specialized training programs tailored to our department's needs.
3. **Training Modules**: Design and deliver at least 3 program-specific training modules in collaboration with these institutions, ensuring coverage of key areas identified in our needs assessment.
4. **Participation Metrics**: Achieve a minimum of 80% staff participation in the annual training programs, tracked through attendance records and participation logs.
5. **Feedback and Evaluation**: Implement a robust feedback mechanism to evaluate the effectiveness of the training sessions. This will include pre- and post-training assessments to measure knowledge gains and competency improvements, with a target of achieving an average improvement score of at least 20% across all modules.
6. **Continuous Improvement**: Use the feedback data to refine and enhance the training plan for the subsequent year, aiming for a satisfaction rate of 90% or higher among participants regarding the relevance and quality of the training.

CAPITAL FACILITIES/TECHNOLOGY

This year we will be using our Electronic Health Record to capture the activities provided by the CSS staff, updating the Bishop Wellness Centers bathrooms to address some water damage, purchasing signs for the two Wellness Centers and paying 50% of an Information Services staff person to work on our technological issues.