MENTAL HEALTH SERVICES ACT- THREE YEAR PLAN
2022-2025

County Demographics and Description - 2022

Inyo County is the second largest county in California encompassing 10,192 square miles and is the second most sparsely populated after Alpine County, one of California's smallest rural counties. 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.

Bishop and the smaller communities in Inyo County have suffered as a result of the pandemic, causing the closures of numerous small businesses as well as some of the larger businesses. The pandemic also brought with it a significant increase in substance use, and concurrent spikes in symptoms for individuals with existing mental health disorders, and emergence of depression, anxiety, and trauma-related symptoms especially for our adolescent and elder populations.

In addition, during summers of 2020 and 2021, California experienced some of its worst wildfires the outcomes of which were even more restricted activity and isolation for those experiencing medical problems and mental health problems associated with isolation, loss of employment, lack of financial resources, and families struggling to work while having children home from school.

At this time, Inyo County Behavioral Health Services is developing new approaches and building out existing approaches that match the intentions and goals of CSC (Coordinated Specialty Care) and CalAIM, an acronym for "advancing and innovating Medi-Cal). We are implementing a "whole person" approach to treatment and being innovative in ways we can meet the needs of our community members. In particular, staff have participated in TIC (Trauma Informed Care) training, and we are also participating in JEDI (justice, equity, diversity, and inclusion) training and we are focused on being a trauma-informed county by incorporating the principles of TIC and JEDI in all our work.

The majority of Inyo County's population identifies as Euro-American, with a significant minority identifying as Indigenous People. 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. service.

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.

Colonization by Euro-Americans within the past one hundred fifty years has had deleterious and lasting consequences for Indigenous tribes in Inyo County, the most significant of which are the diversion of water away from the Owens Valley beginning in 1913, and the subsequent impact on their food sources. are California and the recent history of the colonization of the Western United States.

The impact on the physical, spiritual, and mental health of the Indigenous People is well documented [1] and for the Indigenous People, historical trauma is strongly correlated with higher incidences of 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 have often been dismissed or defined such that stigma prevents people from feeling encouraged or safe seeking recovery or healing services. Seeking culturally relevant healing services is particularly challenging when 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, increased rates of and 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, lack the infrastructure to provide safe, secure housing for justice-involved clients who require a higher level of 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.

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

.

2020 census [edit]

Inyo County, California - Demographic Profile

(*NH = Non-Hispanic*)

Race / Ethnicity	Pop 2010[16]	Pop 2020[17]	% 2010	% 2020
White alone (NH)	12,296	11,035	66.30%	58.03%
Black or African American alone (NH)	102	85	0.55%	0.45%
Native American or Alaska Native alone (NH)	1,895	2,189	10.22%	11.51%
Asian alone (NH)	229	273	1.23%	1.44%
Pacific Islander alone (NH)	15	13	0.08%	0.07%
Some Other Race alone (NH)	21	87	0.11%	0.46%
Mixed Race/Multi-Racial (NH)	391	935	2.11%	4.92%
Hispanic or Latino (any race)	3,597	4,399	19.40%	23.13%
Total	**18,546**	**19,016**	**100.00%**	**100.00%**

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 plans collaborative work 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.

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

1.) Total of unduplicated clients for BH and SUD- **541**
2.) Of those, the number of Spanish-speaking clients- **11**
3.) **Age ranges**
0-5: 26
6-11: 61
12-17: 86
18-20: 17
21-24: 26
25-34: 116
35-44: 87
45-54: 56

55-64: 53
65+: 13

4.) Gender

Male-	**273**
Female	**265**
Not disclosed	**3**

5.) Ethnicity

Non Hispanic- 252
Unknown/not reported- 205
Latino/other Hispanic-45
Mexican/Mexican American- 39

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
- 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 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

The communities of Inyo County are multi-generational with white families arriving in the Owens Valley in the 1800's. The indigenous people had been in what is now Inyo County for hundreds of years, and the experience of colonization by indigenous people is relatively new compared to other regions in California and the United States. Inyo County's division of behavioral health has prioritized awareness and education to staff members around trans-generational trauma and how families have struggled to manage the myriad ways in which developmental trauma manifests. There is more potential for community members to be more involved in prevention and support as volunteers or paid staff.

ICBHS will utilize training and education funding for community members and partners in Mental Health First Aid, Applied Suicide Skills Intervention (ASIST), and other trainings in trauma awareness.

We are rebuilding and revisiting how best to collaborate with our community partners post-COVID 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 departments within Inyo County 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.

PROCEDURES:

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 in the State of California, 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.

This year's planning process was not as comprehensive as the previous planning process due to COVID restrictions and having significant changes in leadership in the first few months of 2022. We have conducted a Community Needs Assessment which was distributed electronically and was made available in hard copy to clients, community partners and agencies within Inyo County HHS. The survey was available for 45 days and number of respondents was significant enough to inform the services and supports plan at least until the Annual Update which is due on June 30, 2023.

ICBHS will discuss and obtain input on the utilization of MHSA funds with our key stakeholders and partners in our quarterly Quality Improvement Committee (QIC) meetings, our MHSA consumer meetings, and monthly

Behavioral Health Advisory Board meetings.

As part of our monthly Advisory Board meetings, Deputy Director and Program Supervisors will inform Behavioral Health Advisory Board and 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,
- Transportation barriers for clients needing transport to the Crisis Stabilization Unit or a psychiatric hospital,
- Homelessness and lack of affordable housing,
- 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 three-year workplan for 2022-2025 is shared with Inyo County's Health and Human Services leadership team from Child Welfare Services, Prevention, Eligibility, Public Health, and the administration. It is shared with the Behavioral Health Division staff and Substance Use Disorders program staff and is made available on Inyo County's website. To maximize resources, Inyo County has historically partnered with Mono, Alpine, and Kern Counties to ensure that we are not duplicating services and are instead combining resources and identifying gaps.

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

Components addressed by the planning process included Community Services and Supports (CSS) "Community Services & Support (CSS) is the largest component of the MHSA. CSS provides direct services to individuals with severe mental illness using a client-centered, wellness, and recovery-focused approach, including housing," (Mental Health Services Oversight and Accountability -(MHSOAC)

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.

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).

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.

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.

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 2022-2025 Three-Year Plan was developed and 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, the MHSA FY 2022-2023 Three-Year Plan was shared at staff meetings and at wellness center stakeholder meetings to obtain additional input and feedback on services. All stakeholder groups are in full support of this MHSA Three-Year Plan and the strategies to maintain services.

Stakeholder Participation

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

2022 CCMU Stakeholder, Community Partner, and Consumer meetings

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

Weekly:	Jail MDT meetings – Behavioral health, SUD program staff, Jail nurse, re-entry staff
Bi-weekly	Meetings with NIHD ER nurse managers to monitor crisis response and amend crisis response protocols as needed. Monitor number of clients who present in the ER due to drug-induced psychosis as opposed to chronic mental illness.
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.
Purpose:	Case management and triage for incarcerated clients and the need for pre-emptive crisis response to keep mentally ill individuals out of jail and in treatment; best practices for re-entry and case planning for severely mentally ill incarcerates.
04/04/22:	Meeting with Inyo County Probation – six participants
Purpose:	Determine percentages of justice-involved clients who are mentally ill and/or substance involved and who have been repeatedly incarcerated due to crimes committed while experiencing episodic psychosis
04/08/22:	Meeting with Bishop Police chief – Deputy Director Pier and Chief Satndridge
Purpose:	Discussion about why ICBHS does not respond to crisis in the field and the need for law enforcement to have support from trained crisis intervention personnel. Develop protocol for coordinated response. Transportation barriers in getting clients to a PHF or CSU. Education for community members and staff in Mental Health First Aid, ASIST, and CIT.
04/21/22	Meeting with Bishop Paiute Police Chief – Deputy Director Pier and Police Chief Julian
Purpose:	Determine how to collaborate with ICBHS on responding to crises and the need for mobile outreach for indigenous people on the reservations.
06/01/22	Meeting with Toiyabe Family Services – Deputy Director Pier, Director Michelle Saenz
Purpose:	Identify needs for crisis response and capacity for responding to the ER

Need for mobile response in the field, especially on the reservations

06/10/22 Summit Meeting – 28 participants (probation, Law enforcement, Inyo Superior Court, behavioral health, DA's office

Purpose: Coordination of a system of care for justice-involved individuals for whom "mental health diversion" may be appropriate and which can be defined as "mental health diversion" according to the CDSH definitions and guidelines

a.) What is a "system of care," and how does Inyo County BHS and SUD programs coordinate with probation, jail staff, law enforcement, the courts, Toiyabe Family Services, and medical providers to ensure a "no wrong door" approach to treatment?

b.) How to coordinate crisis response and intervention without putting undue strain on law enforcement, emergency room staff, and on-call staff.

06/23/22 CCMU Learning Collaborative

Purpose: Adding peers to CCMU grant – Training peers and Promotores in ASIST, MH First Aid to support law enforcement and staff CCMU

07/25/22 Community Needs Assessment Meeting with Northern Inyo Hospital

Attendees: Jennalyn, Outreach, Allison Partridge, Chief Nursing Officer, Topah, NIH Board Member, Joseph Herman, CEO Toiyabe, Mary May, NIH Board member, Kelli Davis, CEO NIHD, Dan David, Outpatient Coordinator

Purpose:

1. How to better provide follow up after ER visit for substance involved individuals and individuals with mental illness.
2. Linking MAT patients with IOP groups at Inyo County by designating one of our SUD staff as a liaison to coordinate with NIH bridge navigator.
3. Establishing regular meetings between NIH ED staff and ICBHS to build the continuum of care and the capacity to better understand the individuals we serve.
4. Develop data driven, outcomes driven services

08/09/22 CCMU Planning Meeting – Health Management

Purpose: Structuring the Action Plan

1. Mission statement
2. Values statement
3. Program Rationale
4. Detailed Implementation plan
5. Goals based on SMART
    a. Specific
    b. Measurable
    c. Attainable
    d. Relevant
    e. Timely
6. Dissemination Plan

08/11/22 NIHD Collaboration Meeting

Attendees: Dan David, Catie Grisham, Hallie Vickers, Arlene Brown, Heather Edwall, Melanie Fox

Purpose: Continue conversation and solutions for creating an MOU between ICBHS and NIH to better coordinate outpatient care for MAT patients

NIHD would like an SUD counselor to be on their campus one day or a half-day during the week to work with the Bridge Navigator

Need to meet the needs of Spanish-speaking clients – perhaps having jean Sprague provide the outreach and engagement at NIH for BH/SUD services?

08/16/22 Virtual meeting with Alma Esquivez with Vision y Compromiso

Purpose: Exploring Promotora training for Inyo County to build capacity to respond to crises in partnership woth law enforcement and ICBHS and to better serve Spanish-speaking clients. Alma will provide and proposal for training and attend a QII meeting for questions and answers on why and how Promotores can be valuable for Inyo County.

08/17/22 CBHDA Rural and Frontier Counties virtual meeting

Purpose: How Rural and Frontier counties are managing the challenge of crisis response with the growing need and understaffing

Santa Barbara County: Telephone triage and crisis response teams, utilizing paraprofessionals (peer support staff, peer partners or promotores)

Amador County: Exploring risks of responding to homes, sustainability challenges of 24/7 response with fewer staff

Mariposa County: working in partnership w/ LE but very challenged by understaffing

San Bernardino County: Using data from crisis calls to determine need for types of crisis response

Colusa County: Training peer support staff in crisis response

Del Norte: Problems with burnout and being unable to recruit staff due to demands of 24/7 response – Identifying access points in the County where individuals can access crisis services

09/06/22 Bishop PD

Purpose: Barriers to crisis response as a coordinated team (LE and BH) and conditions under which Bishop PD does "welfare checks"

Attendees: Chief Standridge, Lt. Josh Ellsworth

Bishop PD will not respond to requests for welfare checks when:

- Individual has a known history of violence
- History of threats to others and who are living alone
- Have weapons in the home

Bishop PD will respond when:

- Individuals ask for help
- Say they need and want to go to the ER
- Have children in the house

Bishop PD would like to be able to contact an on-call clinician to consult with when they are managing a person who is experiencing a psychiatric emergency. Bishop PD is invested in

training officers in POST CIT but none are available. We would like to work together towards a MOST model in Inyo and to have BH and PD partner in crisis response as we implement CCMU

5. 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. 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.

Several different stakeholders were involved in the CPP process and input was obtained through a variety of ways including stakeholder focus groups, surveys, key informant interviews and partner meetings. Input was obtained from clients who utilize services at the Wellness Centers, including the homeless population. The Wellness Centers are consumer-run programs where adults come together, facilitate classes, attend activities, and had formal meetings at least once per month until the enforcement of COVID restrictions in March of 2020 until February of 2022.

When Wellness Centers were open again, surveys were distributed to consumers however, the number of respondents were not sufficient to determine needs and gaps. The Community Needs Assessment surveys from consumers in general were sufficient to determine needs and gaps.

Information was obtained in the following ways:

In May of 2022, we distributed a Community Needs Assessment survey made available electronically or in hard copy in English and Spanish. We collected surveys over a period of three months, the results of which were shared with stakeholders and with the Behavioral Health Advisory Board members at the October meeting. We also distributed Performance Outcomes and Quality Improvement (POQI) surveys to clients which are intended to measure satisfaction with mental health services and to identify needs.

<u>Outcomes of Community Needs Assessments:</u>
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:

1.) 77% of respondents would be more likely to seek support and care from family members than from, friends or from a therapist or a school counselor or clergy.[3]

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

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

2.) 64% of respondents reported that Alcoholism and drug addiction is Inyo County's biggest problem

Why this is significant: A disproportionate number of individuals struggling with addiction are indigenous people and people of color

How MHSA services can meet these needs:

- Partnering with 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 indigenous people and people of color
- Improving on re-entry planning for incarcerated individuals including engagement in Wellness Center services and groups, full services partnerships, and linkage with appropriate resources

3.) 53% of respondents report that Trauma is Inyo County's third most significant problem - chronic or terminal illness, death, divorce, mental illness, followed by lack of access to housing (53%), Trauma related to discrimination (racial and historical trauma or immigration trauma (46%), and lack of resources (42%)

Why this is significant: 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. Homelessness and mental illness are strongly correlated.

How MHSA Services can meet those needs:

- Funding to 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. Two key informant interviews occurred with the Superintendent of Schools and two interviews occurred with four school counselors. Counseling services were identified as well as the need for training around suicide prevention, LGBTQ issues, and stigma reduction. In addition to these interviews, a survey was sent to schoolteachers and administrators.

The CPP also included input from ongoing child and adult staff meetings in behavioral health services as well as multidisciplinary partner meetings. The multiple agencies involved with children's services includes Child Welfare, Juvenile Probation, Toiyabe Family Services, and the schools. The multiple agencies involved with adult services includes Adult Protective Services, Employment and Eligibility, Probation, Law Enforcement and the hospitals.

LOCAL REVIEW PROCESS

30-Day Posting Period and Circulation Methods

This proposed MHSA FY 2022-2025 Three-Year Plan will be posted for a 30-day public review and comment period from February 15, 2023-March 15, 2023. An electronic copy 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 Social Services office; Health and Human Services Administrative office; Health and Human Services, Lone Pine office; and at all county libraries, including the Bishop, Big Pine, Independence, Lone Pine, Furnace Creek, and Shoshone branches. In addition, a hard copy of the proposed Three-Year Plan has been distributed to all members of the Behavioral Health Advisory Board; consumer groups; staff; Wellness Centers (Bishop and Lone Pine); and partner agencies. The MHSA FY 2022-2025 Three-Year Plan is also available to stakeholders upon request.

Public Hearing Information

A public hearing will be conducted on March 27, 2023 at 11:00 a.m. at 1360 N. Main St – Rm 103., Bishop California, 93514 as a special meeting of the Behavioral Health Advisory Board meeting.

Substantive Recommendations and Changes

Input on the MHSA FY 2022-2025 Three-Year Plan 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.

PROCEDURES

Referral: The Full Services Partnership (FSP) referrals may come from multiple sources including hospitals where patients may be frequent visitors to the Inyo County emergency departments as a result of chronic mental illness and co-occurring substance use disorders, Inyo County's Wellness Centers, Inyo County's probation department, local high schools, Inyo County's child welfare system or FIRST program, or other community-based agency. The "No Wrong Door," approach (DHCS BHIN 22-011) which advances the CalAIM initiative to ensure outreach and engagement at all levels of the physical health, social services, educational, and justice systems is integral to identifying for the FSP program.

9 CCR Section 3620.05
Full Services partnership Admission Criteria:

(a) Individuals selected for participation in the Full-Service Partnership Service Category must meet the eligibility criteria in Welfare and Institutions Code (WIC) Section WIC Section 5600.3(a) for children and youth, WIC Section 5600.3(b) for adults and older adults or WIC Section 5600.3(c) for adults and older adults at risk.

(b) Transition age youth, in addition to (a) above, must meet the criteria below.

(1) They are unserved or underserved and one of the following:

(A) Homeless or at risk of being homeless.
(B) Aging out of the child and youth mental health system.
(C) Aging out of the child welfare systems
(D) Aging out of the juvenile justice system.
(E) Involved in the criminal justice system.
(F) At risk of involuntary hospitalization or institutionalization.
(G) Have experienced a first episode of serious mental illness.

(c) Adults, in addition to (a) above, must meet the criteria in either (1) or (2) below.

(1) They are unserved and one of the following:

(A) Homeless or at risk of becoming homeless.
(B) Involved in the criminal justice system.
(C) Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment, or

(2) They are underserved and at risk of one of the following:

(A) Homelessness.
(B) Involvement in the criminal justice system.
(C) Institutionalization.
(d) Older adults, in addition to (a) above, must meet the criteria in either (1) or (2) below:

(1) They are unserved and one of the following:

(A) Experiencing a reduction in personal and/or community functioning.
(B) Homeless.
(C) At risk of becoming homeless.
(D) At risk of becoming institutionalized.
(E) At risk of out-of-home care.
(F) At risk of becoming frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.

(2) They are underserved and at risk of one of the following:

(A) Homelessness.
(B) Institutionalization.
(C) Nursing home or out-of-home care.
(D) Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.
(E) Involvement in the criminal justice system.

(e) This section shall not prevent the County from providing services to clients with co-occurring conditions, including substance abuse, physical conditions/disorders, and/or developmental disorders/disabilities.

When clients meet criteria for FSP, the following procedures apply:

1.) Referral source will contact the Inyo County MHSA Coordinator and link clients for an intake appointment to discuss specific needs for immediate and long-term assistance with housing, food, educational assistance, medical and dental needs, transportation, and family support needs;

2.) MHSA Coordinator will assign a case manager or Peer Support Staff to link clients with behavioral health, SUD, and physical health services;
3.) Case coordinator will determine whether clients in need of housing are candidates for Progress House, Inyo County's 24/7 residential facility for TAY and adults up to the age of 54.
4.) ICHHS-BH will designate a Health and Human Services (HHS) Specialist to be the Personal Service Coordinator (PSC)/Case Manager for each client, and when appropriate the client's family, to be the single point of responsibility for that client/family. The designated PSC/Case Manager is responsible for developing an Individual Services and Supports Plan (ISSP) with the client and, when appropriate, the client's family. ICHHS-BH will ensure the PSC/Case Manager is culturally and linguistically competent or, at a minimum, is educated and trained in linguistic and cultural competence and has knowledge of available resources within the client/family's racial/ethnic community.
5.) The MHSA staff in the role of the PSC or the other qualified individuals known to the person/family working with MHSA will be available to respond 24 hours a day, 7 days a week to provide after hour intervention. A log of MHSA after hours contact is recorded by Progress House staff screening the calls after hours and reviewed by the MHSA team.
6.) Persons admitted to ICHHS-BH and meet medical necessity for Medi-Cal Specialty Mental Health Services will be reviewed in accordance with authorization cycles and at a minimum have an annual review. MHSA goals will undergo ongoing review as the person completes goals and supportive needs change.

Case Planning and Outcomes

In keeping with MHSA precepts, services are client driven, family driven, needs driven and outcomes driven.

1.) Assessments are completed using the strengths-based tools and the five life domains according to the CalAIM documentation guidelines set forth in DHCS BHIN 22-019 to determine strengths and needs
2.) ICC or Intensive Care Coordination: A comprehensive ISSP (integrated Services and Supports Plan) will be developed by the client's identified treatment team which may include a physical health provider, a behavioral health provider, a psychiatrist, a behavioral health nurse, a case manager or peer support person, family members, SUD counselor, and spiritual advisors a to address needs in each of the life domains.
3.) Progress in each goal will be monitored on a weekly or bi-weekly basis using self-report questionnaires and the Stages of Change model to assist in monitoring treatment and modifying if necessary. Progress notes will follow standard accepted guidelines set forth in DHCS BHIN 22-019.
4.) When the client and the treatment team determine that the client's goals have been met, the client will be graduated out of Full Services Partnership and may choose to step down to case management or maintenance care with behavioral health and SUD providers.

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 experience 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.
The Full Services Partnership provides crisis respite and housing for TAY (Transitional Age Youth aged 18-25) experiencing FEP (first episode psychosis), which is in fidelity to our MHSA model, and the UC Davis Core Practice Model for early intervention and treatment. We will continue to purchase four (4) beds at Progress House, an Adult Residential Facility for individuals with severe mental illness who are transitioning out of acute care, incarceration, and for individuals experiencing homelessness.

We have provided transition services for four transition age youth/young adults with severe mental illness who had spent time incarcerated in our local jail and have spent time in homelessness. In addition, we have served persons who are living within the community who need a respite due to a mental health crisis. We have been able to keep persons within our community and to assist them to successfully transition back into the community through this strategy. We have provided respite services for at least 15 adults. In addition to mental illness, many of the persons served in this way have evidenced co-occurring addiction issues, may have been veterans or at least spent some time in the military, and/or may have had experienced significant adverse childhood events.

This year, we focused on work/volunteer experience to increase transition readiness. We continued to offer work experience in the provision of reception services at the wellness center sites. At least five persons participated in this work experience. We worked with our partners in the HHS Prevention programs to identify events that needed some volunteer assistance including health fairs, community runs and other community events. In addition, we looked at ways to employ peers to support improvement projects at Progress House and to accompany residents on medical visits. We continue to look for ways to increase the effectiveness of this strategy through the implementation of recovery principles.

We are proposing to expand this strategy in the next three years through a combination of funds, including funds received under the Mental Health Block Grant (MHBG) as well as MHSA funds. We will use a social worker working out of the Employment and Eligibility division to assist with these services. The social worker will educate persons who receive social security benefits or general assistance about the opportunities to be involved in work experience. He will identify ways to assist with minimizing the impact of symptoms by helping to identify strengths, best work environments, and need for accommodation. He will also provide support for employees and education of employers. He will also make consumers aware of housing opportunities and will assist in identifying resources to aid in obtaining a stable living environment.

We also continue to offer Latino Outreach through both the wellness center sites and within the community. A

contracted bilingual therapist, also employed by the schools, provides mental health services to Latino youth and their families. These youth and families may be hesitant to come into the traditional clinic especially if there are immigration issues. The therapist treats anxiety and depression related to trauma issue as well as provides family support. This year, there was an increased need expressed around youth impacted by DACA (or the Dream Act).
The contracted therapist has worked to advocate for youth and to provide support services. Approximately 10 youth were served through this CSS strategy along with outreach to at least 50 additional persons.

This year, we are proposing to use a new hired Spanish-speaking Licensed Clinical Social Worker to provide additional services to Spanish-speaking women to address issues of anxiety and trauma. This service will be provided at the wellness center or other community site.

A specific strategy has been needed to address the needs of our isolated southeastern area of the County, the Death Valley area, closer to Nevada population centers than to Inyo towns. While there is a contract with a mental health provider in Pahrump, few persons are willing or able to engage in this service. A limited amount of telemedicine is also available for persons engaged in services. A strategy of using a Mental Health Nurse to outreach and engage with persons with mental illness in this part of the county has been most useful. The Nurse has provided services to several isolated older adults who live in this community as well as checking in with adults or youth and family who have been identified with mental illness. Persons often evidence co- occurring addiction issues as well as related health conditions. The Nurse also participates in a bi-monthly community potluck that serves to connect with residents effectively. The Nurse has further been trained as a certified Mental Health First Aid trainer and has scheduled to provide this training for interested persons in the community.

The CSS programs continue to provide the opportunity to change our service delivery model and build transformational programs and services. Over the past years, staff and consumers have worked together to build a community service program to give back to the community and reduce stigma. Consumers have conducted multiple food drives, assisted with relief efforts for fire victims, helped with park clean-up, visited older adults in a skilled nursing facility, volunteered for community events, and made blankets for the Hospice program. In addition, 3 to 5 consumers volunteer at the local Salvation Army and several more are involved in seasonal bell-ringing. These “stigma-busting” activities have allowed consumers to gain skills, meet new people, and cultivate a positive presence in the community.

The following represents our persons served under CSS strategies:

FSPs Ethnicity by Age Group

	Youth (<16 years)	**TAY (16-25 years)**	**Adult (26-59 years)**	**Older Adult (> 59 years)**	**Total**
Caucasian	1	5	18 (2 veterans)	11 (1 veteran)	35
Native American	0	0	2	0	2
LatinX	1	3	1	0	5
Total	2	8	21	11	42

Average Cost per FSP = $23, 053.. It is a combination of intensive services that might include transitional living at Progress House, participation in the Wellness Center array of services, coordination with health care needs and a variety of "whatever it takes" to address behavioral health needs.

Unduplicated Wellness Center Visitors by Age Group

	Youth (<16 years)	**TAY (16-25 years)**	**Adult (26-59 years)**	**Older Adult (> 59 years)**	**Total**
Bishop	4	33	161	56	254
Lone Pine	0	0	27	1	28

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 assistance, social security disability, and Medi-Cal. domestic violence advocacy necessary services and supports in a welcoming environment.

Case management staff may assist clients experiencing violence in their homes through linkage with Wild Iris. Clients who need assistance with employment may be linked with Job Spot, and clients who would like to explore educational opportunities may be linked with Cerro Coso College or opportunities for training in Peer Counseling through Inyo County Behavioral Health Services. In 2021/22 year, the Wellness Centers served over thirty adults/older adults who were without shelter by offering meals, showers, laundry facilities, and access to other necessary services. During times of more extreme hot or cold or otherwise inclement weather, we have linked persons to temporary shelter provided by the Salvation Army or the Methodist Church.

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 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.

Wellness Center Groups are new in 2022-23 and statistical data for FY 2023 will capture the following metrics:

1.) Groups will based upon community needs and gaps as evidenced by Community Needs Assessment Surveys;
2.) Group will be time-limited to six months
3.) Participants will be asked to self-select into groups, each of which will be focused on an area of need such as how creative expression can help with anxiety, or how to enhance recovery through better nutrition.
4.) Participants will be asked to complete anonymous surveys at the end of the series and report on whether the group met their needs using a Likert scale
5.) Outcomes data will be utilized in planning future groups

Clients may also participate in planting and caretaking of the garden at the Wellness Center during the spring and summer months and will have opportunities to learn to cook with fresh vegetables and to participate in entering vegetables at the fair as part of community inclusion. Clients also take an active part in providing welcoming, sign in and phone support for the wellness center as well as providing help with cleaning and light maintenance. Our Wellness Center clients are able to earn incentive cards as well as to develop a sense of ownership and pride in the facility.

We moved to a new wellness center site in Lone Pine in late spring of 2017. The new property is a duplex in the center of the town and within walking distance to the main resources including social services, school sites, and hospital. We continue to offer cooking and showers as well as to have a slightly bigger group room capability.

Families Intensive Response Strengthening Team (FIRST)

This year, we are proposing to identify additional youth in need of full-service partnership (FSP) within our FIRST program. As part of our overall ICHHS Children's System of Care, the FIRST 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

FIRST 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 may include resources from the First Five program as well as other agencies to intensively support the families. As the result of this expansion, we have served families with younger children.

WELLNESS CENTER – BISHOP

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 model strives to:

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

2.) 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;

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

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

5.) 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.

The Wellness Center provides showers and laundry facilities, and a place to socialize, enjoy breakfast or lunch, and participate in groups. 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.

In keeping with the mission of being welcoming and safe for all community members, the Wellness Center prohibits the use of alcohol and drugs on the premises, and is a tobacco-free environment.

WELLNESS CENTER – LONE PINE

The Wellness Center in Lone Pine provides case management, access to laundry facilities and assistance with accessing financial help, food, housing, and linkage to mental health services including medication management with a psychiatrist.

Challenges and Mitigation Efforts

We continue to adjust following the pandemic and within the last year, we have re-established services and groups, and have implemented a more structured way of tracking client services through the use of electronic sign-in pads and asking clients to sign up for groups.

Our focus is on building capacity to serve by engaging other community-based agencies, working more closely with Inyo County Jail to meet the needs of justice-involved individuals, and with probation and re-entry staff to determine placement and needs for those who are not able to live independently post-release, or who need a comprehensive case plan to optimize integration back into the community.

The Wellness Center and the Progress House may provide care post-release for individuals with mental illness and who are ready to commit to a recovery program.

Older Adults

We have a growing population of older adults (59+) with health concerns and mental illness in Inyo County. Many have co-occurring substance use disorders which impacts both and which may also compromise their ability to live independently. We work closely with out Ageing and Social Services Division to coordinate care and anticipate needs in terms of healthcare, In-Home Support Services (IHSS), medication compliance, and assistance with ADL's (Activities of Daily Living). We provide transportation for older adults to Senior Centers and Wellness Centers for meals, and groups, or to medical and mental health appointments, and we coordinate with Senior Services to ensure that we are addressing the needs of older adults who may be isolated and struggling with depression.

Annual Projected Cost for Programming at Wellness Centers

Staffing:

Facilities

Food

Equipment

Telephones

Internet

PREVENTION AND EARLY INTERVENTION

Prevention Programs

PEI Prevention Program Descriptions and Outcomes

2022/25: Elder Outreach Program

In order to better serve Inyo County's older adult population, the Elder Outreach Program, our Prevention and Early Intervention (PEI) program has been helpful at identifying at-risk seniors who begin to exhibit signs 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.

The role of the Behavioral Health Nurse is first to provide the initial assessment to potential candidates for prevention services such as the Friendly Visitor Program or Healthy Ideas. A member of the Adult Services team will further involve the Behavioral Health Nurse when intervention may be warranted, especially if any suicidal ideation is noted.

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.

In the past year, outreach visits were made to 48 older adults. This results in a cost of $567.63 per individual. This strategy again targets the more isolated parts of the county. One Native American and one Hispanic older adult have been served with the remainder being Caucasian.

PEI funding also has allowed us to provide care coordination/case management as additional support to the Older Adult PEI program.

2022/25 Friendly Visitor (FV) Program

1.) **Outreach at Senior Centers**
    a. **Ask a Nurse – Two days per month**
    b. **Behavioral health and SUD program reps once a month**
2.) **Transportation to Wellness Centers for groups**
3.) **Home visits to bring food or groceries – bring pets,**
4.) **dog walking, outings to community events**
5.) **Knowing what foods optimize health**

The FV program has been implemented to provide prevention services to isolated seniors who have evidenced symptoms of depression and are living alone in the community. We have funded two part-time Program Services Assistants, one in the northern part of the county and one in the southern part of the county. The meal delivery staff identify seniors who evidence symptoms of depression and/or anxiety and who might benefit from a visitor. The visitor, who may also be a senior, develops a plan with the senior to address the depression and prevent further exacerbation of symptoms.

The program has provided services to 17 seniors at a cost of approximately $360.18. The average initial score on the PHQ9 was 11 with a range of 4 (very mild) to 23 (very severe) with four persons falling in this category. Five participants reported daily thoughts of "being better off dead". A majority of the participants (>75%) reported moderate to severe pain symptoms. The categories where persons reported the most daily difficulty were in "feeling tired" and "trouble with sleep". While there continue to be difficulty in obtaining "post" PHQ9s, participants surveyed report a high degree of satisfaction with the FV and a decrease in feelings of depression.

Challenges and Mitigation Efforts
We continue to struggle with having adequate nursing coverage as well as experiencing other staff turnover in Adult Social Services and the Aging program. This staffing issue makes it difficult to implement evidence-based strategies with consistency. We also continue to struggle with challenges of finding appropriate transitional housing for older adults as they begin to evidence health challenges as well as mental illness. Moving forward, we will investigate the viability of using a regional approach to address residential or other housing needs. We also continue to educate the community around the need for a community system of care solution to address this need.

Significant Changes from Previous Fiscal Year
During the next three-year plan, we propose to add a prevention strategy targeted to youth. Health and Human Services Public Health and Prevention Division has provided prevention services for youth using braided funding from Substance Use Disorder funds, Tobacco Control funds, Women Infants Children (WIC) and various Child Abuse prevention services. In the last year, the Prevention team has expanded its mentoring program as well its use of outdoor programs to build protective factors. This year, we are proposing to expand the outdoor program to include youth who have been exposed to a high number of Adverse Childhood Experiences (high ACES scores). The correlation between high ACES scores and mental health symptoms and risk for substance use disorders has been well-documented. The use of this strategy will be proposed for the FY 18/19 and 19/20 updates to the MHSA PEI Plan.

PREVENTION AND EARLY INTERVENTION

Early Intervention Programs for Youth

2022/25:

Ideas for youth and transitional-age youth:

- **Wellness Centers at Bishop High School and Lone Pine High School schools staffed by youth peer counselors, case managers, SUD prevention and behavioral health providers,**
- **Services would include laundry facilities, a kitchen, hygiene products, LGBTQA+ resources, clothing exchange, reduction of stigma around eating and body image**

2022/25: Parent-Child Interaction Therapy (PCIT) Community Collaboration

Our Child and Family Program Chief had been certified to offer Parent-Child Interaction Therapy (PCIT), an evidence-based intensive parent-training program which has been found to be effective for families with aggressive, defiant, and non-compliant children; families with parents who have limited parenting skills; and families who have experienced domestic violence and/or child abuse. PCIT focuses on promoting positive parent-child relationships and interactions, while teaching parents effective parenting skills. PCIT has been shown to be an effective treatment program for children ages 2-7 years. This program has been adapted as an intervention for many different types of families (child welfare population, at-risk families, adoptive families, foster families, and other languages including Spanish).

PCIT teaches families individualized parenting skills that are developed through a process in which parents directly receive instruction through an earpiece that is linked to a therapist. The therapist, behind a one-way mirror and/or via a live camera feed, observes interactions between the parent and child, coaches the development of relationship enhancing techniques, and gives behavioral interventions for responding to difficult parent-child situations. Sessions last about one hour, occur over 18-20 weekly visits, and show very strong outcomes for both parents and children.

PCIT is a highly effective program and the families show improved outcomes because of this intensive parenting program. In addition, the children and their siblings show improved behavior (positive social interactions, following directions, reduction in acting out behavior) as a result of the program. We have served seven additional families with this intervention. The approximate cost per family served under PCIT is $5731.

In 2016/2017, we served nine families for a total of 27 family members served. The MHSA portion of the costs was $119,805 for an approximate cost of $13,333 per family. Of the nine families served: one family graduated, six families continued in the program, one family withdrew and one family's child voluntarily went to a higher level of care. We are have implemented pre/post assessment measures using the National 5 Protective Factors measure.

Challenges and Mitigation Efforts

A continuing barrier for Inyo County is the small number of staff and the issues caused when staff vacancies occur. In a small county, all vacancies have an impact on service delivery and strategy implementation.

We have addressed the need for school-based early intervention services through a contract with ICOE and 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.

PREVENTION AND EARLY INTERVENTION

Suicide Prevention Programs

PEI Suicide Prevention Program Description and Outcomes

1.) ASIST
2.) SafeTalk
3.) Know the Signs

ICHHS-BH has participated in funding statewide suicide prevention efforts through CalMHSA. In addition, our Program Chief who has expertise in suicide prevention and crisis intervention has provided crisis intervention training in the County jail, the Juvenile facility and with the schools as well as providing ongoing training to staff in behavioral health.

Significant Changes from Previous Fiscal Year

In this three-year plan, we will provide 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.
The first of these trainings occurred in November of 2022. We will offer both trainings annually in addition to other trainings intended to build the capacity in the communities of Inyo County to be "the helpers," and to be available and able to assist those in need of support and crisis intervention.

PREVENTION AND EARLY INTERVENTION

Outreach Programs

PEI Outreach Program Description and Outcomes

ICHHS-BH has participated in funding statewide outreach efforts through CalMHSA. In addition, we have provided four Mental Health First Aid (MHFA) classes, including one class in the southeastern part of the County to community members. We have trained an additional 35 community members in MHFA.

Significant Changes from Previous Fiscal Year
We propose to provide at least three (3) MHFA trainings per year to the community, including at least one per year in south county. Additionally, we propose to fund the North Star counseling staff to be involved in outreach efforts to students in the high schools.

PREVENTION AND EARLY INTERVENTION

Stigma Reduction Programs

PEI Stigma Reduction Program Description and Outcomes

1.) **Indigenous focus.**
2.) **Trauma informed communities – evidence based training**
3.) **Race affinity groups - Ruth King?**

ICHHS-BH has participated in funding statewide stigma reduction through CalMHSA for events such as Directing Change and Each Mind Matters. In addition, we have addressed issues of stigma through consumer participation as volunteers in community events such as health fairs, "trunk or treat" and fun runs. Additionally, Wellness Center visitors and Progress House residents have organized and participated in food drives for the local food banks. We held two kite-flying events during Mental Health Awareness month in 2017.

Significant Changes from Previous Fiscal Year
We propose to fund North Star counseling staff to join the Child and Family team in participation in Directing Change.

INNOVATION

Innovation Program Description and Outcomes

1.) Genesight testing in jail $50,000

2.) Stabilizing Community members as an alternative to hospitals $250,000

a.) Housing (purchase of an existing structure like a motel)
b.) Telepsychiatry on site
c.) Nursing
d.) Therapy
e.) Case management
f.) Residential caregivers 24/7
g.) Transportation
h.) Food

Community Care Collaboration Project

The Inyo County Community Care Collaborative (CCC) was implemented to improve coordination of care with primary health care services for adults, ages 18 and older, with a serious mental illness. Persons with a serious mental illness are more likely to have chronic health conditions, and have shortened life spans by up to 25 years, compared to the general population. Increasing access to and coordination with primary care services for our clients with a serious mental illness is a high priority for ICHHS-BH. By coordinating and co-locating health and mental health services, we are able to improve outcomes for our clients and improve access to primary care services.

The Innovation Project funding supported the development of a CCC Team by partially funding one full-time Behavioral Health Nurse position (1.0 FTE) to coordinate and integrate health and wellness activities for behavioral health clients and partially funding a one full-time Administrative Analyst position to collect, track, and analyze outcome data based on a quality improvement model. While all new consumers entering services assisted to link with a primary care physician, the target population is now behavioral health consumers with serious health conditions who are also enrolled and receiving services at the Northern Inyo Hospital Rural Health Clinic (NIHRHC). We currently coordinate care for 80 individuals to improve health outcomes.

The Coordinated Care Collaborative addressed the following:

Identifies individuals who do not have an identified primary care physician, or routinely use primary care services, and links them to the appropriate provider/health clinic/healer/alternative health care in the community. It is now part of our admission process to assess whether each person has a primary care physician and to link that person with care if it is not in place. As a result of these efforts, nearly all admitted persons have primary care services.

Collecting basic health information, including lab work, on individuals to help understand each person's current health indicators. Staff work with the individual to understand their health indicators (e.g., height, weight, body mass index, A1c and other risks for diabetes, carbon monoxide monitor results, hypertension/blood pressure,

cholesterol, and lung functioning). These health indicators are used to inform both the individual and staff on high risk health factors, and allow them to work together with the health clinic to identify goals on improving their health and wellness.

Participating clients allow for the reconciliation of medications between ICHHS-BH and NIHRHC. A work flow has been tested and developed to allow for the sharing of this information between the two entities to best coordinate the medication needs. This work flow continues to be rather cumbersome and includes faxing of documents between

providers. We continue to look for more streamlined ways to communicate.

Clients and staff work together to develop health and wellness activities to support clients to improve their health. These activities include developing walking groups, nutrition and cooking groups, and mindfulness. There is also a smoking cessation group offered at the Bishop Wellness Center. Wellness information is also offered to CCC clients, to provide support and information to help individuals make healthy choices. These activities help the team provide supportive services which will lead to positive outcomes.

Peer Support has been recognized to be an important component of the coordinated care approach. We have trained peer supporters to assist with health goals and to accompany consumers to medical appointments to provide support and another "listening ear."

We have collected and tracked population health data as well as tracking data on each consumer who has been identified as needing more intensive care coordination.
In the last year the Coordinated Care project has continued to be spread to the jail/re-entry population. As part of the Stepping Up Initiative, we are aware of the persons with a mental health condition within our jail. We serve persons in the jail who evidence mental health conditions as well as health conditions. We track all persons who are receiving psychotropic medication to treat a mental health condition or who have been identified as needing this type of treatment. Our tracking of the number of persons on psychotropic medication proportionate to the total number of inmate population suggests that 25%-34% of inmates have a mental health condition, often in conjunction with a substance use disorder. Approximately 50-70 unduplicated persons received this service per year.

We have continued weekly care coordination meetings with the Behavioral Health nurse, the Corrections Nurse, a Behavioral Health Counselor, the Re-entry Coordinator, and the Deputy HHS Director of the Behavioral Health Division. A coordination plan was discussed for each inmate and the team would make sure that there was ongoing care coordination between the Psychiatrist and the Health Officer and that communication was maintained. The Behavioral Counselor provides outreach and engagement and makes a recommendation for continued services. The Re-Entry Coordinator looks at ongoing needs in the community such as housing, employment, and access to benefits such as Medi-Cal.

A majority of persons in this population have co-occurring substance abuse disorders and several of these persons have health conditions as a result. Most of the persons in this population have not received any consistent primary care or behavioral health treatment. The goal of this coordination is not only to treat and stabilize mental health and health conditions during incarceration but also to support the continued treatment during re-entry back into the community. In FY 16/17, 43 inmates on psychotropic medication were released back into the community. The Corrections Nurse provided medication to the inmates upon release or made arrangements for persons to connect with Behavioral Health for ongoing services and/or to their primary care physician for treatment of ongoing medical conditions. In FY 16/17, four persons with severe mental health symptoms accessed transition services at Progress House. During FY 17/18, a more formalized tracking system is being set up to track coordination efforts.

Challenges and Mitigation Efforts

One of the ongoing challenges is in staff vacancies and turnover both in primary health as well as in behavioral health, including with the administrative analysts. It is difficult to maintain the medication reconciliation and tracking of costs and outcomes. The behavioral health nurses are also pulled in many directions and struggle to keep up with the medication reconciliation as well during vacancies or absences. One strategy to mitigate the impact of this situation is to continue to look for ways to build peer and other natural supports. Another strategy is to set up work flows that can be used by numerous staff and thus to "institutionalize" the gains made and the process of continuing to improve the strategies.

Significant Changes from Previous Fiscal Year

No significant changes are anticipated to the original Innovation project. This Innovation project will expire at the end of FY 2018/2019. ICHHS-BH will develop a new Innovation project at that time.

WORKFORCE EDUCATION AND TRAINING

WET Program Descriptions and Outcomes

1.)	ASIST and Safetalk funded by WET?	$24,000
2.)	Promotora Training to Inyo?	$30,000
3.)	DBT training through BHC?	$20,000
4.)	EMDR/SE trauma training?	$50,000
5.)	Other continuing ed (2022/25)	$50,000

Workforce Education and Training (WET) Coordination

Since the original WET Plan was approved, ICHHS as a whole developed several contracts and strategies with various learning providers to deliver a broad range of trainings to benefit the workforce. In a small rural isolated community, it has been an effective strategy to offer training that assists us to "grow our own" workforce from within our community from those dedicated to the community. We have offered training aimed at the development of consumers and family members. Behavioral Health staff members are trained separately and as part of the larger Health and Human Services staff that includes the Social Services and Aging Division and the Public Health and Prevention Division. Partner agencies such as Probation and Toiyabe Indian Health Plan are also trained. Training topics include a broad range of family engagement, child and family teaming, motivational interviewing, and delivering comprehensive services for promoting wellness and recovery. Team building and transformational change has also been a focus of our trainings.

Fundamental Learning Program

Our training partners include *Relias*, an online training system, which offers courses in confidentiality, ethics, and regulations, as well as an array of clinical skills building courses that also fulfill continuing education requirements for licensed behavioral health professionals. We have purchased a bulk subscription package for our organization that makes these exemplary courses available to staff. As an added training component, we have provided staff and consumers with technical software training to enhance the skill set of staff and consumers/family members who work or volunteer for Inyo County.

In FY 17/18, ICHHS-BH will form a Strengths Model Learning Collaborative with Alpine and Mono counties. This collaborative is a fundamental learning program using an innovative regional approach. It is a fundamental learning program in that it builds skills in keeping with the recovery principles as described below.

Strengths Model Overview: "The University of Kansas School of Social Welfare developed the Strengths Model in the mid1980s as a response to traditional deficit-oriented approaches in mental health. The Strengths Model is both a philosophy of practice and a set of tools and methods designed to enhance recovery. While the tools of the model (i.e. Strengths Assessments and Personal Recovery Plans) are used primarily by community-based direct service workers (e.g. case manager, care manager, care coordinator, community health worker, etc.), the principles of the model have agency-wide application.

The Strengths Model rests on six core principles [that provide both a philosophical base as well as day-to-day guidance for tasks and goals] (Rapp & Goscha, 2012):

"Principle # 1: People with psychiatric disabilities can recover, reclaim and transform their lives;

Principle #2: The focus is on an individual's strengths rather than deficits;
Principle #3: The community is viewed as an oasis of resources;
Principle #4: The client is the director of the helping process;
Principle #5: The relationship is primary and essential; and
Principle #6: The primary setting for our work is in the community."

The Strengths Model is also the curriculum that will be used to train staff. Learning sessions will be focused on recovery goals, engagement, and strengths assessment; group supervision and building recovery-oriented treatment plans from the strengths assessment; developing the personal recovery plan; and naturally-occurring resources and supporting independence from the system. This model is proven to improve outcomes in the areas of housing, employment, education, and increased community involvement. In Inyo County, our participation will include members of the adult services team including all Wellness Center staff, the three adult services clinicians, the Progress House Manager and the Nurse Supervisor as well as representation from the Outcomes and Evaluation team. While we would like to spread this training to our entire team, we are starting with 12 key staff to ensure fidelity to the model. It is our goal to "institutionalize this knowledge to result in spread to training the entire BH team as well as partners to utilize this model. We are implementing fidelity measures from the beginning and will be closely monitoring for system improvement.

What makes the Eastern Sierra Learning Collaborative innovative is the fact that the identification of needs and the planning and implementation of the Collaborative has all been county-driven and that it will also invite community partners to the learning sessions. The development of this Collaborative has been a regional grassroots effort; where other trainings may be grassroots, they are likely not regional and where they are regional, they are rarely grassroots.

As a result of this Innovation project, Inyo, Mono, and Alpine Counties will all have a common need met through a Collaborative that is specifically adapted to the remote, rural environment and includes both systems change and clinical change elements. Moreover, this Innovation project serves as a learning opportunity for how counties can improve their collaborative work and leverage resources to meet common county-identified needs. Finally, it serves as a way to learn more about working with other community partners and developing a common approach to serving clients across organizational boundaries.

In addition to the Strengths Collaborative described above, it is important to identify the strengths of the entire Behavioral Health team, including all front office and support staff as well as all program staff (including those who may not be directly involved in the Strengths Collaborative). We will be assessing team strengths through the Strengths Finder and will conduct a training opportunity and facilitated conversation with the Behavioral Health Director from Alpine County. In this way, we can further identify the strengths of our team and find ways to build on these strengths even as we work with consumers to build on their strengths. The strengths identified will further be used to create professional growth goals for employees. This is an excellent way to "grow" our workforce.

In FY 17/18, ICHHS-BH will also provide Crisis Intervention Training (CIT) for Law Enforcement partners, First Responders, and BH staff. We have long identified the need to increase skills of all first responders who respond to mental health crises. While we do not have the capacity to provide a separate crisis response team, it is important to increase skills and

awareness for all of the team. We will partner with Mono County to offer training to law enforcement including Sheriffs, Bishop Police Department and California Highway Patrol as well as Behavioral Health staff and all other interested partners.

Consumer Pathways Program??

Our Wellness Center sites have offered the best training ground for consumers to gain volunteer and other work experience. As we have strived to make sure that groups and services offered at the wellness center sites are consumer driven and facilitated, we have had consumers act as reception staff, group facilitators and participate in the operation and care of the facility. As a result of these efforts, we are able to identify consumers who may act as peer supporters or who desire to develop other skills for use in the workforce. We offered two entry level temporary positions for persons with lived experience. One person provided general oversight of several Wellness Center activities both in Bishop and in Lone Pine. He also provided assistance with transport and support of medical appointment. Another person worked out of Progress House and provided assistance with improvement projects including painting and general repair. This year we are proposing to take these positions and make them permanent positions as HHS Specialists.

Financial Incentive Program??

We participate in the Statewide Mental Health Loan Assumption Program, which offers two to three employees with master's degree in social work, including a bi-lingual intern, support to pay back school loans for "hard to fill" positions. Due to bargaining agreements with local labor groups, we have not been able to offer tuition reimbursement.

Challenges and Mitigation Efforts
We continue to face the challenge of recruiting bilingual staff. We have one bilingual Latina employee who is pursuing her attainment is Licensed Clinical Social Worker (LCSW). She quickly filled her caseload with Latino/Latina youth and families as the community was made aware of her services and consumers refer other family or friends. We also continue to look for ways to identify TAY to participate as part of the Human Services Certificate program at our community college as well as in other Peer Supporter roles. We look forward to expanding our training capacity and opportunities for both staff and consumers.

Another area of challenge is in the hiring of our licensed psychotherapy staff and behavioral health nurses. Several of our licensed staff have retired and we have been unable to recruit replacements. We are looking for ways to attract interns to our county. Through the Regional WET program, we have been able to avail ourselves of a Roving Clinical Supervisor. Three interns from Behavioral Health as well as one intern employed by another provider have received distance clinical supervision. Two of the interns have completed their hours and have become licensed clinical social workers. One of these recently licensed persons went to work in our local hospital and one moved to a position with the school. One of the other two has completed hours and will be preparing to take the licensure exam, the other will complete in the next year. We are proposing to add at least one intern in the next year and will explore a continued contract with a distance provider in future years if the need exists.

Finally, we are challenged to provide psychiatry services. While we currently have an excellent experienced "in person" psychiatrist, she is moving toward retirement. As with many other counties, we will move forward with tele-psychiatry to at least partially address the shortage in

psychiatry. We propose to look for incentives to attract another in-person psychiatrist, will work with partners in the area for a possible shared position, and will consider the use of a "head hunter" to assist with recruitment.

While we participate in the Mental Health Loan Assumption Program, we have not been able to offer tuition reimbursement to date, due to bargaining agreements with local labor groups. We continue to look for ways to offer this strategy.

Significant Changes from Previous Fiscal Year
In FY 17/18, ICHHS-BH will form a Strengths Model Learning Collaborative with Alpine and Mono counties. Please see above description.

In FY 17/18, ICHHS-BH will provide CIT training in partnership with Mono County.

CAPITAL FACILITIES/TECHNOLOGY

Capital Facilities and Technology Projects

1. In 2022/2025 will funds be used for Credible?
2. Wellness Center upgrades?
3. Expansion of internet access to outlying communities?

Capital Facilities funding was used for remodeling needs for the newly-purchased wellness center in Bishop. These funds helped to upgrade the facility to meet Americans with Disabilities Act (ADA) requirements and to create a more welcoming environment.

ICHHS-BH chose to utilize the bulk of CFTN funding for a system-wide IT upgrade to achieve an Integrated Information Systems Infrastructure. We began implementation of our new Cerner/ Kings View (KV) system in July 2016. The implementation included not only clinical assessments and progress notes, but also treatment planning and the use of the client signature into the electronic record. Electronic prescriptions and medication monitoring are also components of this IT system, as well as lab orders and results. We have explored ways to take a next step toward a more integrated health record by attempting to record health conditions and reconcile medication across primary health and health. Use of the Kings View product also positioned us to move forward on needed telemedicine services as we look towards the retirement of our long-term Psychiatrist within the County. We have implemented telemedicine for a block of four hours per week as we transition to this modality. In FY 17/18 we will be expanding telemedicine and teleconferencing capabilities to the jail and to the outlying communities. We will also use teleconferencing for participation in the Learning Collaborative as well as to access webinars and other training opportunities.

Challenges and Mitigation Efforts

As we have implemented our new electronic health record product, we discovered the challenges inherent to the use of a new product including the understanding of the language and terminology for functions that might differ from the previous product. In addition, we have found that there is less direct access to raw data than was found in our last product. However, we are now able to receive reports on demographics, penetration rates and productivity through a report generated out of the system. This cuts down on the number of "excel spreadsheets" used to track basic data. It remains clear that the current product is a rather complex billing system and takes a very large investment of staff time to navigate. We will continue to explore ways through use of our electronic record, as well as additional "add on products" to find ways to communicate cross systems such as some form of registry where there is not a requirement for duplicate entry.

Finally, we have also continued to explore the ways to further collect and track outcomes in a meaningful way. We see the need to collect a set of cross program measures to more fully tell the story of transformational change across a system of care as opposed to outcomes from a very small program or strategy. We continue to explore ways to include outcomes data as part of our record. In FY 17/18, we will add the Milestones of Recovery (MORS) to our record as well as the mandated Child and Adolescent Needs and Strengths (CANS) and other measures. As an HHS Department of which Behavioral Health is a division, it is our ongoing goal to develop our HHS Outcomes and Evaluation team to look for ways to benchmark community-wide indicators of health and wellness.

Implementation Benchmarks and Delays
All admissions transferred into KV system: June 2016
All new admissions, treatment plans and progress notes into KV: July 2016
New billing out of KV: September 2016
Completed all assessments in KV: June 30, 2017
Use of Electronic signature: implemented for all intakes: Delayed to September 2017, still in process for treatment plans.
Use of reporting functions: increase through the fiscal year and beyond.

Significant Changes from Previous Fiscal Year
The CFTN funds have been fully expended.