RIVERSIDE COUNTY BEHAVIORAL HEALTH COMMISSION
SITE REVIEW

The information provided is to educate other board members and the general public regarding the mental health and substance abuse services being provided in their region of Riverside County. ***The Site Review Form will be completed in collaboration with staff or supervisor of the facility being reviewed.***

SUPERVISOR/ STAFF: *Prior to the personal visit from Commissioner/ Regional Board member, please complete the following sections:*

- SUPERVISOR/ STAFF COMPLETING FORM
- DATE COMPLETED
- NAME OF FACILITY/ PROGRAM
- ADDRESS, PHONE NUMBER
- TYPE OF PROGRAM
- REGION SERVED
- PROGRAM SUPERVISOR, PHONE NUMBER, E-MAIL
- PROGRAM/ CLINIC INFORMATION
- MISCELLANEOUS SERVICES OFFERED
- STAFF ADDITIONAL RECOMMENDATION/ COMMENTS

After completing form, please return to Behavioral Health Commission Liaison, Maria Roman either by e-mail (MYRoman@rcmhd.org) or interoffice (MS #3810).

COMMISSIONER/ REGIONAL BOARD MEMBER: *Please complete the following sections:*

- COMMISSIONER/ REGIONAL BOARD MEMBER REVIEWING FACILITY
- DATE COMPLETED
- BEHAVIORAL HEALTH COMMISSIONER OR
- REGIONAL BOARD MEMBER; INDICATE REGION.
- ACCESSIBILITY & SECURITY
- BOARD RECOMMENDATION/ COMMENTS

After completing form, please submit to Behavioral Health Commission Liaison, Maria Roman either by e-mail (MYRoman@rcmhd.org) or by mail at: 2085 Rustin Avenue, Riverside, CA 92507, ATTN: Maria Roman. Commissioner or Board Members are required to present findings at the next Commission or Regional Board meeting (BHC Liaison will confirm date). Please be prepared to give a 5-minute presentation providing information and highlights of the program/clinic.

SUPERVISOR/ STAFF COMPLETING FORM: **DATE COMPLETED:**

COMMISSIONER/ REGIONAL BOARD MEMBER REVIEWING FACILITY: **DATE COMPLETED:**

BEHAVIORAL HEALTH COMMISSIONER **REGIONAL BOARD MEMBER**

Desert Mid-County Western

NAME OF FACILITY/ PROGRAM:

ADDRESS: **PHONE NUMBER:**

TYPE OF PROGRAM: *(Check what applies)*

Mental Health Substance Abuse County Facility Contract Provider

REGION SERVED:

Desert   Mid-County   Western

PROGRAM SUPERVISOR: **PHONE NUMBER:**   **E-MAIL:**

ACCESSIBILITY & SECURITY

Is the Program/ Clinic Easily Located:

YES   NO

Is there ample parking:

YES   NO

Is the entrance easily located:

YES   NO

Handicap Parking Spaces:

YES   NO

Wheelchair Ramps:

YES   NO

Automatic Doors for handicap access:

YES   NO

Low clearance counters:

YES   NO

In case of emergency, are exits clearly marked:

YES   NO

Description of program/ clinic space: *(Check all that apply)*

Lobby/ waiting room   Indoor area   Outdoor area

Childcare or kid space   Recreational areas   Cafeteria or vending machine

Security: *(Check all that apply)*

Security fence around clinic   Security cameras in facility   Cameras in parking lot

Emergency exits   Security guard

PROGRAM/ CLINIC INFORMATION

Program/ Clinic Type(s): *(Check all that apply)*

Outpatient   Inpatient   Day Treatment   Residential

Does this program require a referral:

YES   NO

Program Age Group: *(Check all that apply)*

Children/ Youth(0-16)   Transition Age Youth(16-25)   Adult (19-59)

Older Adult (60+)

Type of Services provided: *(Check all that apply)*

Assessment/ Intake   Physical Health Screenings   Medication Assisted Treatment

Individual Therapy   Group Therapy   Detoxification

Classes or Education Groups   Peer Supports   Crisis Intervention

Case Management   Integrated Care

Program/ Clinic Capacity: Max Possible: Monthly Average: Daily Average:

Does this facility provide medication:

YES NO

Are medications stored in a secure area *(behind two locks or badge entry)*:

YES NO Not Applicable

Please indicate which staff handles and provides medication: *(Check all that apply)*

Physician
Physician Assistants
Nurses (LVN, RN, etc.)
Pharmacist
Other (authorized personnel)
Not Applicable

Average length of stay in facility, time requirement/ allowance for participation in program/treatment:

14-Days 30-Days 60-Days 90-Days Not Applicable

Number of clinical staff (psychiatrist, psychologist, therapist, counselor, nurse, etc.):

5-10 10-15 15-20 20 or more Not Applicable

Number of administrative staff (office assistants, secretaries, accounting, etc.):

5-10 10-15 15-20 20 or more Not Applicable

Type of staff in clinic/ program/ treatment: *(Check all that apply)*

Peers
Family Advocates
Parent Partners
Behavioral Health Specialist
Clinical Therapist
Psychologist
Psychiatrist
Physician/ Primary Care
Physician Assistant
Nurse
LVN/ Psychiatric Technicians
Office Assistant
Community Services Assistant
Not Applicable

How does this program/ clinic implement the "Recovery Model": *(Check all that apply)*

Client Choice
Client Empowerment
Cultural Competency
Installation of Hope
Self-Help
Not Applicable

What "Evidence-Based Practices" does this program/clinic use: *(Check all that apply)*

Multi-Dimensional Family Therapy (MDFT)
Treatment Foster Care Oregon Formerly (MTFC)
Aggression-Replacement Therapy (ART)
Wraparoud
Cognitive Behavioral Therapy (CBT)
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Parent-Child Interaction Therapy (PCIT)
Incredible Years (IY)
Triple P
Depression Treatment Quality Improvement (DTQI)
Strengthening Families Program
Cognitive Behavioral Interventions for Trauma in Schools (CBITS)
Mobile PCIT

"Evidence-Based Practices": *(Continued)*

- Dialectical Behavior Therapy (DBT)
- Recovery Management (RM)
- Integrated Co-occurring Disorders Treatment (COD)
- Assertive Community Treatment/ Integrated Services Recovery Centers
- Specialty Multidisciplinary Aggressive Response Treatment (SMART)
- Nonviolent Crisis Intervention
- Wellness Recovery Action Plan (WRAP)
- Cognitive Behavioral Therapy (CBT) for Late Life Depression
- Seeking Safety
- Mamas Y Bebes (Mothers & Babies)
- Program to Encourage Active Rewarding Lives for Seniors (PEARLS)

MISCELLANEOUS SERVICES OFFERED

Housing Assistance:
(Section 8, Vouchers, etc.)

YES NO

Benefits Assistance:
(SSI, healthcare, etc.)

YES NO

Transportation Available:
(Drop-off/ Pick-up)

YES NO

Meals/ snacks available:
(Provided or for purchase)

YES NO

Home Visits:

YES NO

Follow-up Care:

YES NO

STAFF ADDITIONAL COMMENTS: *(if any)*

BOARD RECOMMENDATION/ COMMENT(S): *(If any)*

SUPERVISOR/ STAFF INSTRUCTIONS:
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