Department of Mental Health
County of Riverside

Jerry Wengerd, Director

Cultural Competency Plan

2010

COVER SHEET

**An original, three copies, and a compact disc
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due August 31, 2010**

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DEPARTMENT OF MENTAL HEALTH

Jerry Wengerd, Director

2010
CULTURAL COMPETENCY PLAN

CC Plan Compiled By:

Name	Department
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Name	Department
Myriam Aragon, Program Manager	Cultural Competency Program
Ninfa Delgado, Chair	Riverside Community Health Foundation
Moises Ponce, Chair	CTI, Perris Mental Health Clinic
Jansseen Diaz	Substance Abuse
Dr. Renda Dionne	Indian Child & Family Services
Melissa Dovalina	BHS, Substance Abuse
Consuelo Durazo	Peer Specialists, Wraparound Program
Alison Emery	Director, Consumer Affairs
Claudia Espinoza	Sr. MH Peer Specialist, Family Advocate
Alex Fajardo	El Sol
Yolanda Fullwider	Clinical Therapist, TRAC Team
Myriam Gomez	Volunteer, Cultural Competency
William W. Harris	Supervisor, Friday Night Live, DMH
Veronica Hilton	Program Director, CHA
Alfredo Huerta	Clinical Therapist, Indio Mental Health
Carmelo Isales	Supervisor, Jefferson Wellness Center
Ben Jauregui	Disability Program Manager, IEHP
Brandon Lee	Admin. Services Analyst Program Support
Susanna Luu	Volunteer, Cultural Competency
Mike Madrigal	Interfaith Council
Gloria Moriarty	CODIE
Juan Ramirez	Consumer
Benita Ramsey	Consultant, LGBT
Anthony Richmond	Peer Specialist, Jefferson Wellness Center
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Jewel Thompson	Inland Empire Multi-Cultural Counseling Ctr.
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Jennifer Vaughn-Blakely	Chair, The Group
Lydiah Wanjau	Volunteer, Cultural Competency
Amanda Wilbur	NAMI Representative, DPSS

Riverside County Department of Mental Health has been a State leader in cultural competency and continues to enhance its services in an ongoing effort to provide the best possible cultural and linguistic services for all people of all ethnicities, cultures, beliefs, lifestyles, and languages. Population Projection indicate that the county population increased by 36.0% from 2000 to 2008 and will continue to increase by (8.6%) from 2008 through 2011. During the fiscal year 2007-2008, Riverside County Department of Mental Health (RCDMH) provided services to a total of 38,945 clients.

This rise in population and the multicultural and multilinguistic diversity of its communities will continue to challenge the Department in its efforts to provide barrier-free access to all groups. The Department understands the important role that culture and language play in the delivery of mental health services. We want our services to be able to adapt in order to effectively meet the mental health needs of our County population regardless of what values, beliefs, and lifestyles they bring with them.

The Cultural Competency Plan is consistent with the Cultural Competence Plan Requirements (CCPR) per California Code of Regulations, Title 9, Section 1810.410. It is a "living" document that provides a framework for developing and increasing cultural competency and linguistic services over time. The Cultural Competency Reducing Disparities Committee drives and facilitates this critical plan. The members of this committee represent direct line staff all the way up to top administrators, community, consumers and family members.

This CCPR (2010) indicates efforts being made on an ongoing basis to achieve cultural competence and to reduce mental health disparities by Riverside County Department of Mental Health. It is a unique plan that was developed to reflect the current times. It highlights the current work undertaken for the planning, implementation and monitoring of the Mental Health Service Act (MHSA.) The Department has made an effort on developing a cohesive relationship between the activities that are undertaken in support of cultural competency with those that support the MHSA. This unified approach will allow us to move forward in an efficient, cost-effective, and structured manner that will enable our staff to feel that they are working towards a common goal - improving our service delivery and outcomes regardless of whether the action plans are under the umbrella of Cultural Competency, Quality Improvement (QI) and/or the MHSA. As MHSA expands and increases services, the Department is opening doors to a more comprehensive cultural and linguistic mental health system. It is an underlying assumption that the accomplishment of the 2010-2011 Cultural Competence Plan's goals and objectives are critical for producing organizational changes that achieve organizational cultural and linguistic competence. The plan is based on the idea of "organizational cultural competence", which aims to increase

compatibility between Riverside County Mental Health and the community by developing strategic changes in both organizational infrastructure and direct service levels.

Cultural Competence Plan Requirements
Goals and Objectives
2010-2011

Goal 1: Developing capacity/strategies to reach underserved populations via community driven process

1.1. **Objective:** Developing of Community driven process using a Logic Model

Activities	2010-2011 Outcomes
1.1.1. Organize and present the information collected from the Cultural Competence Needs Assessment Focus Groups.	1.1.1. Focus Groups Report
1.1.2. Develop the components of the Logic Model Outline with the CCRD Core group and the consultants via phone conferences	1.1.2. List of prioritized ideas and recommendations.
1.1.3. Develop the list of actions to be taken and by whom.	1.1.3. List of actions and target outcomes.
1.1.4. Develop an outline of the community's driven process and a policy for ongoing participation of the committee in the transformation of the system.	1.1.4. Community driven process guidelines and policy.

1.2. **Objective:** To strengthen and to grow partnerships with community organizations and other agencies to facilitate and improve the representation of diverse community in the Cultural Competency/Reducing Disparities Committee (CCRD).

Activities	2010-2011 Outcomes
1.2.1. Conduct targeted outreach activities in diverse communities to identify culturally and linguistically diverse leaders.	1.2.1. Increase representation of Ethnic specific Community leaders in the CCRD committee.
1.2.2. Create Regional CCRD Subcommittees.	1.2.2. Regional CCRD subcommittee meetings and reports.

1.2.3.	Conduct targeted outreach to consumers and family members representative of diverse communities to increase their participation in the CCRD committee.	1.2.3.	The committee will have membership of at least one consumer or family member of the following communities: Deaf and Hard of Hearing, Native American, Asian American, LGBT, African American.
1.2.4.	Conduct focus groups with Purepecha community in Eastern Coachella Valley.	1.2.4.	Establish community leadership to facilitate distribution of mental health information.

CRITERION 2

COUNTY MENTAL HEALTH SYSTEM

UPDATED ASSESSMENT OF SERVICE NEEDS

Goal 2: Ongoing Community Needs Assessments Updates

2.1. Objective: Provide   update   information   on   Community   Needs Assessment

Activities		2010-2011 Outcomes	
2.1.1.	Presentation of a summary of Consumers' Utilization data and Clients Population Profile Report to the CCRD committee.	2.1.1.	Analysis of data and recommendations from CCRD committee twice a year.
		2.1.2.	Provide an analysis of disparities and determine changes on disparities.

CRITERION 3

COUNTY MENTAL HEALTH SYSTEM

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

Goal 3: Reducing Disparities/ Monitoring of disparities

3.1. Objective: Monitor trends over time in access to and appropriateness of mental health services to racial/ethnic and cultural diverse groups.

Activities	2010-2011 Outcomes
3.1.1 Request data analysis by QI and Research and Evaluation for performance indicators.	3.1.1. Determine factors that cause disparities in relevant performance indicators.
3.1.2 List disparities and link it to the necessary strategies.	3.1.2. Identification of effectiveness of strategies in the reducing disparities effort.

CRITERION 4

COUNTY MENTAL HEALTH SYSTEM

CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

Goal 4: Development of indicators of integration of the client/family members/community Cultural Competence/Reducing Disparities committee within the county mental health system.

4.1. Objective: Increase and sustain the participation of CCRD committee members in the review of all services, programs, and the overall planning and implementation of services at the county.

Activities	2010-2011 Outcomes
4.1.1. Consultation with other counties' Ethnic Service Managers and other experts regarding integration of the Cultural Competency committee and other committees.	4.1.1. Determination of factors and strategies that indicate the integration of the committee.
4.1.2. Periodic presentations of other county's committees and/or programs to the CCRD committee to obtain their input on current issues.	4.1.2. Schedule presentations by the QI committee, MHSA planning and implementation committees, and other county wide and regional programs.
4.1.3. Improve the cultural competence of the CCRD committee by determining additional cultural competence trainings.	4.1.3. Monthly cultural competence training based on committee recommendations.
4.1.4. Conduct regular leadership trainings for the communities' representatives.	4.1.4. Overall better understanding on how the system admits consumers, and how to inform their communities in a clear and culturally competent way.

CRITERION 5
COUNTY MENTAL HEALTH SYSTEM
CULTURALLY COMPETENT TRAINING ACTIVITIES

Goal 5: Cultural Competence training for mental health staff including management, supervisory, clinical and support staff.

5.1. Objective: Provide county staff and contract agencies staff with a least 3-hour training that focuses on the department's implementation of cultural competence requirements; identify best practices in elimination of disparities.

Activities	2010-2011 Outcomes
5.1.1. Create a training curriculum for a 3-hour training on Department's Cultural Competence requirements to be presented as part of a new employee orientation.	5.1.1. Training scheduled and evaluations.
5.1.2. Create a training curriculum for 3-hour training on Department's Cultural Competence requirements to be presented to contract agencies.	5.1.2. Schedule presentations and evaluation.

5.2. Objective: Implementation of California Brief Multicultural Training Program (CBMC) Provide twice a year.

Activities	2010-2011 Outcomes
5.2.1 Conduct CBMCS trainings at two convenience locations to increase staff participation.	5.2.1. Two trainings a year with approximately 60-80 staff attending the training. 5.2.2. Compile CBMCS training evaluations and dissemination of the evaluations and staff feedback among program managers and supervisors.

5.3. Objective: Implementation of Providing Interpretation Training twice a year.

Activities	2010-2011 Outcomes
5.2.3. Conduct Providing Interpretation trainings at two convenience locations to facilitate staff participation.	5.2.4. Two trainings a year with approximately 40 staff attending the training.
	5.2.5. Compile training evaluations and dissemination of the evaluations and staff feedback among program managers and supervisors.

CRITERION 6

COUNTY MENTAL HEALTH SYSTEM

COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

Goal 6: Recruitment and retention of ethnically, culturally, and linguistically diverse staff representative of the Department's service areas as the budget allows

6.1.1. **Objective:** Recruitment, hiring, and retention of a multicultural workforce to provide services to the identified unserved and underserved populations reported in the Workforce Education and Training component of the MHSA.

Activities	2010-2011 Outcomes
6.1.1. Coordinate with Riverside Asian American Community Association (RAACA) to have a community forum to develop a relationship among the different Asian American communities and to identify Asian American Community Leaders to promote wellness and quality of life including mental health.	6.1.1. Training of Asian American leaders on mental health information and resources.
6.1.2. Coordinate presentations about the ongoing progress of implementation of the Workforce Education and Training Plan to the Cultural Competence/ Reducing Disparities Committee.	6.1.2. Schedule presentations and documentation of recommendations from the committee.
6.1.3. Target outreach and engagement activities with culturally and ethnically	6.1.3. Increase marketing and recruitment of culturally diverse communities to

specific communities which will include promotion of Mental Health careers, volunteer, and internship opportunities.	participate in the promotion of mental health activities and volunteer program and internship programs.

CRITERION 7

COUNTY MENTAL HEALTH SYSTEM

LANGUAGE CAPACITY

Goal 7: Ongoing assessment and monitoring of Department's language capacity

7.1. Objective: Provide consumers and family members with services and written materials in their language of choice.

Activities	2010-2011 Outcomes
7.1.1. Coordinate availability of 24-hoursphone line access for Deaf and Hard of Hearing.	7.1.1. Access line utilization Report.
7.1.2. Develop an in-service training to be provided to staff on how to access the 24-hour phone line in order to meet the client's linguistic needs.	7.1.2. Training curriculum and schedule.
7.1.3. Deaf and Hard of Hearing language capacity building.	7.1.3. Help eliminate the language barrier and provide support that is culturally and linguistically competent for the Deaf and Hard of hearing population.
7.1.4. Develop language capacity with Purepecha community at Eastern Coachella Valley.	7.1.4. Help eliminate the language barrier and provide support that is culturally and linguistically competent for the Purepecha community.

CRITERION 8
COUNTY MENTAL HEALTH SYSTEM
ADAPTATION OF SERVICES

Goal 8: Ensuring that consumers and family members are receiving effective, understandable and respectful care, provide in a manner compatible with their cultural health beliefs, practices and preferred language.

8.1 **Objective: Develop a list of alternatives and options that accommodate individual's cultural and linguistic preferences.**

Activities	2010-2011 Outcomes
8.1.1. Identify and describe of Cultural and linguistically specific programs provided by the county and the county's contractors.	8.1.1. Completed list and summary of culturally and linguistically specific services available for consumers and family members.
8.1.2. Identification of cultural competence indicators and lessons learned regarding implementation and outcomes of ethnically and linguistically specific programs.	8.1.2. Presentations of effective practices.

I. County Mental Health System Commitment to cultural competence

Policies, Procedures, or Practices

Riverside County Department of Mental Health's (DMH) commitment to providing culturally competent services has been in place since early 1990s. This philosophy of embracing cultural and linguistic diversity has been allowed to permeate the Department's Policies and has had an increasingly powerful impact on its administrative direction. The DMH not only expects to see provision of cultural and linguistic competency within its own services but contract providers are required to address these issues as well. Department documents have been reviewed and updated to emphasize the value and commitment that is placed on meeting cultural and linguistic needs of the communities we serve. This commitment can be seen in the Mission Statement, Strategic Plan, Operating Principles Policy Manual, Human Resources Recruitment and Retention Policies, Contract Requirements and Monitoring tools.

Mission Statement

The Riverside County Department of Mental Health's Mission Statement is as follows:

> The Riverside County Department of Mental Health exists to provide effective, efficient and culturally sensitive, community-based service that enable severely mentally disabled adults and older adults, children at risk of mental disability, substance abusers, and individuals on conservatorship to achieve and maintain their optimal level of healthy personal and social functioning.

> In short, "Providing Help, Empowering Recovery"

Statements of Philosophy

The overall philosophy of the Department is to maximize services to clients and to provide support to their families, friends, and significant others within of resources of the Department.

Riverside County Department of Mental Health Statement of Operating Beliefs and Principles adopted on January 17, 2007 are a clear operationalization of the philosophy of the Department (Attachment # 1)

Strategic Plans

As the Department develops, implements, and updates strategic plans such as the Mental Health Plan, Community Service and Support Plan, Prevention and Early Intervention Plan, Workforce Education and Training Plan, and Innovation Plan, the planning process, goals and objectives are reflecting cultural competency standards. It is important to the Department that there is a strong relationship between the MHSA planning process and the Cultural Competency Plan Requirements.

Policy and Procedures Manual

The Department's main policy in support of Cultural Competency is Policy #162 (Attachment #2). This Policy is considered to be a dynamic document in support of cultural competency. As the Department develops policies, the initial drafts of these policies are disseminated to direct service and support staff as well as the Cultural Competency Program for their review and input before they undergo final approval. Other policies that support components of the cultural competency efforts include:

- Policy #290 Consumer Brochures and Posters. This Policy supports the accessibility and dissemination of consumer information and includes documents in the threshold language (Attachment #3).
- Policy #291 and #297 both stress the importance of the family's involvement in the client's recovery process (Attachment #4).
- Policy #342 and #348 both support staff development and retention issues by allowing employees to further their education through reduced work schedules (Attachment #5).
- Policy # 123-0 Translation of Documents. This Policy highlights the procedure to provide standards and guidelines for translation of documents, as well as ensure the quality, distribution and availability of translated informational materials, forms and any written documents (Attachment #6)

Human Resource Training and Recruitment Policies

Riverside County Department of Mental Health recognizes the value of providing staff with training and tools that will assist them in providing effective cultural competent services. The current practice is to ensure that all the trainers include cultural competency into their course materials as it relates to their training topic and the communities we are currently serving. In addition the cultural

competency training 'known as California Brief Multicultural Competency Training will be implemented twice a year.

Efforts are made to recruit, hire and retain staff members that represent the cultural and linguistic diversity of the population we serve. Riverside County's Workforce Education and Training (WET) component of the Three-Year Program and Expenditure Plan addresses recovery-oriented skill enhancement, retention, and recruitment of the Public Mental Health System workforce. Individuals, groups, and agencies that contract with Riverside County to provide services to our consumers are included. This Workforce Education and Training component complies and supports the vision, values, mission, goals, objectives and proposed actions of California's MHSA Workforce Education and Training Five-Year Strategic Plan (Five-Year Plan) and this County's current MHSA Community Services and Supports component. Actions to be funded in this Workforce Education and Training component supplement State administered workforce programs. The combined Actions of California's Five-Year Plan and this County's Workforce Education and Training component together address this County's workforce needs as indicated in Attachment #7.

All proposed education, training and workforce development programs and activities contribute to developing and maintaining a culturally competent workforce that includes consumers and family members capable of providing consumer-and-family-driven services that promote wellness, recovery, and resiliency. This Workforce Education and Training component has been developed with stakeholder and public participation and leads to measurable, value-driven outcomes. All input has been considered, and adjustments made, as deemed appropriate.

Contract Requirements

Contracted providers are required to reflect the values and commitment to cultural competency of the Department. To ensure that the contractors achieve the Department's standards of cultural and linguistic awareness, appropriate clauses are included in all service agreements and contract monitoring tools (attachment #8). Attachment #9, is an excel spreadsheet (with multiple tabs) for all county clinics and their compliance to cultural competency related matters. Attached is an excel spreadsheet (with multiple tabs) for all Contract Providers and the details of services they provide. This includes data on all providers and all clinics as it relates to cultural competency matters.

II. County Recognition, Value, and Inclusion of Racial, Ethnic Cultural, and Linguistic Diversity within the System

   A. Practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic communities with mental health disparities;

including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.

Maintaining meaningful relationships with our ethnic and cultural diverse communities has become increasingly important for the Department. Community engagement and participation throughout the MHSA planning process has increased tremendously in the last 4 years.

The following are descriptions of some of the Community Outreach and Engagement activities that the Cultural Competency Program is involved with:

Regional Outreach Coordinators

The Department has three (3) clinical therapists as Regional Outreach Coordinators dedicated to outreach and engagement in the community. They are dedicated to identify and network with communities in order to learn the needs of the diverse communities, and to develop collaborations and partnerships with local social services, education and community service providers involved with the Hispanic community and other underserved populations, as well as to establish and sustain a network of service providers, interested community leaders, natural community leaders, and non-traditional groups (churches, homeowners associations, etc.) In 2009 and 2010 the Outreach and Engagement Coordinators participated in a total of **214** community outreach events (Attachment #10).

Promotores de Salud Mental Program

The Riverside County Department of Mental Health under the Prevention and Early Intervention Plan is in the process of establishing a Promotores (as) de Salud Mental Program to address the needs of our culturally diverse Latino community. This program is designed to provide temporary, short term support, information on mental health topics, and assistance on how to navigate the mental health system. The Promotores(as) de Salud Mental will conduct weekly educational presentations and perform community outreach activities addressing PEI needs to groups and individuals within community organizations such as schools and churches. These services will be offered countywide.

Call to Care Program

The Call to Care Training Program for non-professional caregivers has the goal to provide training and support to community leaders that are connected to underserved populations in order to increase their awareness and knowledge of mental health, mental health resources. Additionally its goal is to increase their readiness to identify potential mental health issues and eliminate stigma and

discrimination associated with mental illness. The Call to Care Training Program has an interactive format which helps the participants practice the skills being taught. It centers first on the needs of the person seeking support or help, and secondly on increasing self-awareness of the caregivers. At the same time, it strives to point out and clarify the skills, knowledge and boundaries that the caregiver needs in order to be effective. The program teaches core qualities of a caregiver including good communication skills, cultural issues, mental health and recovery issues, loss and grief, care of self, suicide risk, stigma and discrimination, psychosocial impact of trauma, and dealing with at risk populations, particularly with the older adult population.

The target population to receive the Call to Care Training Program are community-based and faith-based organizations, non traditional health care providers, indigenous traditional helpers, traditional healers, midwives, bone-setters, herbalists, and other specialists that offer different services aimed at preventing illness, restoring health and maintaining individual, collective and community health.

This program has provided services in the Desert Region for the last 4 years and beginning in 2010 the program was expanded to provide services throughout the rest of the county.

Outreach and Engagement of Lesbian, Gay, Bisexual, and Transgender (LGBT) Population

The Department hired a consultant to complete a needs assessment and to identify available community resources providing services to the LGBT. Focus groups and face to face interviews were conducted with Department staff and community organizations providing services in our community. A completed report on findings and recommendations was ready at the beginning of 2008 (Attachment
#11).

In December 2008 Department of Mental Health established a LGBT Taskforce which is a coalition of LGBT-related organizations, consumers and providers in partnership with the Department of Mental Health throughout Riverside County. The role of the LGBT Taskforce is ongoing assessment of attitudes and conditions throughout Riverside County regarding mental health needs of gay, lesbian, bisexual, and transgender persons and issues across their lifespan.

The LGBT Task Force also makes recommendations for changes and seeks implementation of these recommendations on issues such as (1) the Department wide environment for gay, lesbian, bisexual, and transgender consumers, staff, and providers; (2) appropriate supportive services for LGBT consumers; (3) educational programs for consumers, staff, and providers; (4) other matters affecting the lives of gay, lesbian, bisexual, and transgender community members in Riverside County.

Since 2008 an LGBTQ Taskforce has worked on developing and implementation of a strategic plan with identified key priorities. At the same time the Taskforce is involved with the community in four major LGBTQ community events a year (Attachment #12).

Deaf and Hard of Hearing Impaired Community Engagement:

The Department has conducted focus groups with the Deaf and Hard of Hearing community as part of the process of development of the Prevention and Early Intervention Plan. With participation of the Cultural Competency Committee, the Deaf and Hard of Hearing outreach and engagement plan was developed (Attachment #13).

The Cultural Competency/Reducing Disparities Committee has members representing the Center of Deafness Inland Empire (CODIE). A sign language interpreter is provided at each meeting.

There are two contracts in place specifically for sign language interpretation services only. They are:

Dayle McIntosh Interpreting
714/620-8341

Life Signs
951/275-5035

Asian American Pacific Islanders Population Outreach and Engagement:

The Cultural Competency Program has established a relationship with the Riverside Asian American Community Association (RAACA). Regular monthly meetings are taking place with RACCA.

An Asian American community member is currently volunteering services at the Cultural Competency Program focusing on creating a list of resources in the community that are available for the Asian American community.

As part of the Prevention and Early Intervention Plan and through the community planning process, input was solicited from key Asian American Community Leaders. It was decided, as part of the efforts of reaching out and meeting the needs of underserved Asian Americans, to implement the Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF). The target population of the SITIF Program is Asian American/Pacific Islander immigrant parents and/or caregivers with poor parenting skills to effectively discipline and nurture their children. The primary strategies of the program are community education and outreach workshops, bicultural parenting classes, and family support service linkage.

The Cultural Competency Program developed an Outreach and Engagement Plan that focuses on continued relationship with community leaders and building a network of individuals from the Asian American/Pacific Islander communities to promote mental health in a cultural and linguistic manner (Attachment #14).

Native American Population Outreach and Engagement:

Six focus groups and three interviews with American Indian adults utilizing services in Riverside County were held on May 2nd, May 6th, and May 13th 2008, June 10th, 2008, July 14th, July 15th, and July 16th 2008, August 4th and August 26th 2008 to solicit information about their experience with Riverside County Mental Health and inquire about mental health needs. The groups and interviews were facilitated by Dr. Renda Dionne, an American Indian Clinical Psychologist who has been working within the local American Indian communities for the past 13 years. Four focus groups were held with American Indian parents, participants of two focus groups including the Board of Directors from Indian Child and Family Services and members from the community. The ICFS Board of Directors included tribal delegates from 8 of the 11 tribes in Riverside County and a board delegate from Riverside-San Bernardino Indian Health Incorporated, which had board delegates from 8 of the 11 tribes. The Board Chairs of Riverside-San Bernardino Indian Health Inc. and Indian Child and Family Services were present at these groups. A focus group was also held with the Torres Martinez Tribal TANF program in Anza. This TANF program serves the Indio, Anza and San Jacinto areas. Interviews were conducted with the Director of Riverside and San Bernardino Indian Health Incorporated Behavioral Health Department (a tribal consortium that has clinics on several reservations). Also included were the School Counselor for the Noli Indian school serving middle and high school American Indian children located on the Soboba reservation, and the Executive Director of Indian Child and Family Services, an American Indian Child Welfare Consortium that has been serving Riverside County for over 25 years. Below is a synopsis of major findings. Forty-eight participants representing approximately 20 tribes participated, 29% represented local tribes and 71% represented out of state tribes. 37% were male and 63% were female. Additionally surveys were distributed at American Indian events. Thirty-six surveys were completed (Attachment #15).

In addition, the Cultural Competency Program Manager is actively involved in the Riverside County Tribal Alliance for Indian Children and Families. The goal of this Alliance is to minimize court and county intervention and increase Tribal participation and control by developing culturally appropriate services for Native American children and their families, and to create and sustain partnerships founded upon understanding, communication, and cultural awareness among the sovereign tribal nations and community and government agencies.

African American Population Outreach and Engagement:

Riverside County Mental Health Department has received information and input from African-American community leaders and representatives involved with community organizations and congregations in the Western, Mid-County and Desert regions of Riverside County. It is necessary to continue the work of the consultant to engage these leaders and representatives in four key activities that will increase the communication and understanding of culturally competent mental health services. All activities will be conducted under the Prevention and Early Intervention Plan. Each proposed activity will be evaluated by participants. The following are some of the proposed activities recommended at the focus groups:

- Consultation with Key African-American Community Leaders.
- Formation of African-American Mental Health Advisory Group.
- Support/informational groups/education about mental health in the community.
- Participation in community events targeting the African-American Community (Attachment #16).

Spirituality and Mental Health Recovery

Riverside County Department of Mental Health's Cultural Competency Committee does not endorse any specific faith, religion/lack of religion and/or spiritual beliefs, but recognizes the importance of the role of spirituality in mental health recovery.

With participation of community spiritual leaders the Cultural Competency Spirituality Taskforce developed a PowerPoint to begin presentations about the Spirituality Project and with the purpose of:

1. Introducing the Mental Health Spirituality Initiative in the Department.
2. Creating a dialogue, and increasing awareness on the importance of Spirituality in mental health Recovery.
3. Increasing participant's comfort in discussing spiritual issues.

In an effort to provide the best spiritual support to people in recovery, the Department's Cultural Competency Spirituality Taskforce has the following activities as priorities:

1) Increase the participation of members of the Spirituality Taskforce.
2) Train Department staff to open dialogue and establish guidelines (Attachment #17).
3) Establish roundtables with Spiritual Leaders.
4) Engage Spiritual Leaders and organizations.

Outreach and Engagement Materials for Distribution

With participation of consumers and family members involved in the Cultural Competency activities, the Department identified mental health promotional information for distribution (Attachment #18).

> B. **County's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services.**

The Riverside County Department of Mental Health, RCDMH, is committed to an open, welcoming and transparent planning process facilitating engagement and relationship building with racial, ethnic, cultural and linguistically diverse consumers/family members, community residents, organizations, advisory committees and mental boards in order to assess the needs and to develop appropriate, efficient and acceptable services for these communities, consumers and family. RCDMH values its diverse community stakeholders, organizations, consumers and family members as equal shareholders in the planning, monitoring/evaluating and implementing of all mental health programs and services

The local Mental Health Board has been actively involved in the planning process throughout the planning, development, changes including reductions of all Mental Health programs. Riverside County is a large county which is divided into three regions and within each region there is a mental health advisory board. Regional boards are comprised of community members who to provide input to both the Mental Health Board and to the Regional Manager. The Ethnic Services Manager frequently provides reports to both the Mental Health Board and regional boards regarding the status of culturally competent programs, issues, needs, and changes to encourage their active and continued participation in planning process. Members of Mental Health Board as well as regional boards have participated in the development of the CSS, PEI plans and have been active in the Multicultural Organizational and Community Development Initiative. There is a need for more diverse representation on these boards which they are aware of and they are actively recruiting members from diverse communities.

Realizing the need for greater community and consumer/family participation in the planning process and to achieve the goal of system transformation the RCDMH launched the Multicultural Organizational and Community Development Initiative in June of 2008. In order to accomplish this monumental endeavor the RCDMH established contracts with consultants who possess skilled knowledge of diverse racial, ethnic and cultural communities including, LGBTQ, Native American, and the Deaf community. Focus groups as well as surveys have been used as the primary process to solicit input. Targeted focus groups were

conducted throughout the Department in all regions and were inclusive of consumer/family members, mental health and regional boards, administrative, managerial, supervisory and line staff. A total of 32 groups were conducted with a total of 358 individuals participating in the focus groups.

Once Department's focus groups were completed, the same process was used to solicit input from the community. Community focus groups were conducted in all three regions of the county. A total of 20 community focus groups were conducted with 324 individuals participating.

Data has been collected, reviewed and organized using the framework of The Lewin Model also known as "Indicators of Cultural Competency in Health Care Delivery Organizations: An Organizational Cultural Competency Assessment Profile" This model adopted by the Health Resource and Service Administration (HRSA) provides for a structure that the organization can utilize to further develop cultural and linguistic competency. The model is based on the following seven HRSA domains: Governance, Organizational Values, Planning and Monitoring, Communication, Staff Development, Organizational Infrastructure and Service Intervention. Focus group information/data was reviewed and aggregated into one or more of the seven HRSA domains. Data was further analyzed and catalogued according to strengths, challenges and recommendations. .

RCDMH has also successfully engaged the community in the planning process for the submission of the PEI Plan. Between July 30 and October 10, 2009 a total of 108 community focus groups and forums were conducted with a total of 1,147 individuals participating. Ten focus groups were conducted in Spanish.

To ensure and to engage racial, ethnic, cultural and linguistic groups and consumer and family member participation in the PEI planning process the RCDMH established the Reducing Disparities Task Force, (RDTF), in July of 2009. This task force included community stakeholders from the Asian, Hispanic, African American, LGBTQ, Native American, Middle Eastern and Deaf communities. This committee was instrumental in providing input to the PEI planning process. As a result of the success of Reducing Disparities Task Force and the need for a process of continuous community participation became paramount. To achieve this goal and with the support of the administration and Cultural Competency Committee (CCC) a new avenue was created for a continuous community engagement and relationship building process. The RDTF and CCC have been combined into one committee bringing to the table diverse community stakeholders, organizations, consumers and family members as equal and valuable partners to address issues of cultural competency, disparities, planning, monitoring and implementation. Furthermore, the CCRD committee has been charged with the responsibility of the next phase of the development of a strategic plan for cultural competency and the reduction of

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disparities through the use of the Logic Model developed by Mario Hernandez from the University of South Florida. This will be a community driven process.

Data analyzed from the focus groups will provide the CCRD Committee the information needed to be used as their foundation to further debate, prioritize and develop strategies for creation of a comprehensive plan to move the Department toward the reduction of disparities and to become a culturally competent organization. This Committee will be trained by the University of South Florida and will work closely with consultants under contract with Riverside County. RCDMH expects to have a comprehensive Department Cultural Competency Reducing Disparities Plan in place by December, 2010. This Plan will be developed in conjunction with the DMH's Cultural Competency Plan Requirements but will far exceed those requirements. A copy of the first draft /work in progress is presented in Attachment #19.

C. A narrative, not to exceed two pages, discussing how the County is working on skills development and strengthening of community organizations involved in providing essential services.

The Department is committed to community capacity building and reducing stigma of mental illness. As implementation of the MHSA CSS Programs, Workforce Education and Training, and Prevention and Early Intervention is being done, the Department realizes the need to have a coordinated ongoing comprehensive approach to work in collaboration and partnership with the diverse communities. The following is the description of the Capacity Building Initiative:

Goals

1. Educate the community to reduce the stigma of mental illness.

   a. Build awareness of mental health issues.
   b. Build understanding of the needs of those with mental health problems.

2. Reduce barriers that keep people from acknowledging their problems and seeking help.

3. Build welcoming communities and resources that support and engage those with any level of mental health problems.

   a. Build specific supports in communities targeted to high risk individuals.
   b. Build support activities and engagement strategies for the mentally ill in their communities outside of county funded mental health services.
   c. Promote, support and train communities in growing their own culturally appropriate and linguistically accessible mental health prevention programs and resources. Strengthen the ability of communities to act on

their own behalf to promote the wellbeing of their members.

d. Promote and support identification and utilization of cultural and linguistic community resources for treatment and early intervention in mental health problems (Attachment #20).

D. Share lessons learned on efforts made on Items A, B, and C above.

The Department has implemented different ways to work in collaboration and partnership with the communities in order to engage and facilitate community participation:

- Connecting isolated individuals to each other to build support systems.
- Connecting individuals with existing community resources.
- Working with already established community resources to provide support and promote mental health.

<u>Emerging Lessons</u>:

- Need to have a more precise and concrete definition of the communities.
- Need to have clear definition of "building community capacity" as the effort of the Department to provide support and facilitation to increase the ability of the communities to act on their own behalf.
- Allocation of funding at the same time that the Department manages budget shortfalls.
- Listening to the communities and their recommendations. The communities are not asking for traditional services at the Department clinics. The communities are asking for support in their efforts to strengthen their current resources. The community is asking the Department to increase the utilization of current community-based organizations already operating in the communities by strengthening the ability of communities to promote the mental health of their members without having to receive services that are more costly.
- Helping connect individuals currently receiving services to natural community support systems, while helping to establish or strengthen natural support systems.
- Shifting the understanding of community and community capacity building, as well as the role of the Department in relation to meeting the needs of the mentally ill in our communities.
- Developing leaders from the community to participate in the efforts of community capacity in partnership with the Department. It is necessary to engage community leaders and stakeholders as partners in making decisions to insure a maximum impact on the shifting of perceptions.

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- Earning the trust of communities and inspiring confidence among the people of diverse backgrounds.

E. Identify County Technical Assistance Needs.

None identified at this time.

III. Each County has a designated Cultural Competency/Ethnic Services Manager (CC/ESM) Person Responsible for Cultural Competency

Riverside County Department of Mental Health has a full time LMFT Program Manager position designated to the Cultural Competency Program. The Cultural Competency Program Manager works in collaboration and partnership with agencies in the community and with the Department's Administration and Program Managers to ensure the embedding of cultural competence at all levels of the organization.

A. Written description of the cultural competence responsibilities of the designated CC/ESM.

The following is the list of key activities/responsibilities of the Cultural Competence Program Manager:

- Develops and Implement cultural competence plan within the organization

- Leads the Cultural Competency/Reducing Disparities Committee.

- Leads Ethnic and Cultural Specific Community taskforces.

- Participates in the development of Department/Program budget and cost control systems, and collecting actual cost data.

- Analyzes organizational factors and develops strategies to integrate cultural competence principles in the day-to-day operation of the Department.

- Obtains cooperation and team support to pursue long-term development objectives.

- Develops administration policies and monitoring policy systems.

- Works in collaboration and partnership with the Director, Assistant Director for Programs and Program Managers.

- Facilitates translation and interpretation services.

- Develops and implements an Outreach and Engagement Program targeting the ethnic communities.

- Coordinates Cultural Competency trainings for the Department

- Provides training on different topics such as providing interpretation training, and cultural competency trainings.

- Participates in the implementation of the California Brief Multicultural Competency Scale Training Program.

- Managing a County wide outreach and engagement program.

- Participates in the monitoring of County and service contractors to verify that the delivery of services is in accordance with the local and State mandates as they affect underserved population.

- Assists program managers in defining program objectives and goals and target groups to reduce mental health disparities.

- Coordinates and jointly develops behavioral health services programs and budgets with administrative staff.

- Advises Management Team and other staff on defining, designing, developing and evaluating program services and projects.

- Analyzes computer produced reports and other management information sources related to the implementation of cultural competent and linguistic programs and their impact in the elimination of disparities.

- Assists in the formulation and development of new programs, through needs assessment and a community-based planning process.

- Evaluates and recommends on the advisability of and justification for grant or contract requests.

- Participates in the coordination of contractual agreements with public and private agencies for the provision of services.

- Makes Cultural Competency Program planning presentations to Department, County Management and Public Commissions and Agencies as necessary.

- Maintains on-going liaison with community organizations, planning agencies and private groups in reference to mental health services.

- Develops and maintains clear communication channels between local agencies and County staff.

The Cultural Competence Program Manager is Knowledgeable in the:

- California State Cultural Competency Requirements and Standards.

- Current trends, principles and application of organization and program planning concepts in a Mental Health Services settings.
- Program evaluation and research methods and techniques.
- Principles and practices of health care management, staffing and budgetary control.
- Theories of personality growth and development, diagnostic categories, normal and abnormal behavior, psychiatric treatment modes and techniques.
- Cultural, socioeconomic and language factors that affect service delivery to ethnic populations served.
- Grant preparations.
- Laws and regulations relating to mental health care services.
- Principles of program development and coordination.
- Public relations applicable to the coordination of local, State and Federal Agencies; and health planning agencies.
- Principles of community organization, health education and resources in the health field.
- Principles of supervision and training.

The Cultural Competency Program Manager has the ability to:

- Plan, coordinate, and evaluate mental health programs.
- Prepare, present, and interpret factual and statistical data.
- Interpret mental health programs to individuals and groups.
- Identify the need for and develop proposed changes in program practices and policies.
- Establish and maintain the confidence and cooperation of diverse ethnic client populations.
- Establish and maintain effective working relationships with Departmental personnel; local, State and Federal agencies, and health planning agencies;
- Supervise the work of subordinate professionals.
- Prepare clear and comprehensive correspondence and reports.
- Make effective oral and written presentations.

Cultural Competency Program

The Cultural Competency Program is responsible for the implementation of system wide Cultural Competency Plan that addresses enhancement of workforce development, as well as enhancing the ability of the whole system to incorporate the languages, cultures, beliefs and practices of it's consumers into the services. It promotes services that are cultural competent, it enhances consumers' access to those services, and encourages consumers' input.

IV. Identify Budget Resources Targeted for Culturally Competent Activities

Evidence of a budget dedicated to cultural competency activities.

Riverside County Department of Mental Health strives for culturally competent service delivery in all programming. Strategies and enhancements are planned to reduce ethnic and linguistic disparities and to ensure sensitivity and responsiveness to consumer age, gender, culture, ethnicity, language, physical disabilities, beliefs and lifestyles. The Department's commitment to providing cultural and linguistic competent services is demonstrated by the allocation of budget dedicated to cultural and linguistic activities. The Department's Cultural Competency Program has a budget of approximately $1,683,929 as follows:

Cultural Competence Program Staff

Position/ Job Classification	Allocated Time	Year Budget
Mental Health Service Program Manager	1.00 FTE	$127,324
Clinical Therapist/ Outreach Coordinator	3.00 FTE	$279,143
Secretary	1.00 FTE	$ 66,462
LGBT Consultant	By the hour	$ 25,000
Native American Consultant	By the hour	$25,000
Cultural Competence Program Consultant: CC Organizational Assessment	By the hour	$75,000
African American Consultant	By the hour	$ 25,000
Deaf and Hard or Hearing	By the hour	$ 25,000
Administrative Staff Analyst	0.50 FTE	$41,512

Cultural Competence Program Activities

Activities and Services	Description	Project Budget Allocation
Interpretation and Translation Services	Interpreters Line Interpretation Face to Face Translations	$60,000 (Interpretation) $70,000 (translations)
Financial incentives: Stipends for community members participating in the Cultural Competence activities	Facilitates the participation of consumers, family members and community leaders in committees and planning process meetings	$10,000

Activities and Services	Description	Project Budget Allocation
Outreach and Engagement Activities: Community Capacity Building	Community Fairs Outreach materials/ Promotional Items/give a ways	$30,000
Call to Care Program	Outreach to train and assist lay persons to initiate and maintain understanding, caring relationships with the persons of their religious communities, and to volunteer to use their counseling skills in their communities	$75,000
African American Outreach and Engagement Project.	Ethnic and cultural leaders from the African American Community in collaborative efforts. Identification of key community leaders and building a network of individuals from the community to promote mental health.	$ 65,000
Asian American Outreach and Engagement Project	Ethnic and cultural leaders from the Asian American Community in collaborative efforts. Identification of key community leaders and building a network of individuals from the community to promote mental health.	$65,000
Native American Outreach and Engagement Project	Ethnic and cultural leaders from the Native American Community in collaborative efforts. Identification of key community leaders and building a network of individuals form the community to promote mental health.	$65,000
Deaf and Hard of Hearing Outreach and Engagement Project	Ethnic and cultural leaders from the Deaf and Hard of Hearing Community in collaborative efforts. Identification of key community leaders and building a network of individuals from the community to promote mental health.	$65,000
Promotores(as) Program	The Promotores de Salud Mental address the need within the large number of Hispanic/Latino communities in Riverside County.	$250,000

Spirituality and Mental Health Project	Riverside County Department of Mental Health. Initiative in an effort to provide the best spiritual support to people in recovery, the Spirituality as Part of Mental Health Recovery shall have: 1) Training. 2) Roundtables. 3) Engagement of Spiritual Leaders and organizations. 4) Spirituality Taskforce	$50,000
California Brief Multicultural Training Program (CBMCS)	Two four days classes twice a year: Overview of the CBMCS Training Modules: • Multicultural Knowledge (day one) • Awareness of Cultural Barriers (day two) • Sensitivity and Responsiveness to Consumers (day Three) • Socio-cultural Diversities (day four)	$10,000
Interpreters Training	3 regional classes per year to focus on understanding the fundamental principles for using an interpreter, developing a team/partner relationship with your interpreter, understanding the limitations & benefits in the use of interpreters, Understanding the roles of both the staff using interpreters & the interpreter when services are provided, Understanding the protocol and ethics of interpreting.	$ 6,000

A. **A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:**

1) Interpreter and translation services:

Riverside Department of Mental Health maintains a 24 hour Language Line. Riverside County has a county wide Interpreters Unlimited BPO of $750,000. So far to date we have used approximately $60,000 of the total county BPO. In addition to the allocation of budget for the interpretation and translation services via outside contract, the Department has staff positions that are designated as

bilingual. Bilingual staff in these bilingual positions receive bilingual pay (Attachment #21).

2) Reduction of racial, ethnic, cultural, and linguistic mental health disparities:

The efforts of the Department in the reducing of racial, ethnic, cultural and linguistic mental health disparities is well documented in the planning process and implementation of the MHSA components. As described in each one of the MHSA plans all the identified strategies have the overall goal of reducing disparities among the target populations.

3) Outreach to racial and ethnic county-identified target populations.

Outreach & Engagement (O&E) is a vital component within the Mental Health Services Act (MHSA), which aims to provide information to the community at large and toward specific ethnic, cultural and linguistic individuals in our community. The outreach and engagement activities focuses on a wide diversity of backgrounds and perspectives represented within the County, with a special emphasis on underserved and unserved populations. It seeks to facilitate the creation of an infrastructure that supports partnerships with historically disenfranchised communities, faith based organizations, schools, community-based agencies, and other County departments.

Moreover, what have been the lessons learned from the PEI Planning is the need to increase focus on cultural and linguistic outreach and engagement as a strategic priority.

Three RCDMH Outreach and Engagement Staff, one in each geographic region of the County, provide community outreach and engagement activities targeting ethnic populations increase community awareness and knowledge of mental health and mental health resources, such as prevention and early intervention programs, and increase community readiness to address mental health issues and eliminate stigma associated with mental health issues.

4) Community Education: Culturally competent targeted community education to destigmatize mental illness in the community and to increase awareness and participation in Prevention and Early Intervention Programs. This includes attendance at community health fairs including those targeting specific cultural populations, conducting cultural and linguistic mental health/prevention and early intervention radio programs, and participation in community workgroups such as the Reducing Disparities Taskforce and the LGBT Taskforce. The staff will "get the word out" to the community about available resources.

5) Psychosocial Educational: Provide culturally appropriate psychosocial education and activities to communities, families, and impacted individuals in order to better understand the early treatment and support services within the

family and their communities. Staff will be the liaison with Promotores de Salud, and the key community leaders in order to provide accurate information and resources and to bridge the gaps for individuals in need of PEI services.

6) Referral and Linkages: Improve communications and referral linkages across the school system, enforcement, courts, senior centers, churches, and legal support systems. Improve and expand linkages across all systems of care: Primary care, social service, public health, and schools in order to provide early mental health screening, linkages across community members and providers.

7) Financial incentives for culturally and linguistically competence providers, non-traditional providers, and/or natural healers.

Riverside County Department of Mental Health has a contract with Jefferson Transitional Program for administrative activities related to providing stipends for consumers, family members and non traditional providers/natural healers when they provide services in the Department's programs.

I. General Population

County General Population

Riverside County is a geographically large county with 7,303 square miles and a total population of 2,119,618 people. The County has a large youth population with 28% percent of the total population comprised of youth age 17 and under (Figure 1 page #23).

- Riverside County is large with 7,207.37 sq. Miles.
- Population projections indicate that the County's population increased by 36% from 2000 to 2008 and will continue to increase by (8.6%) from 2008 through 2011.
- White and Hispanic are the majority race/ethnic groups in Riverside County (46% white, and 40.9% Hispanic). Of the remaining 13%, the largest population is Black, followed by Asian/ Pacific Islander, Multi-race and American Indian. There is no significant difference in the number of females versus males within the County. Females comprise a slightly higher percentage of the population than males (Attachment #20).
- Projected changes from 2008 to 2011 indicate that the Hispanic proportion of the County's population will increase while the proportion in Non-Hispanic Whites will decrease. Yet, overall Non-Hispanic White residents will remain the largest racial/ethnic group.
- RCDMH programs are provided in three (3) geographic regions: West, Mid-County and Desert.
- Adults comprise 52.9 % of the population.
- Transition Age Older adults 55-64 are 7.70% of the population and older adults (65+) are 11.4% of the total population.

County Population by Age

14.1%

28.6%

57.3%

Legend:
- Under 17
- 18 to 59
- 60+
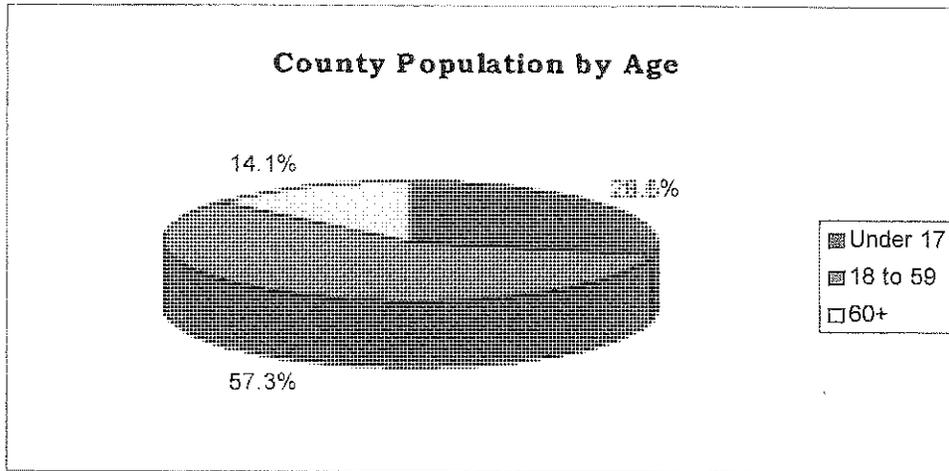
The majority of the race/ethnic population in the County is represented by the White and Hispanic/Latino groups with much smaller proportions of African American/Black, Asian American and Native American groups (Figure 2).

Total County Population by Race/Ethnicity

Race/Ethnicity	Percentage
White	46.1%
Hispanic	40.9%
Asian/PI	4.6%
American Indian	0.5%
Black	6.3%
Multirace	1.7%
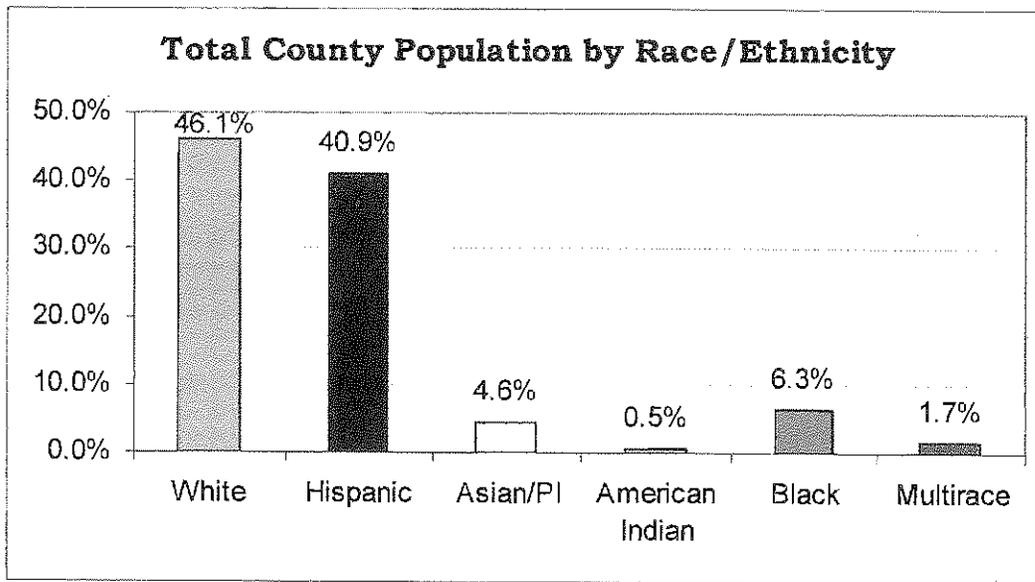
There is no significant difference in gender distribution in youths under age 18 and in adults ages18-59 population. However, in the older adult population age 60 and above, 55% of the population is female and 45% is male.

An analysis of age by race/ethnicity showed that the distribution varies by age group. The populations for each age group are dominated by the two largest race/ethnic groups in the County which are White and Hispanic /Latino. There is some variation in the pattern depending on the age group. Older adults are predominantly White while a large proportion of youth under age 18 are Hispanic/Latino. The adult population is dominated by the two largest race/ethnic groups in the County which are White and Hispanic/Latino in nearly the same proportions. A much smaller proportion of the adult population (7%) is African American/Black or Asian American, Pacific Islander and an even smaller proportion is Native American (<1%) and 1% reports is multiracial. The same pattern is true for the youth with most of the population falling into the White or Hispanic/Latino groups and a much smaller proportion in the African American/Black or Asian American, Pacific Islander groups. For older adults the Hispanic/Latino population is much smaller than in the adult and youth age groups. The proportion of older adults that are in the remaining race/ethnic groups is similar to the youth and adult pattern with 5% African American/Black slightly fewer in the Asian American, Pacific Islander groups and fewer still in the Native American or Multiracial group.

Bar chart with legend: □ White ■ Hispanic ▨ Black □ Asian/Pacific Islander ■ American Indian ▨ Multirace

Youth <18: White 36%, Hispanic 51%, Black 6%, Asian/Pacific Islander 4%, American Indian 0.4%, Multirace 3%

Adults 18-59: White 45%, Hispanic 41%, Black 7%, Asian/Pacific Islander 5%, American Indian 0.6%, Multirace 1%

Older Adults 60+: White 70%, Hispanic 19%, Black 5%, Asian/Pacific Islander 4%, American Indian 0.6%, Multirace 1%

II. Medi-Cal Population Services Needs (Use current CAEQRO data if available)

The County shall include the following in the CCPR:

   A. Summarized Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).
   B. Provide an analysis of disparities as identified in the above summary.

According to the Medi-Cal population and client utilization data provided by CAEQRO for calendar year 2008, the average number of people eligible for Medi-Cal in Riverside County was 336,844 and the total number of beneficiaries served by the RCDMH was 18,547.

Age

Over half the total Medi-Cal eligible population (53.7%) are youth under the age of 18. Adults are the next largest group (33.3%) with older adults comprising only 12.8% of the total Medi-Cal eligible population. According to the CEQRO 2008 calendar year data RCDMH served a total of 18,457 beneficiaries. Over half the beneficiaries served were adults (56.13%) between 18-59 years of age. Youth under the age of 18 represented 36.77% of those served and older adults were 7.10% of the beneficiaries served. See Figure 1 for a comparison of Medi-Cal eligible population to Medi-Cal population served by age groups.
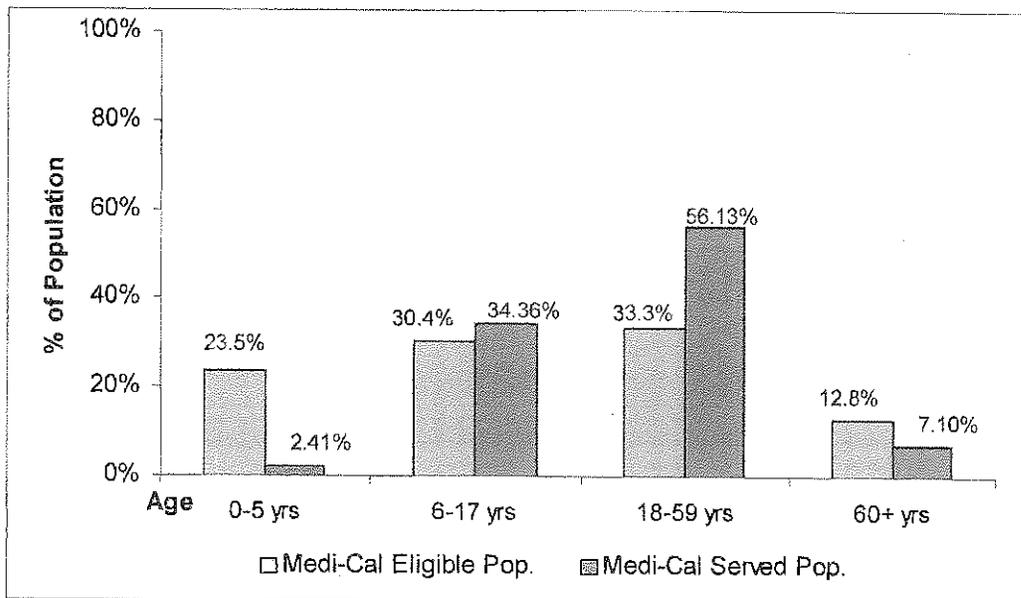
Disparities are present for youth and older adults in the Medi-Cal population. A smaller proportion of youth is utilizing services than the proportion they represent in the Medi-Cal population. Youth comprises 53% of the Medi-Cal population but only 36.77% of those are served. The penetration rate for youth in Riverside County at 6.22% is less than the rate for large counties (8.01%) and the state (8.0%). Also, the penetration rate for youth ages 6-17 in Riverside County decreased between 2007 and 2008. The older adults served are also disproportionate to their representation in the Medi-Cal population. However, the disparity for older adults has shown slight improvement with the penetration rate increasing from 2.81 in 2007 to 3.05 in 2008. The older adult penetration rate is slightly lower than the rate of other large counties and the state.

Adults represent a smaller proportion of the Medi-Cal population yet are served in a much larger proportion compared to the youth and older adults served. Adults are served in a proportion that is greater than their representation in the Medi-Cal population (34% of Medi-Cal population and 56% of those served). The rate for adults at 9.28% is higher than the state rate and similar to other large counties.

Females represent a greater proportion (57.13%) of the total eligible population than males (42.87%). The gender distribution of beneficiaries served was 53.21% female and 46.79% male. Females comprised a larger proportion of the Medi-Cal population.

Ethnicity

The distribution of Medi-Cal eligibles and Medi-Cal served by Race/Ethnicity is presented in Figure 2. The Hispanic group is the largest proportion of Medi-Cal eligibles while the proportion of White Medi-Cal eligibles is one half that of the Hispanic/Latino group. Black/African American comprises a much smaller percentage of the eligible population and Asian American/Pacific Islander and Multirace are the smallest groups of Medi-Cal eligible beneficiaries. This race/ethnic distribution could be affected by the age of the beneficiaries since a large proportion of the Medi-Cal eligibles are youth and the youth population in Riverside County is 51% Hispanic/Latino. Beneficiaries served by ethnicity/race group showed that more White beneficiaries are served than any other race/ethnic group. Figure 2 shows the distribution of each race/ethnic group for those in the total Medi-Cal population and the population of RCDMH beneficiaries served. The white group served is nearly twice the proportion represented in the Medi-Cal population. The Hispanic proportion served is just over half the proportion represented in the population. The Black group showed an overrepresentation given the proportion in the total Medi-Cal population. The Hispanic and Asian/Pacific Islander group shows the most disparity although the Asian/Pacific Islander group is a much smaller proportion of the total Medi-Cal population.

Comparasion of Medi-Cal Eligible to Medi-Cal Served by Race/Etnicity

Legend: ■ % Medi-Cal Total Population □ % Medi-Cal Served
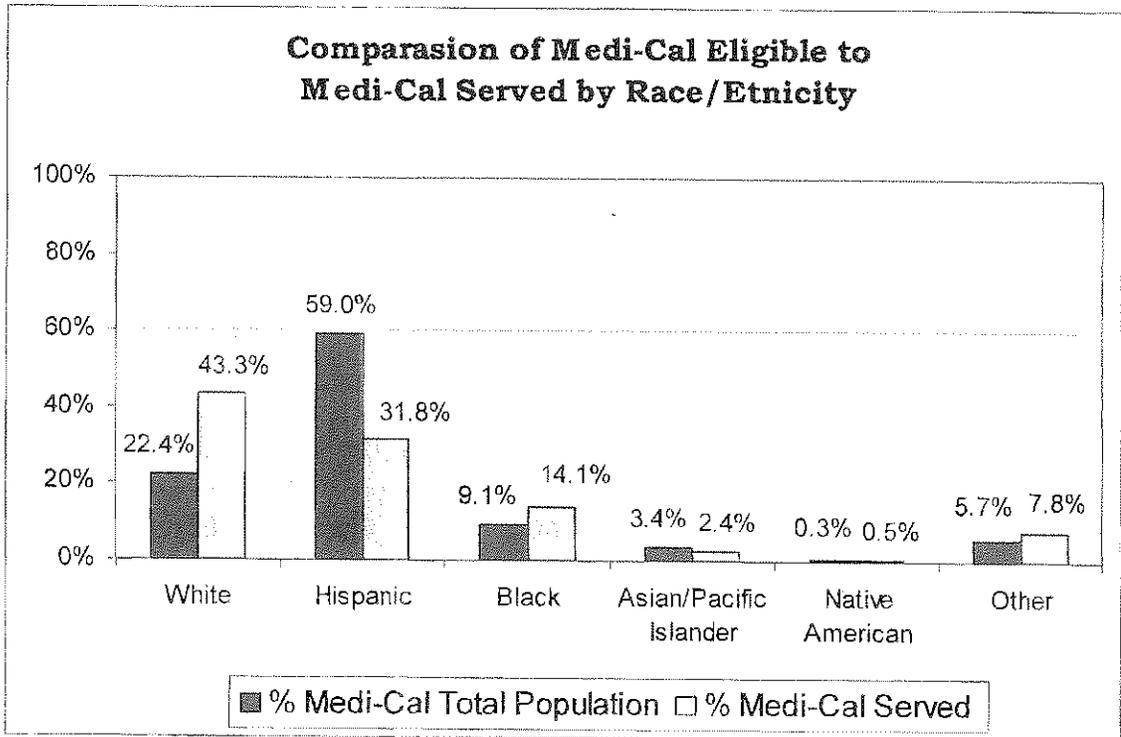
Medi-Cal penetration rates for each race/ethnicity further illustrate the disparities for Hispanic/Latino groups and Asian American beneficiaries (Figure 3). Overall Riverside County penetration rates in 2008 were lower than other large counties and the state across all race/ethnic groups. Penetration rates for the Hispanic/Latino group and the Asian/Pacific Islander group are considerably lower than the rates for other race/ethnic groups and are less than the rates for other large counties and the state. Some of the low penetration rate could be accounted for by the age of the Hispanic/Latino Medi-Cal eligibles but this certainly does not explain all of the disparity.

Compasion of Medi-Cal Penetration Rates Riverside County, Large Counties, and State

Fig. 3

Legend: □ Riverside County ▨ Large Counties ▨ State
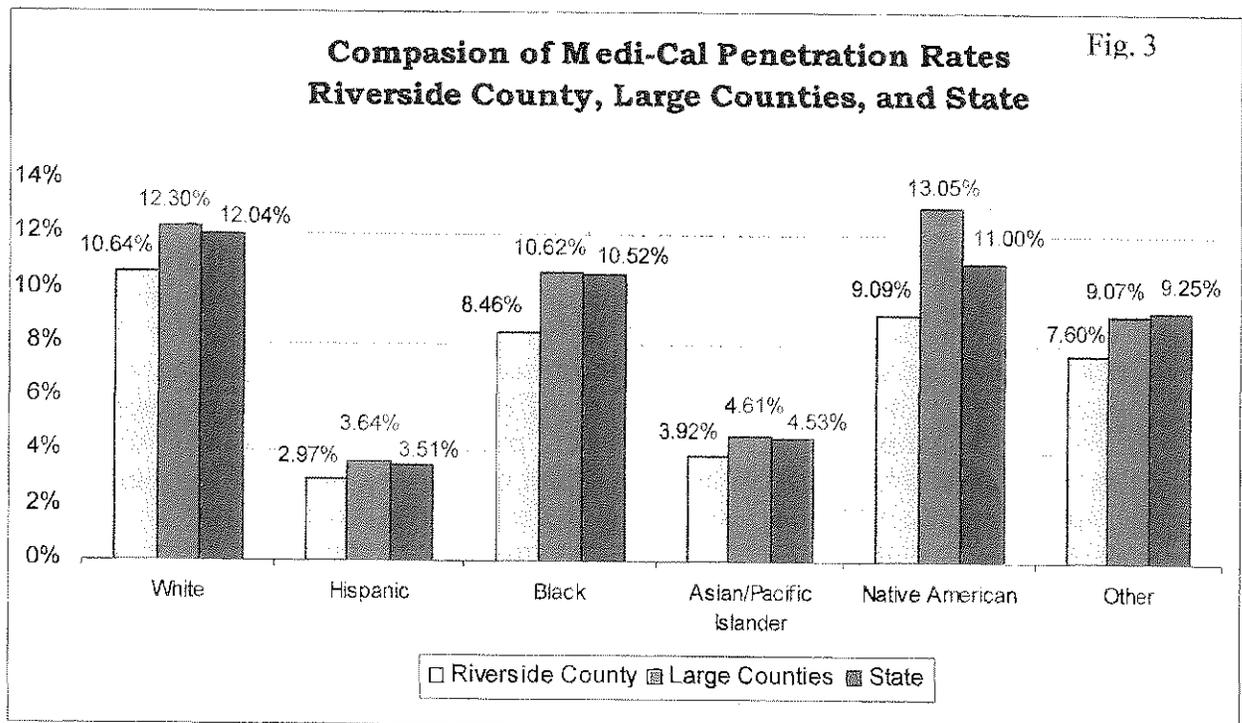
The penetration rate ratio is another method for examining disparities. "Penetration rate ratio" is a ratio of one demographic or ethnic group to another. A ratio of 1.0 reflects an equitable penetration rate based upon the beneficiary population. The further the value is from 1.0, the greater the disparity. Penetration rate ratios for Riverside County are .28 for the Hispanic/Latino vs. White population in calendar year 2007. The average payment per beneficiary served shows less disparity with a ratio of .82 and average claims per beneficiary at $2,388 for Hispanic/Latino and $2,897 for White in calendar year 2007[1].

Note: Objectives for these defined disparities will be identified in Criterion 3, Section III.

III. 200% of Poverty (minus Medi-Cal) Population and Services Needs.

The county shall include the following in the CCPR:

A. **Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race ethnicity language age and gender (other social/cultural groups may be addressed as data is available and collected locally).**
B. **Provide an analysis of disparities as identified in the above summary.**

Population at 200% of Poverty without Medi-Cal Eligibles

Age

The population living at 200% of poverty or below who are not Medi-Cal eligible is another population of interest. Unlike the Medi-Cal eligibles the population at 200% of poverty or less has a much smaller proportion of youth (24.25%) and older adults (7.83%); while the adults are a much larger proportion of this population at 67.92%. An examination of RCDMH service data showed a similar pattern as that shown for Medi-Cal beneficiaries served with a much larger proportion of adults served and fewer youth and older adults served. However, the proportion of adults served (86.5%) is even more disproportionate to the percentage of adults in the 200% of poverty population. The proportion of youth served was about half the proportion (11.5%) they represented in the 200% of poverty population. For older adults the proportion served (2%) was about 3 times less than their proportion in the 200% of poverty population.

Ethnicity

The race/ethnic distribution of the 200% of poverty population (minus Medi-Cal eligibles) is presented in the following Figure.

Comparasion of 200% of Poverty Population to RCDMH Non-Medi-Cal Population Served
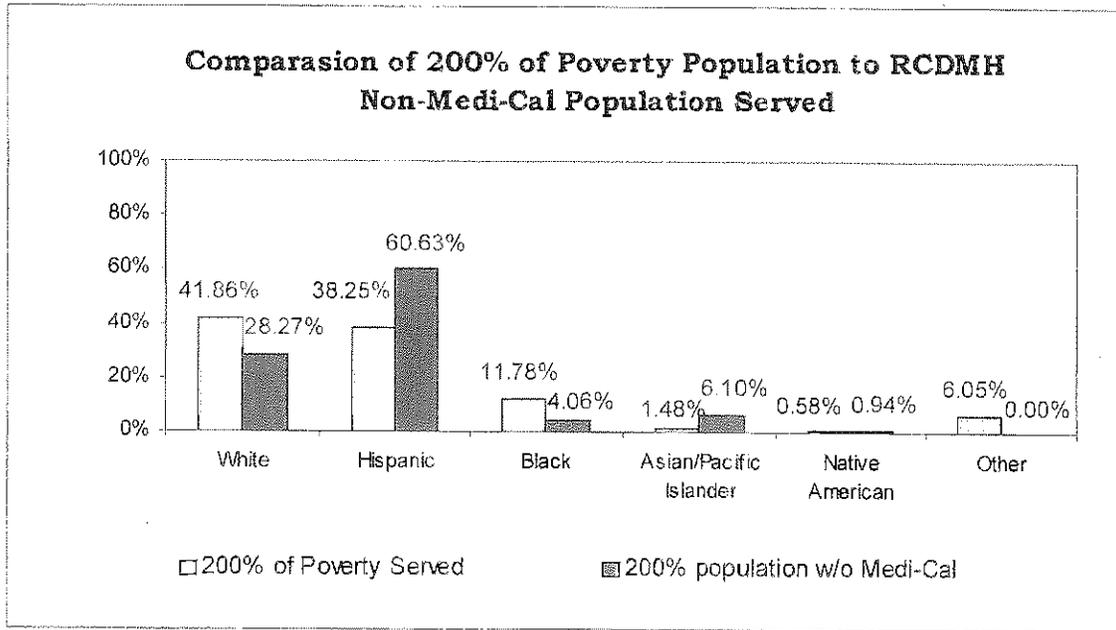
Similar patterns are found in the 200% of poverty population as was true for the Medi-Cal population. The white group represents the largest proportion served and the Hispanic group shows a smaller proportion served than is represented in the population. In this population the Black group is again overrepresented. Disparities are present for the Asian/Pacific Islanders group with a much smaller proportion served than is present in the population. For this low income population the proportion of Whites, Hispanics and other race are similar to the proportion found in the Medi-Cal eligible population. However, differences are noted for the Asian/Pacific Islander group and the Black group. The Asian/Pacific Islander group in this low income population is twice that found in the Medi-Cal eligible population (6.10% compared to 3.4%) and for the Black group the proportion is less than the that found in the Medi-Cal eligible population (9.1% compared to 4.06%).

Examining this population by gender showed that 51% are male and 43% are female. RCDMH service data showed that 63.2% of those served without Medi-cal are male and 36.8% are female. The disproportionate representation may be influenced by the high percentage of male consumers served in RCDMH detention services which is not billed to medi-cal and has a higher proportion of uninsured.

Note: Objectives for these defined disparities will be identified in Criterion 3, Section III.

IV. MHSA Community Services and Supports (CSS) Population Assessment and Services Needs.

The County shall include the following in the CCPR:

A. From the County's approved CSS Plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

B. Provide an analysis of disparities as identified in the above summary.

A full Mental Health Community Needs analysis was developed by the Research Department and incorporated into the CSS planning process. Riverside County anticipated the increase in total population of 9.29% over the next three years. The anticipated population growth included an increase in female population by 9.34%, and male population by 9.26%. It also included the increase in each ethnic group in Riverside County. The largest anticipated ethnic population growth is seen among the Hispanic/Latino population with an increase of 16.99%. The Asian American and Pacific Islander population also shows dramatic growth with a percentage increase of 16.42%.

The Department acknowledges that several of the identified needs crossed over among age groups. These needs surfaced independently through the community input and committee processes. The identified needs that surfaced in multiple age categories were homelessness, co-occurring disorders, and mentally ill population that surface through the juvenile or criminal justice system. Youth experiencing difficulties transitioning from children to adult services appeared in both the youth/children/TAY planning process.

MHSA CSS Population and Service Needs

Similar to the analysis of Medi-Cal and 200% of poverty data, the Hispanic and Asian/Pacific Islander populations were identified in the RCDMH Community Services and Support (CSS) Plan as communities with disparities. Unmet Need was used to examine population disparities in the Department's CSS Plan in 2003-2004. Updates to the original Unmet Need table have been completed with current population and service data and will be described further in the following summary. Utilizing prevalence rates is a useful method for examining disparities. Unmet Need is based on the difference between known prevalence rates and the number of people who received mental health services in the County. To determine 'Unmet Need' a formula is used to estimate the population needing services based on published prevalence rates for Serious Mental Illness

(SMI)/Serious Emotional Disturbance (SED), County population data, and the number of consumers served by the Department. This does not take into account any serve received outside the county system.

It was noted in the CSS plan that the greatest Unmet Need was in the Asian/Pacific Islander and Hispanic/Latino populations. The Hispanic population represented the highest prevalence figure as well as the largest number of unserved children/youth. The Hispanic population was expected to experience significant growth which could further contribute to existing disparities. Unmet Need Analysis provided in the CSS plan showed that out of all mentally ill, Asian/Pacific Islanders, 85% of children remain unserved and 80% of adults remain unserved. Again it was noted that the Asian/Pacific Islander population had a higher total percentage of unserved consumers but they also represent the lowest population total. CSS Plan analysis showed that out of all mentally ill Hispanic/Latinos, 83% of children remain unserved and 78% of adults remain unserved. Also of note in the CSS Plan was the fact that more male Hispanics were served than female Hispanics served in all age groups except for older adults suggesting outreach was needed to particularly focus on female Hispanics. This gender difference did not appear to apply to the Asian/Pacific Islander population. The CSS Plan made note of the needs of youth and older adults as these populations were expected to increase. Gender differences were noted in the older adult population receiving mental health services in that, females served almost doubled the males served.

Additional populations noted in the CSS Plan were deaf and hard of hearing. Prevalence estimates and population data indicated in the data analysis section of the CSS Plan, showed there are 10,939 deaf or hard of hearing mentally ill individuals in Riverside County. Estimates were that less than 100 individuals were receiving or have requested to receive services. There are sign language translation services available, but a need for deaf clinical staff and enhanced training was noted in the Plan. The CSS Plan also noted specific strategies to address the unique needs of the TAY age group, but did not indicate disparities compared to other age groups.

Table 1 shows data for Unmet Need FY 2003-2004 used in the County CSS Plan compared to updated data on Unmet Need. Table 1 shows that Unmet Need has increased for youth and has decreased slightly for adults and older adults. Due to population increases and decreases in the number of youth served the Unmet Need for youth has increased. Decreases in Unmet Need have been shown for adults and older adults.

Table 2 shows Unmeet Need fiscal year comparisons for youth by ethnicity. Unmet Need is highest for the Asian/Pacific Islander youth and has increased since the CSS Plan analysis, however, this group represents a smaller proportion of the population. The Hispanic and White youth have the next highest Unmet Need in similar proportions but with the Hispanic group somewhat higher. The increase in Unmet Need for Hispanic youth is much less than the increases for

other groups. Although lower than the other groups Unmet Need for the Black youth has increased more than other groups.

Unmet Need 2008- 2009 by Age Group (Table 1)

Age Group	Riverside County Population Total[1]	RCDMH Clients Served[2]	Prevalence Total[3]	Unmet Need[4]	% of Unmet Need 2008-2009[5]	% of Unmet Need 2003 - 2004[6]	Change in Unmet need
Youth	594,358	9,763	44,815	35,052	78.68%	74.12%	4.56%
Adults	1,175,678	27,127	77,359	50,232	62.15%	65.03%	-2.88%
Older Adults	291,563	2,054	15,015	12,961	85.59%	88.66%	-3.07%

Unmet Need 2008-2009 by Ethnicity-Youth (Table 2)

Race/Ethnic Group	Riverside County Population Total[1]	RCDMH Clients Served[2]	Prevalence Total[3]	Unmet Need[4]	% of Unmet Need 2008-2009[5]	% of Unmet Need 2003 - 2004[6]	Change in Unmet need
White	219,788	2,680	15,363	12,683	82.56%	68.48%	14.08
Hispanic	313,600	3,864	24,963	21,099	84.52%	83.05%	1.47
Black	38,604	1,067	3,030	1,963	64.79%	51.66%	13.13
Asian/Pacific Islander	23,242	91	1,759	1668	94.83%	85.43%	9.40
Native American	2,468	59	192	133	69.31%	42.39%	N/A[7]
Other/Multi	17,281	2,126	1,320	-806	-61.03%		

Riverside County Population Total-Data source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2005. Sacramento, CA, July 2009.

For adults Unmet Need is highest for the Asian/Pacific Islander and Hispanic groups. The Asian/Pacific Islander group has shown an increase in Unmet Need while the Hispanic group has shown some decrease in Unmet Need since the original CSS Plan analysis.

Unmet Need 2008- 2009 by Ethnicity Adults Age 18- 60+

Race/Ethnic Group	Riverside County Population Total [1]	RCDMH Clients Served [2]	Prevalence Total [3]	Unmet Need [4]	% of Unmet Need 2008-2009 [5]	% of Unmet Need 2003 - 2004 [6]	Change in Unmet need
White	746,872	14,240	46,381	32,141	68.72%	68.67%	-0.05%
Hispanic	532,799	8,885	37,296	28,411	72.42%	77.87%	-5.45%
Black	91,278	3,334	5,769	2,435	32.95%	32.22%	.73%
Asian/Pacific Islander	70,562	620	4,657	4,037	86.47%	79.51%	6.96%
Native American	8,423	188	390	202	51.79%	62.78%[8]	N/A[7]
Other/Multi	17,305	1,914	1,391	-523	-37.57%	62.78%[8]	

Note: objectives will be identified in Criterion 3, Section III.

V. Prevention and Early Intervention (PEI) Plan: The Process Used to Identify the PEI Priority Populations.

The County shall include the following in the CCPR:

A. **Which PEI priority population(s) did the County identify in their PEI Plan? The County could choose from the following six PEI priority populations:**

The PEI Priority Populations that were identified in the planning process are:
1. Underserved cultural populations.
2. Individuals experiencing onset of serious psychiatric illness.
3. Children/youth in stressed families.
4. Trauma-exposed.
5. Children/youth at risk of school failure.

B. **Describe the process and rationale used by the County in selecting their PEI priority population(s) (e.g., assessment tool or method utilized).**

Contact was initiated with stakeholders and members of underserved communities utilizing a network of contacts, telephone, and electronic outreach. Meetings were held with community leaders, community based service providers, and consortiums throughout Riverside County ensuring contact with representatives from each of the three regions (Western, Mid-County, and Desert). The PEI team attended numerous existing community based stakeholder meetings as a part of the outreach campaign to begin the coordination and scheduling of focus groups and community forums. Between July and October 2008, 108 focus groups and community forums were facilitated throughout the County with a total attendance of 1,147 participants. A network of contacts that had been developed through telephone and electronic outreach was used to inform as many members of the community about the available focus groups and community forums. To ensure that stakeholders could fully participate in the community input process, specific Spanish speaking focus groups were facilitated and Spanish translation was available at each community forum. Other specific focus groups were held for older adults, deaf/hard of hearing, Native Americans, and LGBTQ individuals. As a means to further solicit input from community stakeholders a community survey was

developed and posted on the RCDMH website (www.mentalhealth.co.riverside.ca.us) in both English and Spanish.

A total of 2,354 surveys were completed and returned. The survey was designed to ascertain stakeholder input regarding priorities about key community mental health needs and priority populations in Riverside County. PEI Planning utilized the existing four age group MHSA planning committees (Children, TAY, Adult and Older Adult). Due to a great deal of interest in the PEI planning process, there were additional stakeholders who joined each of the committees so that the membership reflected all key stakeholders. Through the planning process, it was determined that there was a need to develop three workgroups to address specific PEI needs. They were the Trauma Workgroup, the Reducing Disparities Workgroup and the Reducing Stigma and Discrimination Workgroup.

There was specific outreach to stakeholders for participation, including members of unserved and underserved cultural communities, community providers with expertise as well as consumers and family members of consumers. Each of the age group committees (Children, TAY, Adult and Older Adult) participated in a two day facilitated process to determine the priority needs and recommendations for the age group they represented. Each committee was tasked with ensuring that the voice of the community was heard in the recommendations that were developed. They began with a review of PEI related recommendations that were gathered as a part of the CSS planning process. Committees also received the analysis of the information gathered from the focus groups, community surveys and the three workgroups (Trauma, Reducing Disparities, and Reducing Stigma and Discrimination). Each committee provided a document with their recommendations and each workgroup assigned representatives to attend the PEI Steering Committee to convey their respective committee and workgroup recommendations. The Steering Committee identified and prioritized the final PEI strategies.

I. Identified Unserved/Underserved Target Populations (with Disparities)

The County shall include the following in the CCPR:

- Medi-Cal population
- Community Services Support (CSS) population: Full Service Partnership population.
- Workforce, Education, and Training (WET) population: Targets to grow a multicultural workforce
- Prevention and Early Intervention (PEI) priority populations: These populations are county identified from the six PEI priority populations.

A. List identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations).

   1. From the above identified PEI priority population(s) with disparities, describe the process and rationale the county used to identify and target the population(s) (with disparities).

Based on the information described in Criterion 2 the identified populations with disparities include youth, older adults, Hispanic/Latino, Asian/Pacific Islanders, Native Americans, and members of the Deaf community.

The population analysis in Criterion 2 showed that youth and older adults are underserved in the Medi-Cal and 200% of poverty population. Hispanic and Asian/Pacific Islander groups showed disparities in the Medi-cal population and the 200% of poverty populations and were noted in the CSS Plan as underserved groups with disparities.

The County CSS Plan population assessment also showed the high Unmet Need for youth and older adults. Services to older adults have shown some improvements but disparities between older adults and other age groups served are still present. Youth have been underserved and existing disparities have increased as the population has grown and the number of youth served has decreased. An analysis of Full Service Partnership Program participants showed disparities in the adult FSP consumers served for Hispanic/Latinos, Asian/Pacific Islanders, and Native Americans groups. In the youth FSP population disparities

were reversed for the Caucasian and Hispanic/Latino groups. Asian/Pacific Islander youth were underrepresented in the youth FSP program. The older adults showed less disparity between the Caucasian and Hispanic/Latino groups reflecting a pattern similar to the County older adult population. The Black/African American, Asian/Pacific Islander and Native American groups are underrepresented in the older adult program compared to their proportion in the population.

II. Identified Disparities (within the target populations)

The County shall include the following in the CCPR:

A. **List disparities from the above identified populations with disparities (within Medi-Cal, CSS, WET, and PEI's priority/targeted population).**

Identified populations with disparities include youth, older adults, Hispanic/Latino, Asian/Pacific Islanders, Native Americans, and members of the Deaf community.

III. Identified Strategies/Objectives/Actions/Timelines

The County shall include the following in the CCPR:

A. **List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.**

The Department strategies for reducing the identified disparities were established during the CSS planning process and outline in the Outreach and Engagement Plan included in the CSS Plan. The Outreach and Engagement strategies are included in each of the programs proposed by Riverside County for MHSA.

The populations to be served under the Outreach and Engagement plan include children, transitional age youth, adults, and older adults with serious mental illness or serious emotional disturbances and their families. Individuals may also have co-occurring substance abuse disorders. Outreach and Engagement activities occur across the County and will target the unserved population identified.

B. **List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:**

<u>**Outreach and Engagement (All ages)**</u> **(total served annually 600 +)**

1. Network of Care

2. Informational/Educational Materials

3. Outreach efforts of Jails, Juvenile Hall, Probation, Hospital

4. Outreach to Gay/Lesbian, Bisexual, Transgender Organizations

5. Outreach to Deaf, Hard of Hearing Community

6. Women's Policy Council Champions Project

7. Outreach Coordinator

8. Networking with Organizations who predominantly work with Ethnic Populations including; Indian Health, Faith Based Organizations, Community Organizations (Hispanic), Public Health Clinics

9. Community Events

10. Recruitment, Training, and Practice Change

11. Ethnic members on Boards and Committee's

12. Advisory Committee

13. Identification of Target Areas

14. Monitoring Progress

15. Law Enforcement Collaborative

Prevention and Early Intervention Strategies (PEI)

All of the seven PEI work plans focus on unserved and underserved cultural populations. This was a focus throughout the community planning process and was highlighted clearly in the PEI Plan. There are programs within the PEI Plan that specifically target unserved and underserved populations. Attachment #48 provides the latest updated on the initial implementation of PEI Programs.

The programs listed below address the target priority populations identified through the community planning process.

Priority Population: Underserved Cultural Populations

• **Outreach Activities** – Three RCDMH outreach and engagement staff provide community outreach and engagement activities targeting those populations that are currently receiving little or no service to increase awareness and knowledge of mental health and mental health resources, such as PEI programs, and increase community readiness to address mental health issues and eliminate stigma associated with mental health issues.

• **Ethnic and Cultural Community Leaders in a Collaborative Effort** – Throughout the community planning process, stakeholders indicated the need for mental health awareness education specifically tailored for unserved and

underserved cultural populations. Input from the community focused on ensuring that individuals providing the mental health awareness information reflect the culture of the communities receiving the information. RCDMH will continue relationships with Ethnic and Cultural Community Leaders from ethnic and cultural populations within local communities in order to identify key community leaders and to build a network of individuals from these communities to promote mental health information and the use of PEI services. The Ethnic and Cultural Community Leaders represent the following populations: African American; Native American; Asian American/Pacific Islander; Deaf/Hard of Hearing; and LGBTQ. The Ethnic and Cultural Community Leaders will assist RCDMH in coordinating an advisory group for the population they represent that will be inclusive of key community leaders, community based providers and faith based organizations.

Each advisory group will work to develop culturally and linguistically appropriate mental health education and awareness materials, which will provide information on mental health, mental illness, and available mental health services. They will also assist the Department in developing culturally appropriate mechanisms to provide mental health related information to the community. In order to achieve this, RCDMH will work with the Ethnic and Cultural Community Leaders to provide mental health educational groups for key leaders within the community. The community leaders will then reach out into their local communities and provide culturally and linguistically appropriate mental health informational meetings for community members.

These activities will ensure that there is increased knowledge within communities about mental health related information and services as well as reduced stigma related to mental health needs. Because the Ethnic and Cultural Community Leaders come from the community they serve they can address barriers due to linguistic and cultural differences, stigma, and mistrust of the system.

• **Promotores de Salud (Community Health Workers)** – As stated earlier, the community planning process revealed that stakeholders indicated the need for community based education and outreach efforts within local communities. The Promotores de Salud program will address that need within the large number of Hispanic communities in Riverside County. Promotores are health workers who work in, and are from the community they serve. They will provide health and mental health education and support to members of their communities. The Promotores have long standing relationships with people in the communities that they serve and, as a result, individuals from those communities are more likely to trust not only the individual but the information they provide. Promotores reduce the stigma associated with mental health related information and services. Additionally, Promotores provide services within the community, which significantly reduces barriers to access such as transportation and limited resources. Promotores will provide outreach to individuals and families within their communities where individuals feel comfortable and may typically gather.

In addition to specific outreach, programs that have been developed or adapted for specific cultural populations and found to be effective with the identified population(s) were identified and included in the PEI Plan. These include:

Priority Population: Children/Youth in Stressed Families and Underserved Cultural Populations

Parent Management Training (PMT) – PMT uses didactic instruction, modeling, role playing, and home practice to teach parenting skills in encouragement, monitoring, discipline, and problem solving. The PEI Steering Committee identified the Spanish-speaking migrant community of the County as a high priority for parenting programs specifically tailored to their needs and culture. A cultural modification of the PMT Program, developed by Charles Martinez, has been shown effective with this population. The program is a 12- week group intervention with 2 ½ hour sessions (including 1 hour for a meal and social interaction time for families to build social support networks).

Priority Populations: Individuals Experiencing First Onset of Serious Psychiatric Illness and Underserved Cultural Populations

* **Mamás y Bebés (Mothers and Babies):** This is a manualized 12-week mood management course during pregnancy (women who are between 12 to 32 weeks pregnant) with post partum booster sessions at 1, 3, 6, and 12 months post-partum. It is an adapted model from the Depression Prevention Course and Cognitive Behavioral Treatment Manuals. The Manual was designed to address the socio-cultural issues relevant to a low-income, culturally diverse population. The purpose is to teach participants to recognize which thoughts, behaviors, and social contacts have influence on their mood, the effect of mood on health, and the benefits of strengthening maternal-infant bonding. Significant and targeted outreach will be done through the use of the Promotores de Salud (as outlined in the Mental Health Outreach, Awareness and Stigma Reduction Project). The group model appears to be "culturally congruent with the collectivist nature of the Latino culture and can provide mutual support among group members, and decrease stigma associated with mental health problems," (Munoz, et al., 2007). This program has also shown effectiveness with African American women.

* **Cognitive-Behavioral Therapy (CBT) for Depression (with antidepressant medication):** This program was developed for use with low-income Latina women. It uses an adapted format of CBT to address cultural issues associated with the Hispanic culture. There is considerable evidence that CBT, alone or in combination with medication, is effective in the treatment of major depression. The use of Promotores de Salud is a key element in the engagement of the Latina women. Mental Health workers trained through the Promotores de Salud model are from the targeted community and are able to outreach to and engage with the women within the culture of their community. Antidepressant medication is also a component of the program and used in

conjunction the CBT show a decrease in depression and an improvement in overall functioning.

Priority Population: Children/Youth at Risk of School Failure, Children/Youth in Stressed Families, and Underserved Cultural Populations

• **Effective Black Parenting Program (EBPP):** The EBPP was originally developed for parents of African American children aged 2 to 12. Most of its evaluation studies have been conducted with this population. However, since beginning the national dissemination of the program in 1988, the program has been successfully used with teenage African American parents and their babies, and with African American parents of adolescent children. Thus, its widespread usage has been with parents whose children range from 0 to 18. The complete EBPP consists of fourteen 3-hour training sessions and a graduation ceremony. The complete program is usually taught for small groups of parents (8 to 20). A briefer version of the EBPP is also available (a one-day seminar version) which is taught with large numbers of parents (50 to 500). This is a cultural adaptation of the Confident Parenting Program. It includes: culturally specific parenting strategies; general parenting strategies; basic parenting skills taught in a culturally-sensitive manner using African American language expressions and African proverbs; and special program topics such as single parenting and preventing drug abuse. The ideal instructor is an African American with a positive ethnic identification, and with a background in child development, African American studies, behavior modification, and group processes. Upon implementation, the weekly parent group will be facilitated by a clinician who will also offer one-day seminars throughout the year. Identified parents who complete the small group program will be provided training to facilitate one day seminars in their communities. A stipend will be offered to parents who facilitate the one-day seminars. Utilizing parents and community members to facilitate seminars will increase the cultural competency of the program, reduce disparities, and build community assets.

• **Africentric Youth and Family Rites of Passage Program:** This program developed by the MAAT Center for Human and Organizational Enhancement, Inc. of Washington, D.C. is designed for African American male youth between ages 11 and 15. The goal of the MAAT program is empowerment of black adolescents through a nine-month rites of passage program. Youth can be referred from a variety of places including courts, mental health, and schools. The program provides a multi-faceted, therapeutic intervention to 15-member youth groups. The first eight weeks are an orientation for the youth, the parents, and the referring agency personnel. A major component of the program is the afterschool program, held for two hours, three days per week. It offers modules on knowledge and behaviors for living; module topics include manhood development, sexuality, and drugs. Modules on creative arts, math, and science are also offered. After each module is completed, the youth develop topic-related projects, such as the production of culturally oriented T-shirts, anti-

substance abuse buttons, videotapes, and concerts. For effective prevention, all programming activities need to be interesting and pro-social so that youth are engaged and benefit from the resiliency building aspects of the activity. Family and caretaker involvement is stressed in this program. Family enhancement and empowerment buffet dinners are held monthly. The objective of the dinners is to empower adults to advocate on behalf of their children and families and to work toward community improvement. The dinner conveys to parents that they are valued and that the program is hospitable and nurturing. This message is necessary because initially most parents distrust the MAAT Program because of previous negative experiences with human services organizations. Staff demonstrates their caring to parents through ongoing outreach and communication. Another component of the program includes casework and counseling with linkage to needed services. The staff includes a clinical social worker as well as non-professionals who can provide formal, informal, and crisis counseling. Outreach is an essential component to engage the students and families as well as maintain them in the program. Staff outreach via telephone and transportation to and from the program (Harvey et al., 1997).

Priority Population: Trauma-Exposed and Underserved Cultural Populations

• **Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)** – The CBITS Program is a cognitive and behavioral therapy group intervention for reducing children's symptoms of Post Traumatic Stress Disorder (PTSD) and depression caused by exposure to violence that has been used successfully in inner city schools with multicultural populations. CBITS has shown cultural evidence for African American youth. CBITS has three main goals: to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support. CBITS was designed for use in schools, but can also be implemented in a community setting, for children ages 10-14 who have had substantial exposure to violence and who have symptoms of PTSD in the clinical range. Treatment includes group with 5-8 students for 10 sessions along with 1-3 individual sessions, two parent education classes, and a teacher informational meeting.

Priority Populations: Underserved Cultural Populations, Children/Youth in Stressed Families, and Children/Youth at Risk for School Failure

• **Incredible Years – Native American Adaptation (SPIRIT):** Incredible Years is a set of comprehensive, multifaceted, and developmentally based curricula targeting 2-12 year old children, their parents, and teachers. The parent training intervention focuses on strengthening parenting competencies and fostering parents' involvement in children's school experiences to promote children's academic and social skills and reduce delinquent behaviors. The model was developed as a group intervention; however SPIRIT is a culturally-tailored evidence-based practice that was adapted by Dr. Renda Dionne for the

Riverside County American Indian community. The adaptation is a 15 week in-home parenting program for children ages 0-11 years old.

• **Guiding Good Choices (GGC):** GGC is a prevention program that provides parents of children in grades 4 through 8 (9-14 years old) with the knowledge and skills needed to guide their children through early adolescence. It seeks to strengthen and clarify family expectations for behavior, enhance the conditions that promote bonding within the family, and teach skills that allow children to resist drug use successfully. Due to the historical trauma within Native American populations, substance abuse is inextricably linked with the development of depression and major mental illness, including Bi-Polar Disorder and Post Traumatic Stress Disorder. Therefore, a program to address substance abuse prevention is essential in addressing the prevention of mental health problems. This family group intervention is a five-session curriculum that addresses preventing substance abuse in the family, setting clear family expectations regarding drugs and alcohol, avoiding trouble, managing family conflict, and strengthening family bonds. This program can be adapted to be implemented in-home with individual families. Sessions are interactive and skill based, with opportunities for parents to practice new skills and receive feedback, and use video-based vignettes to demonstrate parenting skills.

• **Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF): A Curriculum for Immigrant Families** – This is a selective prevention intervention. The target populations of the SITIF program are immigrant parents and/or caregivers with inadequate parenting skills to effectively discipline and nurture their children. The primary strategies of the three components of the program are: (1) Community Education/Outreach Workshops: these are one-time workshops on effective bi-cultural parenting and family management. The workshops help demystify the stigma associated with parenting classes and mental health issues, provides tips to parents, and are an effective recruitment strategy; (2) Bicultural Parenting Class Series: This is a 10-week, culturally competent, skill-based, interactive, and manualized parenting and family management curriculum to the target parents and/or primary caregivers once a week for 2 hours per week in a group format; (3) Family Support Service Linkage: When parents indicate additional need for mental health and/or other social services, staff provide consultation and linkages to linguistically and culturally competent community service entities. The curriculum has been applied to immigrant parents of various ethnic origins.

The curriculum has various language versions including Chinese and Vietnamese. The intervention uses a team approach with 2 Parent/Family Specialists who are bi-lingual in the language of the immigrant families they work with. They will conduct the parenting curriculum and provide consultation on an as needed basis. The team also works in the capacity of a community organizer to serve as a liaison between the program and the community. They have a good understanding of the local community and immigrant experience and are able to network with people and recruit them to the program. The activities are delivered at locations that are natural congregation places for the immigrant

families such as schools, community service delivery settings, community-based and culturally competent behavioral healthcare center.

Work Force Education and Training (WET)

Cultural Competency and Diversity Education Development Program (RCDMH WET plan Action #6)

Capitalizing on the linguistic skills of our bilingual staff, who often serve as the primary interpreters for our linguistically diverse consumers and their families, RCDMH will develop Interpreter's Training in order to enhance staff's interpretation and translation skills. We will also develop a central, accessible list of bi-lingual and multi-lingual staff in order to create easier access for non-English speaking consumers. Furthermore, Riverside will fund the training of bilingual/Spanish volunteers (preferably consumers or family members) as *Promotores de Salud Mental.* These volunteers will serve as community liaisons and mental health educators. Depending on the success of this program, similar models will be developed to outreach other cultural groups. RCDMH has already offered "Survival Spanish" to staff and will explore its effectiveness.

Professional Licensure Support Program (RCDMH WET plan Action #12)

Greater diversity is seen in our licensed-waivered (Clinical Therapist I) staff: 44% Caucasian/European origin; 27% Latino/Hispanic; and, 9% African-American/Black. We need to continue to support our licensed-waivered staff to become licensed to build the diversity of our workforce.

The development of our licensed-waivered staff to become licensed mental health practitioners is a strategy intended to remedy the shortage of qualified individuals who provide services to consumers with severe mental illness. Supporting our already licensed staff to maintain their status not only maintains a qualified licensed workforce, but also validates professional staff regarding their contribution, thereby increasing their satisfaction and retention.

Public Mental Health Graduate School Internship Program (RCDMH WET plan Action #13)

Increase the diversity of students graduating with professional behavioral science degrees.

Financial Incentives for Workforce Development (RCDMH WET Plan Action #14)

RCDMH has a current 20/20 program. Qualified regular (permanent) full-time employees are permitted to divide their working and training/education hours on

a weekly 20/20 hour basis while continuing to be paid as full-time employees. In return, selected employees agree to a service commitment for a period of time equal to the period they receive financial training assistance. Preference is currently given to bilingual and bicultural candidates in order to better meet the needs of our underserved populations.

IV. Additional Strategies/Objectives/Actions/Timelines and Lessons Learned

Riverside County Department of Mental Health has no additional or new strategies included in CSS, WET, and PEI at this time. Implementation and monitoring of current strategies has been the main focus for the Department.

V. Planning and Monitoring of Identified Strategies/Objectives/Actions/Timelines to Reduce Mental Health Disparities

A. List the strategies/objectives/actions/timelines provided in Section II and IV above and provide the statue of the County's implementation efforts (i.e. timelines, milestones, etc.).

The listed strategies/ goals/ actions identified are presented in the following attachments:

Attachment # 12 LGBTQ Outreach and Engagement

Attachment # 13 Deaf and Hard or Hearing Outreach and Engagement

Attachment # 14 Asian American Outreach and Engagement

Attachment # 15 Native American Outreach and Engagement

Attachment # 16 African American Outreach and Engagement

Attachment # 48 PEI Implementation Report

Attachment # 49 WET Implementation Report

B. Discuss the mechanism(s) the County will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and what measures and activates the County uses to monitor the reduction or elimination of disparities.

There are several consumer outcome measures that are cultural specific. The Mental Health Statistical Improvement Program Survey has been developed to give an assessment of consumer satisfaction and contains components that measure cultural competency specifically. There are also instruments such as Penetration/Retention Rates and the Unmet Needs study that give a view of

where our services are being utilized and among which cultures and languages our services are needed.

Riverside County Department of Mental Health Research & Evaluation Unit provides quarterly reports of total of services provided and the profile of client population served by gender, ethnicity, education, primary diagnosis, and other relevant information such as marital status, employment, etc.

The Unmet Need report is another report that provides the estimate of how many of the estimated mentally ill individuals in Riverside County are not receiving mental health services. This report presents the percent of Unmet Need by Ethnicity, by age, by regions, and by programs.

For the Prevention and Early Intervention strategies the RCDMH will coordinate with evidence-based practice model guidelines and fidelity measurements to determine the appropriate outcome measures to be utilized and monitored for this project in order to meet objectives. In addition, demographic information will be collected for each participant in PEI services. The RCDMH Research and Evaluation Unit will work closely with program monitors to track program participants, carefully monitoring increased access by underserved cultural populations.

In efforts to increase access to the underserved populations in Riverside County, RCDMH made concerted outreach to new providers who have knowledge of the specific target communities identified in the PEI plan and who have relationships within these communities. To assist new providers RCDMH will utilize clinical staff members to ensure that training in evidence-based practices is provided to all service providers. The Department will also assist the service providers in implementation of those evidenced based programs. The clinical staff will hold monthly team meetings with all practitioners of a particular model in order to maintain fidelity, provide clinical consultation, and practice skills required for implementation. The staff member will also assist with infrastructure stability at each site by guiding practitioners to maintain all needed materials and environment set-up. This will allow for greater adherence to the often stringent requirements of evidence-based practices as well as provide assistance to smaller organizations when staff turnover impacts service delivery. Consistent training and coordination of needs will be available to all PEI programs within the County system as well as any partner agency delivering PEI programs. By assisting with the development of and continued support for solid infrastructure within small organizations that work in underserved communities, we will help build community capacity and increase access to mental health services for underserved cultural populations thereby reducing disparities.

The Workforce Education strategies are currently in implementation and need to establish an ongoing process to monitoring outcomes of the strategies identified to grow a multicultural workforce, and to develop indicators of success

C. Identify county technical assistance needs.

See identified technical assistance needs presented in Criterion 6.

I. **The County has a Cultural Competency Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.**

A. **Brief description of the Cultural Competency Committee.**

The Riverside County Department of Mental Health formed a Cultural Competency Committee in the late 1980's. This committee consists of members representing of various program and ethnicities within the Department, including all levels of staff positions, plus consumers and family members hired by the Department.

In 2008, as part of the Cultural Competency Organization and Community Assessment Project, the Cultural Competency Committee recognized the importance of community members' participation. A decision was made to integrate the Cultural Competency Committee with the recently created Disparities Taskforce. After several meetings with both committees the integration of the committee took place and the committee was renamed to Cultural Competency/Reducing Disparities Committee (CCRD). Currently, the Department has the Cultural Competency/Reducing Disparities Committee membership including staff and community leaders representing the target populations.

The newly created committee worked on the roles and responsibilities of the committee as well as an overall description of the committee functions (Attachment #23).

The Cultural Competency/Reducing Disparities Committee meets monthly and is currently working on the following activities:

- Developing the theory of change for the County of Riverside Department of Mental Health Cultural Competency Program.
- Ethnic and Cultural Specific Outreach and Engagement of community, consumers and family members.
- Bilingual list task force update and dissemination.
- Cultural Competency Webpage development.
- Cultural Competency Awareness Column for the Department's Newsletter.
- Participation in the planning and implementation of MHSA.

- Participating in the development of policies and procedures to ensure access to quality services.

B. Policies, procedures, and practices that assure members of the Cultural Competency Committee will be reflective of the community, including County management level and line staff, clients and family members for ethnic, racial and cultural groups, providers, community partners, contractors, and other members as necessary;

The Cultural Competency/Reducing Disparities (CCRD) Committee serves as an advisory group for the implementation of the Riverside County Department of Mental Health Cultural Competency Plan Requirements. It provides overall direction, focus and organization in the planning and implementation of the MHP. All the recommendations developed by the Committee are forwarded to the RCMHD Management team for their review, approval and implementation.

The Cultural Competency/Reducing Disparities Committee is comprised of members of the Department, contract agency representatives, consumers, family members, and community based organizations representatives. To ensure broad-based representation and to be inclusive, representatives from each region will be appointed to serve on this Department wide Committee.

Attachment #24 shows the Cultural Competency Flow Chart which illustrates the ongoing communication process that takes place in order to implement the Cultural Competency Plan Requirements.

C. Organizational Chart;

Attachment #25 Illustrates the position the Cultural Competency Program Manager has in the organization. The Cultural Competency Program Manager, also known as the Ethnic Service Manager (ESM) is part of the Management team at the administration level.

D. Committee membership roster listing member affiliation, if any.

The Cultural Competency/Reducing Disparities Committee shall be composed of up to 36 members (Attachment #26).

- Members should possess expertise and leadership in the community.
- Demonstrate strong communication links with diverse communities and stakeholders.
- Possess ability to work effectively with others with different backgrounds and perspectives.
- Demonstrate a commitment to the successful development and implementation of the Committee's goals and objectives

II. The Cultural Competency Committee is integrated within the County Mental Health System.

A. Evidence of policies, procedures and practices that demonstrate the Cultural Competency Committee's activities, including the following:

The Department of Mental Health established Cultural Competency standards and policy requirements for the Department in Policy #162 (Attachment #2).

The Cultural Competency Program Manager is in charge of working with the Cultural Competency/Reducing Disparities Committee (CCRD). Attachment #23 describes the Committee's responsibilities and the procedures for integration of the committee within the County Mental Health System.

B. Provide evidence that the Cultural Competency Committee participates in the above review process.

Participation of the Cultural Competency/Reducing Disparities Committee is documented in the committee meetings minutes, attachment # 31.

The Cultural Competency/Reducing Disparities Committee has on going Cultural Competency Sub-committees. The following picture illustrates how the Committee operates:

Cultural Competence/ Reducing Disparities
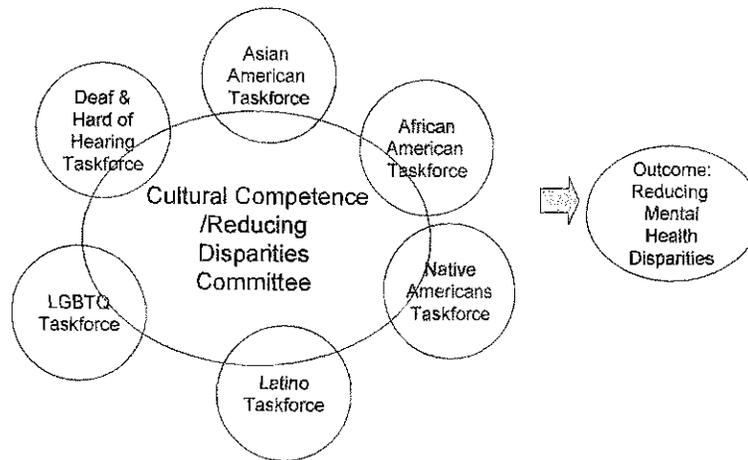
C. Annual report of the Cultural Competency Committee's activities including:

1. Detailed Discussion of the Goals and Objectives of the Committee:
   a. Were the goals and objectives met?
      - If yes, explain why the County considers them successful.
      - If no, what are the next steps?

Attachment #27 is an update of the goals and objectives outline in the 2005's Cultural Competency Plan.

Although, all the goals and objectives were met, the Cultural Competency Committee decided to continue developing monitoring systems and/or policies that ensure the procedures are implemented on an ongoing basis, for example, the development of the Translation Policy (Attachment #6) was based on the need to provide translated materials to the LEP consumers and family members.

In September, 2007 the Cultural Competency Committee completed an In-house CCC Assessment Survey to develop a plan of action to strength the Committee members' knowledge, sensitive and skills in working with diverse communities (Attachment #28). As a result of the survey the Committee agreed to do in-service trainings, each meeting on key cultural competence issues (Attachment #29).

2. Reviews and Recommendations to County Programs and Services:

The Cultural Competency Committee is actively involved in providing recommendations regarding county programs and services. The Committee has provided written recommendations for the MHSA planning process. The recommendations of the Committee are an integral part of the planning process. Before any major decision is made, the Committee has the opportunity to provide input and recommendations. In Attachment #30, you will find documentation on recommendations from the Committee.

3. Goals of Cultural Competency Plans:

The Department's Cultural Competency Program goals are to develop, recommend and maintain a formal practice, through a participatory process in partnership and collaboration with the community; for the purpose of implementing and optimizing the State mandated Cultural Competency Plan that ensures fairness and equality across systems in order to reduce mental health disparities in Riverside County.

The Cultural Competency Plans' Goals Currently Include:

- Provide barrier-free access to all residents of the diverse communities in Riverside County.

- Increase the capacity of the Department to provide culturally and linguistically appropriate services by developing recruitment and retention strategies to target consumers, family members and staff representative of the County's diversity.
- Provide cultural competency training for all mental health staff (including management, supervisors, clinical and support staff), consumers, family members and community at large.
- Develop and maintain collaboration and partnerships with community organizations and other agencies to facilitate and improve access to services available in the community.
- Build Community Capacity.

Page #4 lists the goals, objectives, activities, and outcomes that the Department is going to be undertaking during years 2010-2011.

4. Human Resources Report:

Riverside County Department of Mental Health (RCDMH) developed a comprehensive needs assessment process designed to complement the 2005 findings from the initial community planning for Community Services and Supports (CSS) funds. Key research reports pertaining to the demographics and linguistic skills of the current workforce and the Unmet Needs of the community were reviewed to establish a foundation for targeted workforce development. The established Mental Health Board; Children's, Adult and Older Adult System of Care Committees; our Cultural Competency Committee; and the MHSA Stakeholder Leadership Committee reviewed the Workforce Education and Training planning and implementation (Attachment # 7).

5. County Organizational Assessment:

See Criterion 1, Section II Item B, for a description of the organizational assessment project currently taking place in the Department.

6. Training Plans:

All proposed education, training and workforce development programs and activities contribute to developing and maintaining a culturally competent workforce that includes consumers and family members capable of providing consumer and family driven services that promote wellness, recovery, and resiliency.

The following is a description of the activities listed in the WET Plan -

Workforce Education and Training Coordination

Workforce Education and Training (WET) Coordination requires a team responsible for the central management and implementation of this WET Plan and for the primary oversight of all Actions in this Plan. A full-time Workforce Education and Training Coordinator leads the coordination, interface with the community, advises stakeholders, and writes the annual State progress evaluations. A Full-time office assistant and a Full-time staff analyst will assist in organizing, plan implementation, managing fiscal/budgetary oversight, and integrating important community research.

WET Coordination staff is responsible for ensuring that MHSA's essential elements and the values underpinning MHSA to guide the implementation of this Plan's actions. To guarantee the quality of programs, the WET Coordination team also includes a full-time Staff Development Officer who specializes in the observance and application of professional licensing regulations, oversees quality improvement of training programs, and recruits consultants and develops experts on recovery, cultural competence, and clinical practice.

To optimize resources and to create regional networks for mental health education and career pathways, the State Department of Mental Health has coordinated regional partnerships among California's counties. RCDMH is a member of the Southern Regional Partnership. WET Coordination staff also serve as liaison to the Southern Regional Partnership.

Riverside's WET plan (Attachment #7) includes many new programs. Some of these programs are designed to support Workforce Development (Actions 4, 5, 6, 7, 8, 9, 10, 12) and some programs are designed to support and promote mental health education (Actions 11, 13, 14). To facilitate these actions, additional WET staff will be needed for the Staff Support units as described in Actions 2 and 3. The WET Coordination Staff will serve as the primary back-up for these Workforce and Education Staff Support units.

    7. Other County Activities, as Necessary:

All the activities and efforts of the Cultural Competency Committee are documented on the monthly meetings minutes. Minutes are distributed to all the program managers and supervisors for discussion at their staff meeting (Attachment # 31).

I.   The County System shall require all Staff and Stakeholders to Receive Annual Cultural Competency Training.

   A. The County shall develop a three year training plan for required cultural competency training that includes the following:

      1. The projected number of staff who need the required cultural competency training. This number shall be unduplicated.
      2. Steps the County will take to provide required cultural competence training to 100% of their staff over a three year period.
      3. How cultural competency has been embedded into all trainings.

Riverside County's Workforce Education and Training (WET) component of the Three-Year Program and Expenditure Plan addresses Cultural Competency training plan. Action # 6 of the WET plan title: Cultural competency and Diversity Education Development Program was approved as part of the WET plan and provides funding for the implementation of Cultural competency Training.

Riverside County is one of the fastest growing counties in the nation. In the year 2000, our total populations was 1,553, 902. By 2006, the population had increased to 2,026,803. With the exception of Caucasian/European origin, all ethnic groups showed an increase during those eight years. The greatest increase took place among Latinos, who went from 36% of the population in 2000 to 42% in 2006. After English, Spanish is the language most preferred by our Department consumers.

Our stakeholders reminded us of the need to understand cultural competency in broader and more nuanced terms. They pointed out the need to recognize diversity within ethnic groups, as well as the need to incorporate LGBT, deaf and hard of hearing, and faith communities under the cultural umbrella. Unfortunately, there still exists a lack of understanding and lack of representation of these groups among our helping professionals. To address this, the WET team will work jointly with RCDMH's Cultural Competency Manager and Cultural Competency Committee in developing a structured and inclusive training program to enhance and expand our workforce's cultural knowledge. All RCDMH staff, including administrative and support staff, will undergo cultural competency training.

RCDMH has already initiated the implementation of the California Brief Multicultural Competence Scale training program to provide on-going cultural competency support for our workforce.

Additionally, our stakeholders identified the need to outreach members of cultural communities in their own language and from their unique perspectives. Capitalizing on the linguistic skills of our bilingual staff, who often serve as the primary interpreters for our linguistically diverse consumers and their families, RCDMH is implementing Interpreter's Training in order to enhance staff's interpretation and translation skills. We will also develop a central, accessible list of bi-lingual and multi-lingual staff in order to create easier access for non-English speaking consumers. Furthermore, Riverside will fund the training of bilingual/Spanish volunteers (preferably consumers or family members) as *Promotores De Salud Mental.* These volunteers will serve as community liaisons and mental health educators. Depending on the success of this program, similar models will be developed to outreach other cultural groups. RCDMH has already offered "Survival Spanish" to staff and will explore its effectiveness. It is also exploring the need to expand this coursework to other languages including American Sign Language.

Upon the implementation of an electronic learning management system through the Information Technologies component of the MHSA, we will explore converting some training topics of this program into electronic courses.

WET funding allocation for cultural Competency and Diversity Education Development Program is estimated based upon prevailing speakers and training cost for the following topics:
- Training for Promotores de Salud Mental
- Californian Brief Multi-Cultural training
- Bilingual Interpreters Training
- Latino Culture Training
- Asian- Pacific Islander Culture Training
- Native American Culture Training
- African American Culture Training
- Lesbian, Gay, Bisexual, Transgender Culture Training
- Deaf and Hard of Hearing and Physically Disable Culture Training

The projected numbers of staff who need the required cultural competency training during the next three years is approximately 811.

A four day California Brief Multicultural Competency Scale (CBMCS) training will be offered two times a year in order to have 100% of our staff trained. Training is mandatory for all staff and consists of a 32-hour curriculum (4 day class). The Department is currently implementing a least two classes per year to train approximately 80 staff. During year 08-09 the department trained a total of 120 staff.

In addition, all of our trainings, regardless of topic have culturally competent information as required for all of our instructors who in turn have embedded it into their course curriculum.

II. Annual Cultural Competency Trainings

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees and Total	Date of Training	Name of Presenter(s)
CBMCS	Overview of multicultural knowledge, awareness of cultural barriers, sensitivity and responsiveness to consumers, and socio-cultural diversities.	Four day training (total of 28 hours of instruction time). Offered two times a year.	*Direct services county *Support services	19 1 Total: 20	March 2, 3, 10 and 18, 2010	Myriam Aragon, Renda Dionne, Rudy Lopez, Benita Ramsey
Evolution of the Consumer Movement	To gain insights to help consumers while understanding the origins of the movement.	Three hours, offered it twice.	*Direct service county *Direct service contractor *Community member *Consumers	61 7 2 15 Total: 85	February 25, 2010	Jay Mahler
Psychopharmacology	To learn about the current treatment of consumers with psychotropic medications.	Three hours, offered two times a year.	*Direct services county *Direct services contractor *Community member	32 9 2 Total: 43	February 9, 2010	Jerry Dennis
Illness Management and Recovery	Emphasizes hope, personal responsibility, education and self advocacy and is designed to empower consumers to manage their illness, find their own goals for recovery.	Two day training (total of 11 hours) annually.	*Direct services county *Community member	37 1 Total: 38	May 13 and 14, 2009	Harry Cunningham
Seeking Safety	A present focused therapy to help people attain safety from trauma/PTSD and substance abuse.	Two day training (total of 11 hours) annually.	*Direct services county *Direct services contractor *Community member	80 4 11 Total: 95	April 23 & 24, 2009	Lisa Najavits
Bridges out of Poverty	To identify the challenges of living in poverty and the underlying factors that perpetuates it.	5.5 hour training, annually.	*Direct services county *Direct services contractor *Community member *Support services	30 1 2 6 Total: 39	April 7, 2009	Jodi Pfarr

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III. **Relevance and Effectiveness of All Cultural Competency Trainings**

A. **Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:**

1. **Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities;**

According to the report on the California Brief Multicultural Training pilot project, the CBMCS Multicultural Training Program was quite effective in improving the cultural competency of RCDMH staff. That is, results suggest that the training program had a positive impact by increasing the overall level of participant's self-perceived cultural competency. For RCDMH, the results are promising and are congruent with the results of other counties who have implemented this training program. Specifically, across four other California counties, results indicate that the CBMCS pre-post self-report multicultural competence score improved significantly on three modules (i.e., Multicultural Knowledge, Awareness of Cultural Barriers and Socio-cultural Diversities) and found no change on Module III (Sensitivity and Responsiveness to Consumers). The CBMCS 21-item scale has been used in the past to identify those who need training. Pilot test results from other studies suggest that those who are in most need be "targeted" for training (i.e., those who score relatively low on a given CBMCS subscale measure (Attachment # 32).

1. **Results of pre/post tests (Counties are encouraged to have pre/post testing for all trainings).**

The Department doesn't provide pre/post tests for all the trainings. The training unit provides post tests for substance abuse counselors who receive CE per their board requirement. The California Brief Multicultural Training program (CBMCS) is the only training with pre/post tests.

2. **Summary report of evaluations.**

The Department Training Unit offered 69 trainings in 2008-2009. All 69 evaluation summaries are located in the U drive - MHSA WET - Training & Tech Assistance - Staff Development - Forms – Evaluation Summary (Attachment # 33 is an example of an evaluation summary).

3. **Provide a narrative of current efforts that the County is taking to monitor advancing staff skills/post skills learned in trainings.**

See response for Item 4.

4. **County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.**

The Department does not have an established methodology or protocol for following up and ensuring that staff is utilizing their learned skills. The Department is currently looking at developing a modified Chart Audit Checklist that will include culturally competent and recovery language indicators considered in assessment, planning & services, as well as recovery language. This is a simple effort the Department is trying to exercise.

The current goal is to obtain a baseline related to identification, planning and service outcomes, current evidence of family inclusion in services, and current levels of cultural consideration in assessment, planning and services.

If the Department can establish a baseline, figure out how to increase staff's awareness, and change practice across domains, then should begin to see evidence of progress in charts via chart audits, which contains evidence of more consistently documenting family and cultural elements during assessment, planning, and services.

After the Department gets a sense of baseline, will work to change practice via increased awareness, targeted skill building, coaching, etc. As well as, do some more work around measuring change in which planned intervention and services reflect active inclusion and effective service provision supported by better treatment outcomes.

One of the items the Department needs technical assistance in, is developing protocols to ensure that the trainings are effective and that the skills learned are utilized as a tool for clinical supervision and coaching.

B. **The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's, personal experiences with the following:**

    1. Family focused treatment;
    2. Navigating multiple agency services; and
    3. Resiliency

Recovery Management Training Program

The Recovery Management Training also known as Illness Management Recovery (IMR) is one of the six SAMHSA evidence based programs. It consists of weekly sessions where practitioners help consumers develop personal strategies for coping with mental illness and moving forward in their lives. It generally lasts between eight to twelve months in an individual or group format (Attachment # 34).

Parent Partners Program

Parent Partners are hired to work in clinics with families and professional staff to assist in the planning and provision of treatment for children and families. This includes, but is not limited to: Orientation for families newly entering the mental health system; parent education; support groups; monitoring; advocacy and parent-to-parent support.

In Attachment #35 you will find a report of The Parent Support and Training Program for 2008-2009. Parent Partners are involved with "Parents and Teachers as Allies" that is a training that will soon be facilitated at local schools countywide. They also have I.E.P. trainings for parents; both the EES Classes and Open Doors Support Groups are in English and Spanish. Parent Support & Training Program also does presentations at Community agencies, Clinics, and Mental Health Board Meetings.

Family Advocate Program

The primary function of the Family Advocate Program is to assist family members in coping with the illness of their adult family member through the provision of information, education, and support. In addition, the Family Advocate Program provides information and assistance to family members in their interaction with service providers and the mental health system in an effort to improve and facilitate relationships between family members, service providers, and the mental health system in general. The Family Advocate Program also provides weekly support groups in both English and Spanish.

The family Advocate Program staff are themselves family members so families may feel confident that they will be dealing with individuals who are sensitive to their concerns.

NAMI Family- To Family Education Program

Since 1997, the Department has coordinated the NAMI Family-to- Family Education Program in Riverside County. The NAMI Family-to Family Education Program is a 12-week course for family members and significant others who are in need of education, information and support. Courses are offered at various locations throughout Riverside County on an ongoing basis. These classes are also offered in Spanish. To date, over 1000 family members in Riverside County have completed the course.

Children's Clinic Orientation

Parents are given information about clinic services, resources, and expectations. These are presented by parent partners who mostly provide families with needed information on services, role, and rights. This was developed by parents and meant to empower the families of consumers.

Educate, Equip, and Support

This training program is presented by trained parent partners to provide parents information and skills on family focused treatment, navigating multiple agencies services, and treatment resiliency.

Wraparound Orientation

This training/orientation informs potential families about their role in this family focused program. It empowers them to direct the services and support that they will receive.

The tracking of trainings that are provided to staff, families and consumers, regarding Consumers' Culture has not been well done. The Department's Training Unit only has information on the trainings that were coordinated by them, and usually trainings that provide Continuing Education Units. Each of the programs and clinics do provide trainings to staff, consumers, and family members, but those trainings are not reported to the training unit.

IV. Counties Must Have a Process for The Incorporation of Client Culture Training Throughout the Mental Health System.

The Department hired a Director of Consumer Affair to facilitate and implement consumer's culture training and to promote consumer's involvement and participation in the training of consumer's culture.

The Department has ongoing training on Consumer Culture provided by consumers, family members, Parent Partners, and Family Advocates:

Peer Support Training Program

Keeping Recovery Alive presentations are done at the clinic's regular staff meetings, and other special staff meetings. It is done by consumers hired by the Department to provide their expertise in implementing recovery programs.

Jay Mahler training; "The Evolution of the Consumer Movement" training has been conducted at the department.

Jefferson Transitional Program, "In Our Own Voice" presentations throughout the year in clinics and in the community.

Culture of Poverty Training

Bridges Out of Poverty: The Department provides this training at least once a year. Bridges Out of Poverty training was developed to identify the challenges of living in poverty and the underlying factors that perpetuate it, and assists professionals to create a better relationship with the customer, and gain insight to be more effective in the delivery of human services. It develops an accurate mental model of generational poverty and explores the impact of poverty on those served by the organization, reviews research on the causes of poverty, explores the hidden rules of economic class, examines the impact of poverty on family structures and explores registers of language, discourse patterns, and cognitive issues. This training helps to identify ways in which the information can be used to improve relationships and outcomes: individual, organizational, and community.

CRITERION 6

COUNTY MENTAL HEALTH SYSTEM

COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE:
HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT
STAFF

I. Recruitment, hiring, and retention of a multicultural Workforce from, or Experienced with, the identified unserved and underserved populations

A. Workforce Assessment for the Workforce Education and Training (WET) component.

Riverside County Department of Mental Health (RCDMH) developed a comprehensive needs assessment process designed to complement the 2005 findings from our initial community planning for Community Services and Supports (CSS) funds. Key research reports pertaining to the demographics and linguistic skills of our current workforce and the Unmet Needs of our community were reviewed to establish a foundation for targeted workforce development.

The Grand Total Workforce is located on Page 9 of attachment # 7. It is noted that some Network and Contract Provider staff declined to provide ethnicity for the survey. These provider staff ethnicities were recorded in an additional 7th race/ethnicity category called "Unknown". Column 4, "# FTE estimated to meet need in addition to # FTE authorized," was obtained by looking at the prevalence of acute mental illness of persons who are at 200% of poverty line and below. The WET plan applied current caseload standards to these estimated numbers in determining the estimated number of additional staff needed. Contractors were asked how many additional staff they anticipate needing; their responses are recorded on Workforce Needs Assessment (Attachment #7).

B. Compare the WET Plan Assessment Data with the General Population, Medical population, and 200% of poverty data.

In Attachment # 7 Page 9, Column 4, "# FTE estimated to meet need in addition to # FTE authorized," was obtained by looking at the prevalence of acute mental illness of persons who are at 200% of poverty line and below. The WET plan applied current caseload standards to these estimated in determining the estimated number of additional staff needed.

C. Response to the cultural consultant technical assistance recommendations as reported to the county during the review of their WET Plan submission to the State.

The following is the list of items or concerns, and the responses and recommended actions taken during the review of the WET plan:

<u>Where are the results of RCDMH's participation at the Asian-American Health Conference in June and what were the resulting impacts on the WET plan?</u>

The results of our participation were submitted at the time of our original request for feedback and included the formal report on data received from questionnaires completed at the Conference.

Regarding Workforce Development and WET planning, participants cited that having bilingual, Asian staff in our clinics would increase their comfort in seeking services. This did not change the overall WET goals, as had already included increasing the diversity of the service staff as an objective.

<u>Technical Assistance need</u>: Outreaching our diverse communities to encourage the development of careers in public mental health and, additionally, creating an influential relationship with higher education in order to increase marketing/recruitment to a diverse student body in behavioral sciences.

<u>What strategies will be used to promote recovery, resiliency, community collaboration, meaningful inclusion of consumers and family members? And will cultural competency be promoted?</u>

- Training offered specific to recovery, resiliency: Evolution of the Consumer Movement (for both staff and consumers); Recovery Practice for Supervisors; Advanced Recovery Practice for Paraprofessional Staff (in development/pending); Recovery Management.

- Training specific to cultural competency: California Brief Multicultural Competency Scale Training; Bilingual Interpreters Training; Deaf and Hard of Hearing Sensitivity; Cultural Competency: A Practical Application (Graduate school intern training); Working with LGBTQ youth and their families (Graduate school intern training).

- Department sponsored or collaborative training that includes consumer and family member presentations: Mental Health/Law Enforcement training for law enforcement officers; Foundation for Assessment (Graduate school intern training); California Brief Multicultural Competency Scale; Evolution of the Consumer Movement (for both staff and consumers); Recovery Practice for Supervisors; Advanced Recovery Practice for Paraprofessional Staff (in development/pending).

- Consumer Integration: The WET plan includes a consumer workforce development action which provided for pre-employment training and on-going monthly meetings of peer employees. Peers are also trained in WRAP facilitation. Since plan approval, WET has promoted 3 Peer Support Specialist into Senior Peer Support positions which provide regional and administrative support to our peer employees. These Senior

Peers are also key developers of our Peer Intern and Volunteer programs designed to increase peer participation in service delivery as well as offer a trial work period.

- All instructional vendors, regardless of subject matter, are provided with the 5 Essential Elements of the MHSA and their descriptions. They are asked to integrate these concepts into their training presentation. Participants are asked to complete an overall evaluation at each training; this evaluation tool includes a question on the success of cultural competency inclusion into the training presentation. All presenters receive a summary of their evaluations.

- Keeping Recovery Skills Alive. Monthly refresher training on aspects of recovery work.

<u>There is no mention of the RCDMH having invited, discussed with, or engaged any of the 12 federally recognized tribes and Native American reservations located within Riverside County.</u>

Under Exhibit 2, Stakeholder Participation Summary, it is indicated that each cultural community had their own focus group – including Native Americans. RCDMH has a Native American cultural consultant and community liaison, Dr. Renda Dionne, who is also Native American. Dr. Dionne identified key Native American community stakeholders to participate in the group. Tribe affiliation was not requested nor identified. Dr. Dionne has provided further recommendation and reports on Native American needs and mental health through our Cultural Competency Office.

Specific to workforce development, participants indicated that Native Americans would like to see more Native American practitioners in the county clinics or to have services provided by Native American organizations. Participants also suggested that for non-Native American staff to better understand Native American engagement that staff really needed to be immersed into Native American helping agencies to witness this first hand. As a result, the Department's developing interns program includes the plan to create one-day cultural immersions for the student interns to begin influencing the next generation of practitioners.

<u>Technical Assistance need</u>: Outreaching to our diverse communities to encourage the development of careers in public mental health and, additionally, creating an influential relationship with higher education in order to increase marketing/recruitment to a diverse student body in behavioral sciences.

1. Our biggest barrier has been any staff development in a time of staff downsizing. This results in two primary avenues of staff development around cultural competency:

- Improving the cultural competency of our existing staff (see Training information above).

- Encouraging and supporting our educational partners and peer employment programs to market, recruit and diversify their students/participation.

Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.

The issue of fidelity and the effectiveness of training has been an identified concern since the inception of the WET unit. Though the Department has no consistent measures or strategies to address this systematically, there are some tools and procedures that are in place.

a.) Many of our evidence-based practices have fidelity measures built into the models: Recovery Management; Multi-dimensional Family Therapy; Parent-Child Interaction Therapy; Aggression Replacement Therapy; Depression Treatment Quality Improvement; Non-violent Crisis Intervention. The Department has monitored fidelity in several of the programs both through internal reviews and reviews by the original developers (through the CIMH Development Teams).

b.) Other RCDMH training that have defined follow up measures: i.) Co-Occurring Disorder (COD) Group Manual Training – In order to facilitate the Department's COD manualized group therapy program, treatment staff must participate in a series of training that orient them to related skill application as well as the application of the manual itself. RCDMH's COD Curriculum Committee has developed fidelity review measures that require an annual observation by a committee member who completes corresponding evaluation tools.

A summary of the results with recommendations for practice are provided to the COD Group facilitators. The committee member also serves as a consultant to the application of the COD manual. ii.) Dialectical Behavioral Therapy (DBT) – Our DBT training consists of both a foundation for practice and advanced training components. The instructor for this series has availed himself to mentor staff in application along with offering to return to provide application strategy training for those practitioners who have been utilizing DBT.

c.) RCDMH training that promotes clinic follow-up:

As a part of the Department's staff development, special training needs have been targeted for paraprofessional staff, the majority of whom are identified in our Behavioral Health Specialist job classification. National research indicates that even though paraprofessionals comprise the largest number of mental health service delivery staff, they often receive the least amount of training. The

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Department is developing a series of trainings designed specifically for this job classification that includes: Mental Health Risk; Law, Ethics and Boundaries; Recovery Practices; Orientation to the DSM; Foundations in Counseling and Communication.

The Department recently completed the first training in that series: Mental Health Risk. Participants are provided with vignettes/scenarios that involve a potential risk element. They are encouraged to provide these materials to their supervisors for follow-up practice in their regularly scheduled clinic staff meetings.

As a part of this series, the Department would like to develop follow-up materials with instructions that would be provided to every participant's supervisor so that continued practice of the material can take place at regular staff meetings.

County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

a) After each department training, staff is provided with an evaluation of the training that includes a question if staff would like more training in the topic area as well as a request for any follow-up wanted. These results do influence our training choices and the frequency of trainings on that topic. Having follow-up or advanced training on a topic assists with staff receiving the most current knowledge as well as keeping the training material more available to them.

b.) At the close of training, staff is informed they can submit any application or follow-up questions to our Staff Development Officer who will forward questions to the training instructor. Though this is offered, it is rarely utilized.

c.) WET unit representatives are made available to program supervisory meetings to not only provide updates on WET activities, but to receive feedback on trainings provided as well as staff challenges or successes in applying the material learned. This also allows us to provide practical feedback to the instructor on areas that need to be clarified or enhanced during the training so it can be modified to meet the learning needs of staff.

d.) RCDMH Peer Support Specialists are allocated time during regularly scheduled clinic or program staff meetings to present on "Keeping Recovery Skills Alive." During this interactive presentation, a recovery topic is discussed and its application is reviewed in clinical practice.

Technical Assistance need: Developing and implementing fidelity and/or training follow-up protocols that reinforce staff skill development and are realistic yet effective in this time of fiscal challenges and limited staff resources.

   D. Summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

1. At the time of the WET planning, the total professional clinical staff (Clinical Therapist I and II) was 17% Latino. Examining just the licensed-waivered staff (CT I), it was learned that 27% of our licensed-waivered staff was Latino. **Target:** Support pre-licensed staff to become licensed in order to increase the diversity of our CT II staff. The WET plan has contacted The Employee Development Agency (EDA) to ascertain the availability of workforce stimulus funds to assist with the costs of license examination study materials and instructors. The initial conversations have led to a $50,000 dollar allocation. The Department is in the process of developing the survey tools necessary to gather the staff information requested by EDA to establish which funding source they will utilize.

2. Our stakeholders identified the need to outreach members of cultural communities in their own language and from their unique perspectives. Capitalizing on the linguistic skills of our bilingual staff, who often serve as the primary interpreters for our linguistically diverse consumers and their families, RCDMH will develop an Interpreter's Training in order to enhance staff's interpretation and translation skills. **Target:** Improve the cultural competency of public mental health service providers by providing them with bi-lingual interpreters training. Training has been scheduled for 07/14/10 and 10/21/10.

3. Under the WET plan, RCDMH will develop a comprehensive mental health leadership program that includes training on supervising a culturally diverse workforce. **Target:** Improve retention of a diverse line staff by enhancing the supervisory skill. A meeting has been scheduled on Tuesday, June 29th, with Nancy Taylor of our central human resource's Center for Government Excellence to discuss and plan for leadership development.

4. Under the WET plan, the Department further developed a Public Mental Health Graduate School Internship Program which included culturally competent objectives. **Target:** Increase the diversity of students graduating with professional behavioral science degrees.

   The Department has been challenged by Human Resources policies that prevent us from requiring students to report their cultural identities. Without this data, we are unable to successfully measure this outcome. This challenge has been reviewed concluding that starting with this academic year (Fall 2010); the Department will provide students with a demographic survey at the start of their field placement during one of our centralized trainings. To encourage the voluntary report of this information, an orientation will be provided to the purpose and benefit of this data collection.

5) Under the WET plan, the Department anticipates offering some financial incentives for workforce development. These incentives included increasing the number of therapists who could serve our underserved consumers. **Target:** Increase the diversity of the public mental health workforce.

Due to budget constrictions that have led to workforce downsizing, a central challenge has been how to develop a diverse staff at a time when the Department is not adding new employees to our workforce. We have participated in some financial programs as described:

A) 20/20 Participants:

2009 Graduates:
Elena Inzunza: Hispanic/Bilingual (Spanish) (now hired as a CT I)
Miranda Rivas: Hispanic/Bilingual (Spanish) (now hired as a CTI)

2010 Graduates:
Luis Carlos Lamadrid: Hispanic/Bilingual (Spanish) (job offer pending)
Willaim Gonzalez: Hispanic/Bilingual (Spanish)

Currently, this program is suspended. No new applicants were accepted following the year that Luis and William were awarded.

B) Mental Health Loan Assumption Program -- March 2009 Application Cycle:

This is a State-administered WET program that is managed by the Health Professions Education Foundation. Professional employees of the Public Mental Health Service System can be awarded funds to repay educational loans in exchange for continued service. As the Department Designee and member of the Application Review Board, my duties include: 1) Verifying an applicant's employment in a hard to fill position; 2) If the employee speaks a language other than English, verifying if that language is needed to meet the services needs of Riverside consumers; 3) Reading and scoring applications from other counties.

The WET plan does not have the application information for awardees from the Department. According to H.R. information on current staff, the Department has thirteen employees receiving Loan Assumption Program in 2009.

<u>C) MHSA Stipend Programs – 2009-2010 School Year</u>

Stipend programs are also administered by the State. Graduate students who receive a stipend agree to payback the stipend by working in the Public Mental Health Service System for 1 year following graduation. Universities are designated as administrative agents. The Department's primary role is to provide field placement during their stipend year. The Department is taking a more active role with LLU MFT stipend students as LLU indicated in its RFP that it would involve counties. The Department has helped develop protocols, forms, and participated in student selection. Preference in scoring was given to consumer/family lived experience, bicultural identity, bilingual abilities.

Attachment #36 provides a list of students and their cultural and linguistic backgrounds.

E. Share Lessons Learned on Efforts in Rolling Out County WET Planning and Implementation Efforts.

1. Supporting any mental health workforce development in a time of budget crisis that has resulted in downsizing staff instead of staff development.

2. Measuring Quantitative Data: a) Ethnic identity can only be requested voluntarily creating an obstacle to measuring accurate numbers; b) The Department has no data collection standards for requesting information on sexuality, gender identity, physical or psychiatric disability.

3. Addressing staff discomfort when voluntarily asking for such data. Concerns from Caucasian staff that ethnicity is being used as a primary recruitment measure that excludes them. General culture of fear regarding identifying as a member of an oppressed group when that identity is not readily apparent in a social setting (transgender, sexuality, disability) resulting in either a refusal to report or suspicion at the question.

4. Partnering with Universities regarding the recruitment and marketing of behavioral science degrees to a diverse student population.

5. Developing field instructors who have mastered knowledge on supervising a diverse student population that not only includes understanding the student's worldview but how to best teach a student to integrate that worldview as an asset in their clinical development.

6. Developing and providing support for the recruitment and retention of volunteers from diverse communities is challenging. In the last year the Peer Support Training Program was done in Spanish for Spanish speaking consumers and family members interested in becoming Peer Specialist and/or Volunteer Peer Specialists.

F. Identify County Technical Assistance Needs.

The Department will benefit from technical assistance to address and plan strategies related to problems identified in Section E.

In addition to those issues identified in Section E, the Workforce Education program needs technical assistance to establish an ongoing process to monitor outcomes of the strategies identified to grow a multicultural workforce, and to develop indicators of success.

I. Increase Bilingual Workforce Capacity

A. Evidence of Dedicated Resources and Strategies Counties are Undertaking to Grow Bilingual Staff Capacity, Including the Following:

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

Our threshold language is Spanish. According to a 3-year average of the American Community Survey United States Census statistics on languages spoken in Riverside County, 15% of Riverside County's total population reported they speak Spanish and either do not speak English or do not speak English very well. RCDMH has made concerted efforts to increase the capacity of our bilingual staff. The percentage of our direct and support staff with Bilingual/Spanish proficiency is: 31% Support staff; 38% Paraprofessional staff; 30% Clinical Therapist I (licensed-waivered) staff; and, 9% Clinical Therapist II (licensed) staff. The Department needs to continue to support our licensed-waivered staff to become licensed and to nurture our paraprofessional and support staff into pathways that lead to licensure (Attachment # 7, Page 9).

Riverside County is one of the fastest growing counties in the nation. In the year 2000, our total population was 1,553,902. By 2006, the population had increased to 2,026,803. With the exception of Caucasian/European origin, all ethnic groups showed an increase during those eight years. The greatest increase took place among Latinos, who went from 36% of the population in 2000 to 42% in 2006. After English, Spanish is the language most preferred by our Department's consumers.

Our stakeholders reminded us of the need to understand cultural competency in broader and more nuanced terms. They pointed out the need to recognize diversity within ethnic groups, as well as the need to incorporate LGBT, deaf and hard of hearing, and faith communities under the cultural umbrella. Unfortunately, there still exists a lack of understanding and lack of representation of these groups among our helping professionals. To address this, the WET team will work jointly with RCDMH's Cultural Competency Manager and Cultural Competency Committee in developing a structured and inclusive training program to enhance and expand our workforce's cultural knowledge. All RCDMH staff, including administrative and support staff, will undergo cultural competency training. RCDMH has already initiated the development of the

California Brief Multicultural Competency Scale training program to provide on-going cultural competency support for our workforce.

Additionally, our stakeholders identified the need to outreach members of cultural communities in their own language and from their unique perspectives. Capitalizing on the linguistic skills of our bilingual staff, who often serve as the primary interpreters for our linguistically diverse consumers and their families, RCDMH is providing Interpreter's Training in order to enhance staff's interpretation and translation skills. The Department will also develop a central, accessible list of bi-lingual and multi-lingual staff in order to create easier access for non-English speaking consumers. Furthermore, Riverside will fund the training of bilingual/Spanish volunteers (preferably consumers or family members) as *Promotores De Salud Mental.* These volunteers will serve as community liaisons and mental health educators. Depending on the success of this program, similar models will be developed to outreach other cultural groups. RCDMH has already offered "Survival Spanish" to staff and will explore its effectiveness. It is also exploring the need to expand this coursework to other languages including American Sign Language.

2. Updates from Mental health Services Act (MHSA), Community Services and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

The Department has bilingual pay for designated positions. To establish positions as eligible for one of the bilingual levels, the Department must designate a position as eligible for bilingual pay at either level 1, 2, or 3*. The Department must verify that the position requires the use of a second language at least five times per week or once per day. Testing is required for all levels and designation occurs only once approved by the Department of Human Resources.

The authorization for bilingual compensation is tied to the individual's position. Therefore, any changes in employee position, including transfer to other programs, will result in the loss of bilingual pay and a new designation form would be required.

Level 1: Basic oral communication such that employees perform bilingual interpretation(oral) and/or provide services in a second language as part of their job function and regular duties at least five times per week or once per day.

Level 2: Basic oral and written communication: Employees at this level perform bilingual interpretation as described in level 1 as well as providing written translations. These are provided as part of their job function and regular duties at least five times per week or once per day.

Level 3: Complex written and/or oral Medical Legal Interpretation: Employees at this level perform complex verbal and written translations. Employees at this level perform complex verbal interpretation (simultaneous interpretation for a group of people) and written translations of documents and other written information by participating in the translation committee.

It is a goal of the Department of Mental Health, as part of the Cultural Competency Plan, to have a minimum of 50% bilingual staff in each job classification within each clinic, and more if clinic needs require it.

Of a total of 926 active employees, the Department currently has a total of 273 bilingual staff in Spanish, 5 American Sign Language, 2 bilingual Vietnamese, 2 bilingual in Tagalog, and 1 bilingual in Arabic. A total of 31% of the current staff is bilingual and receiving bilingual pay.

The Department also has a 24-hour phone line with statewide toll-free number that meets the linguistic needs of the population, including TDD.

In addition to the bilingual staff, the Department has a interpreting services contract with Interpreters Unlimited. The services that are provided by Interpreters Unlimited are face-to-face interpreting and telephone interpreting services for all languages other than sign language. There are two (2) contracts in place specifically for sign language interpreting.

3. Total Annual Dedicated Resources for Interpreter Services.

The Department has a projected budget allocation for the interpretation line, interpretation face-to-face, and translations of approximately $130,000 a year.

In addition the Department has budged the bilingual pay positions.

II. **Provide Services to Persons Who Have Limited English Proficiency (LEP) by Using Interpreter Services.**

A. **Polices, Procedures, and Practices in Place for Meeting Clients' Language Needs, Including the Following:**

1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

It is the Department's goal to provide services to all clients regardless of the language they speak. Policies and procedures have been developed to assist

the Department with meeting this goal. Two Policies in particular that address language accessibility is Policy 162 (Attachment #2) and Policy 123-0 (Attachment # 6).

Riverside County Department of Mental Health maintains a 24-hour toll-free telephone access that provides services in all languages.

It is the policy of the Department to inform Limited English Proficiency individuals, in a language they understand, that they have a right to free language services. An Interpretation Services Available Poster was provided by the contract vendor for the purpose of identifying individual's language, as well as informing them of the availability of interpretation services at no cost to them (Attachment #37).

At each key point of entry the Department has access to Teletype (TTY) or Telecommunication Device for the Deaf (TDD) equipment for the Deaf and Hard of Hearing individuals to have access to our services. The TDD equipment is located at regional clinics and programs determined to be key points of entries. The Department's Guide to Services provided the TDD/TTY phone numbers for each location.

Riverside County 24-hour phone line is a toll free telephone access that provides services in all languages. The Department has a contract for interpretation services with Interpreters Unlimited. The services that are provided by Interpreters Unlimited are face-to-face interpreting and telephone interpreting services for all languages other than sign language.

There are two contracts in place specifically for sign language interpreting. These are the vendors that do only sign language:

Dayle McIntosh Interpreting and Life Signs (Attachment #38)

2. Training for staff that may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability. Currently all the Department staff gets in-service training during their staff meeting regarding the availability of the 24-hour phone line and the availability of interpretation services.

B. Evidence that Clients are informed in writing in Their Primary Language, of their Rights to Language Assistance Services. Including Post of this Right.

It is the policy of the Department to inform Limited English Proficiency individuals, in a language they understand, that they have a right to free language services. An Interpretation Services Available Poster was provided by the contract vendor for the purpose of identifying individual's language, as well as informing them of the availability of interpretation services (Attachment #37).

The right to free language services for all consumers is not only mentioned verbally to all consumers and family members during the first contact, but it is also noted in written documents such as the Guide to Services, posters at the clinic's sites and in program pamphlets and brochures.

C. **Evidence that the county/agency accommodate persons who have LEP by using bilingual staff or interpreter services.**

1. Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.

It is the Department's policy that bilingual staff members and contract providers are available during regular operating hours to provide interpretation or direct services in the consumer's preferred language.

The following is the list of some of the lessons learned as the Department ensures the availability of linguistic services:

- Difficulties of monitoring accuracy of the interpretation when the providers insist on interpreting the information "literally" or "word by word". This is not possible. The context of the statement will not make sense when interpreting literally into another language.
- Lack of understanding on the cultural context of the information. The interpreters cannot identify or relate the information provided by the consumer because the information does not register for him/her.
- Bilingual staff providing interpretation services is usually with no knowledge, background and experience in the mental health field.
- Difficulties of the staff providing interpretation services to be able to tie the information received into another cultural knowledge.
- Relevance of the information. Some aspects of Mental Health Services are very different for the different cultural and linguistic groups. Because of the differences within the diverse communities the interpreter's vocabulary should include terminology variances.
- Providing services in the client preferred language is the goal of the Department, but the use of interpretation service has become the only services available at some clinics.
- Consideration of new technologies such as video language conferencing especially with Deaf and Hard of Hearing consumers and the cost tied to the upgrading of the equipment is a challenge in times of budget difficulties.
- Ongoing training and dissemination of information regarding the use of 24-hour toll free line and the use of TDD machines is very important.

- Providing Interpretation Training, cultural competency, and technical assistance to the bilingual staff that is providing interpretation services in order to increase their interpretive skills.
- Development of quality control evaluation and vocabulary assessment tools for the interpreters providing services in the mental health setting.

D. Share Historical Challenges on Efforts Made on the Items A, B, and C above. Share Lessons Learned.

The following are efforts and lessons learned:

- Providing Interpretation Services training on a quarterly basis to ensure all bilingual staff providing interpretation services attend training once a year (Attachment #39)

  Lessons learned:
    - Training needs to include more information regarding cultural knowledge of the diverse population receiving services.
    - Need to provide a list of terms and expressions related to mental health and mental illness.
    - Need to increase sensitivity of providers providing services via interpretation regarding the interpreters dilemmas related to cultural and linguistic variations.
    - Need to increase the attendance of the providers providing services via interpreters to the training.

- Spanish Survival Classes: During 2008-2009 the Department provided 3 levels of Spanish Survival Classes: Beginning, Intermediate, and Advance classes. A total of 191 staff enrolled in the class. Staff attending these classes were able to:

  > Review "Survival Spanish" vocabulary, including numbers, time and date, family members, anatomical words.

  > Work with a series of exercises to be conducted in conversational Spanish that focus on the various types of settings that they might have to participate.

  > Learn grammar, vocabulary and phrases useful in greeting the patient, talking about history of the present issues, past medical history and review of systems, medications and drug effects, family history, social and sexual history, mental health, nutrition, and physical examination.

  Lessons learned:

- Need to increase participation of consumers and family members that are volunteering their time in helping with translation and interpretation services.
- Need to have ongoing practice opportunities to improve participant's learned skills.
- Need to determine participant's level of proficiency before and after the class, and to measure improvement and levels of confidence when providing language services.
- Need to develop a plan of instruction to address the level of the learners who will constitute the classes.

Consumers and Family Members Volunteer Program. It has been an effort by the Cultural Competency Program, Family Advocates and the Office of Consumer Affairs Office to increase the number of volunteers that are representative of the language diversity of the county. The Department has a group of consumers and family members that are conducting the Translations field testing, as well as a group of consumers that are assisting with the first and the second translation of the documents.

Lessons learned:

- Providing stipends for consumers and family members increases the level of participation and consistency in attending to the meetings or activities.
- Providing access to computers facilitates their participation with translation activities.
- Providing training, support and technical assistance regarding the challenges of interpretation is essential.

E. **Identify County technical assistance needs.**

None identified at this time.

III. **Provide Bilingual Staff and/or Interpreters for the Threshold Languages at All Points of Contact.**

A. **Evidence of Availability of Interpreter (e.g. posters/bulletins) and/or Bilingual Staff for the Languages Spoken by Community.**

It is the policy of the Department to inform Limited English Proficiency individuals, in a language they understand, that they have a right to free language services. An Interpretation Services Available Poster was provided by the contract vendor for the purpose of identifying individual's language, as well as informing them of the availability of interpretation services (Attachment #37).

The right to free language services for all consumers is not only mentioned verbally to all consumers and family members during the first contact but it is also noted in written documents such as the Guide to Services, posters at the clinic's sites and in program pamphlets and brochures.

B. Documented Evidence that Interpreter Services are Offered and Provided to Clients and the Response to the Offer is Recorded.

The Department has required information on interpretation services provided in the following forms:

- Adult Intake Assessment Form- under "Others present" it mentions, Family, interpreter etc. It is also documented when the consumers was offered interpretation services and their responses.
- Adult Psychiatric Assessment- same as the Intake Assessment Form it mentions if interpretation was provided.
- Consumer Care Plan- there is a section called "Linguistic Services" and three boxes to mark one of the three options (received, offered/refused or N/A.)

The Department has a contract with Language Line services to provide interpretation and translation services (Attachment #38).

C. Evidence of Providing Contract or Agency Staff that are Linguistically Proficient in Threshold Languages During Regular Day Operating Hours.

The Department has a contract with Language Services vendors to provide interpretation services in all languages including American Sign Language. The Department also has 273 bilingual staff receiving bilingual pay in order to provide linguistic services and/or services in the consumers' preferred language.

D. Evidence that Counties Have a Process in Place to Ensure that Interpreters are Trained and Monitored for Language Competency (e.g., formal testing).

The Department recognized the importance of using interpreters that have been trained in the field of mental health. This makes for more meaningful and effective service delivery. Agency-contracted personnel are used to deliver interpretation services. These contracted interpreters have usually passed extensive hiring requirements as well as professional training requirement in order to be certified as medical interpreters.

The Department has bilingual pay for designated positions. To establish positions as eligible for one of the bilingual levels, the Department must designate a position as eligible for bilingual pay at either level 1, 2, or 3*. The

Department must verify that the position requires the use of a second language at least five times per week or once per day. Testing is required for all levels and designation occurs only once approved by the Department and Human Resources.

The authorization for bilingual compensation is tied to the individual's position. Therefore, any changes in employee position, including transfer to other programs, will result in the loss of bilingual pay and a new designation form would be required.

> **Level 1**: Basic oral communication such that employees perform bilingual interpretation(oral) and/or provide services in a second language as part of their job function and regular duties at least five times per week or once per day.

> **Level 2**: Basic oral **and** written communication: Employees at this level perform bilingual interpretation as described in level 1 as well as do written translations. These are provided as part of their job function and regular duties at least five times per week or once per day.

> **Level 3**: Complex written and/or oral Medical Legal Interpretation: Employees at this level perform complex verbal and written translations. Employees at this level perform complex verbal interpretation (simultaneous interpretation for a group of people) and written translations of documents and other written information by participating in the translation committee.

IV. **Provide Services to All LEP Clients Not Meeting the Threshold Language Criteria Who Encounter the Mental Health System at All Points of Contact.**

   A. **Policies, Procedures, and Practices the County Uses that Include the Capability to Refer, and Otherwise Links, Clients Who Do Not Meet the Threshold Language Criteria (e.g., LEP Clients) Who Encounter the Mental Health System at All Key Points of Contact, to Culturally and Linguistically Appropriate Services.**

The Department makes every attempt to not differentiate the services provided to Limited English Proficient individuals that speak the threshold language and those that do not. Through the contract with Language Services the Department is able to have availability of language interpretation for consumers and family members in Sign Language, Vietnamese, and other languages, and to provide written information in their languages, as the budgets permits.

The Department makes efforts to link the non- threshold language consumers with the non-threshold language contract provides in the county. In addition,

another way to meet the needs of non-threshold language consumers is to utilize resources from neighboring counties. RCDMH is fortunate to be in close proximity to Orange County and Los Angeles County both of which have a wide array of threshold languages and are willing to share their translated documents and their list of available resources with us. Currently, intakes, financial information and other key informational brochures are available in Vietnamese and other non-threshold languages.

B. Provide a Written Plan for How Clients Who Do Not Meet the Threshold Language Criteria, are Assisted to Secure, or Linked to Culturally and Linguistically Appropriate Services.

It is a policy of the Department that Limited English Proficient Individuals that do not speak the threshold language are to be assured equal access to cultural and linguistic appropriate services (Attachment #2). Wherever possible, staff and/or contract providers are used to provide services in the consumer's primary language. When staff or contract providers are not available, agency interpreters are used to provide cultural consultation and language interpretation services to enable the consumer to obtain services that can meet their diverse needs. Consumers are also referred to the community resources that are culturally and/or linguistically specific, whenever possible.

C. Policies, Procedures, and Practices that Comply With the Following Title VI of the Civil Rights Act of 1964 (see page 32) Requirements:

1. Prohibiting the expectation that family members provide interpreter services;
2. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services; and
3. Minor children should not be used as interpreters.

It is the Department policy to never expect family members to provide interpretation services. If language services are needed immediately and there are no in-house resources, the Language Line is use to provide immediate services (Attachment #2).

V. Required Translated Documents, Forms, Signage, and Client Informing Materials.

A. Culturally and linguistically appropriate written information of threshold languages, including the following, at minimum:

In order to ensure equal access to services for our threshold language population, the majority of our general program literature has been translated into Spanish. These brochures, pamphlets, forms, and informational materials are all available in clinics lobbies, sessions with clinicians, and website postings.

Attachment #40 provides a list of documents that have been translated into Spanish and available to all staff for their use and distribution in the X: Drive according to the Translation Policy (Attachment # 6).

B. Documented Evidence In the Clinical Chart, that Clinical Findings/reports Are Communicated in The Clients' Preferred Language.

When a client is non-English speaking, there is a check box on clinical and intake forms that indicate if an interpreter was utilized. If the staff is bi-lingual, they are requested to write in 'staff is bi-lingual'.

The actual contents of the chart are in English, as they are documents the client generally doesn't see. All written Information and forms provided to the client in their preferred language is filed in their chart. If the client wants their records, the standard protocol is to write a summary (which would be translated into their preferred language).

C. Consumer Satisfaction Survey Translated in Threshold Languages, Including a Summary Report of the Results (e.g., back translation and culturally appropriate field testing).

The Riverside County Department of Mental Health strives to establish and maintain provider and consumer satisfaction by continuously evaluating services and implementing quality improvement initiatives. As part of these efforts, a telephone survey was administered. Forty-one of the 198 completed surveys were by Spanish Speaking consumers (Attachment #41).

D. Mechanism for Ensuring Accuracy of Translated Materials in Terms of Both Language and Culture (e.g., back translation and culturally appropriate field testing).

It is the policy of the Riverside County Department of Mental Health to follow standards and guidelines for translating documents, as well as ensure the quality, distribution and availability of translated information materials, forms and any other written documents (Attachment #6).

As indicated in the Translation policy, all the translation requests are to be sent to the Cultural Competence Program's Translations Subcommittee and go through a process which ensures accuracy. This subcommittee is comprised of bilingual/bicultural members of the CCC who will provide translation services and/or will review translated documents for approval and distribution. The staff doing the first and second translations are the bilingual staff currently receiving bilingual pay Level 2.

It is clear for this subcommittee that the translation is the process of transferring a written communication from one language to another. It is recommended the translation be at a **six grade reading level**. Each document must be evaluated for reading level before and after translation.

The staff assisting with translation has the following qualifications:

- High degree of familiarity with both source and target language.
- Ability to distinguish between dictionary language and language of clients.
- Inclusion of "real" experiences familiar with both cultures to increase equivalence of translations.
- Recognition that level of readability may need to be altered for some items.
- Understanding guidelines for translation, such as preferred use of concrete terms, addition of explanations for items interpreted figuratively in other culture and literally in another culture, attention to equivalence or non-equivalence of idiomatic phrases in either language by including both the idiom and the literal translation, care with verb tenses, or repetition of nouns and avoidance of passive tense, hypothetical phrasing, and subjective mood rather than use of pronouns.
- Culturally non-equivalent or inappropriate items may require radical modification. Objective is to preserve meaning of item.

For each document translated the Translation Subcommittee follows a protocol for completing the translation to minimize misunderstanding:

Step 1: Independent preliminary first translation by translator fluent in both original and target languages. (First translator)

Step 2: Comparison of first-translated version and the original version. Comparing with English versions will ensure that the content of the original English version is maintained. (Second translator)

Step 3: Field test for acceptability by clients in target language (Consumer and Family member committee).

E. **Mechanism for Ensuring Translated Materials Is At An Appropriate Reading Level (6th Grade). Source: Department of Health Services and Manage Risk Medical Insurance Boards.**

See above response for item D.

I. Client Driven/Operated Recovery and Wellness Programs

The County shall include the following in the CCPR:

A. List and describe the County's/Agency's client-driven/operated recovery and Wellness Programs.

1. Evidence the County has alternatives and options available within the programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.

The following are the consumer operated programs

Contracted Program:

Jefferson Wellness Center:

Jefferson Wellness Center is a campus of specialty integrated services. Vocational services and benefit assistance is provided to consumers receiving services from any Western Region Adult Service Program. Jefferson Wellness Center is also the home of the Adult and Transitional age Youth (TAY) Full Service Partnerships Program.

"The Place" Safehaven Program:

"The Place" is an outreach and engagement program for chronically homeless adults who, due to serious mental health disorder, have rejected housing and resisted support. The program provides a drop-in center that operates 24 hours a day and on-site low demand permanent supportive housing for 25 adults. The drop-in center uses peer-to-peer outreach and engagement in order to engage guest in accepting housing and additional support service. Guests are able to access meals, showers, laundry and linkage to a wide range of community resources

Artworks:

Art Works @ Jefferson Transitional Programs offers artistic programming to individuals who carry a mental health diagnosis in order to promote recovery through creative expression. The program features a gallery space in downtown Riverside where participants, participants' family members, friends, and local artists exhibit and sell fine arts and crafts.

Arts Core:

Arts Core takes the classes from Artworks, taught by consumers, family members and supportive community artists to alternate locations. Classes have been used to assist many people in their recovery. These locations include Juvenile Hall, community and senior centers, group homes, homeless shelters, hospitals and more.

County Operated Programs:

Consumer Affairs:

This Program promotes the consumer perspective in all aspects of the Department from policy and planning to direct service. It seeks to further recovery through training and support for consumers employed as Peer Specialist in the Department. These Peer Specialists having attained a level of personal recovery assist and support consumers of the Department's services. Through this peer-to-peer support, consumers experience hope and are assisted in their own recovery.

Client Empowerment Project:

This program seeks to reach into the community, locating existing "self help" groups while listening to community needs. New groups are planted to answer those needs. The new groups are initially facilitated by certified Peer Specials Volunteers who utilize newly acquired skills to give back to the community thus enhancing their personal recovery. The program compiles information and creates three regional directories of self help groups available to the Department as well as the community.

WRAP:

The Department has an agency-wide approach that supports the concept of recovery on multiple levels. The philosophy of recovery embraces and encourages an individual's capacity for change and personal transformation. The peer-to peer interactions, including the development of a personal WRAP (Wellness Recovery Action Plan), is an integral part of the mental health recovery process. The Department offers a partnership with the person receiving services, so they have the opportunity to experience a real and positive change in their life. WRAP is a very effective way to maintain a life of mental health wellness.

WELL:

The WELL (Wellness and Empowerment in Life and Living) class addresses finding and continuing wellness in all aspects of daily life. The curriculum consists of 15 class sessions that use a holistic approach to promote mental,

physical, social, financial, spiritual and general wellness. Each individual's strengths and experiences are valued and utilized to help them and others succeed in their recovery goals.

PSS Volunteer/Internship:

This program emphasizes the importance of purpose and meaning in the recovery process. Graduates of Peer Employment Training are encouraged to use their life experience to help others and grow in their recovery. This is accomplished when the Department welcomes them to the workforce with confidence. In this program the PSS volunteers are able to decide on the number of hours they would like to work and are granted access to all training and supports available to F/T Peer Specialists.

2. Briefly describe, from the list in 'A' about, those client-driven/operated programs that are racially ethnically culturally and linguistically specific.

In the above list of program that are consumer-driven/operated programs there is not specific program serving only ethnic and linguistic specific communities. All of the programs that are operated by the County or contracted out are required to follow policy 162 to ensure that the programs are particularly addressing languages accessibility and cultural competency issues.

II. Responsiveness of mental health services

A. **Documented evidence that the County/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the County/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider.**

Providing consumers with alternatives and options that meet their diverse cultural, linguistic, and individual preferences can be a valuable resource in a consumer' service delivery and recovery process. When consumers are allowed to pick and choose the options and alternatives that will work best in their individual recovery plan, their success rate will be much greater than if they are forced to follow a rigidly, predefined plan. The consumers and family members are informed of the availability of options through the Guide to Services brochure and are encouraged to work with staff, Peer Support Specialists, and other providers on individualizing their recovery process and alternatives.

As the Departments moves forward with the planning, implementation, and monitoring of the Mental Health Service Act (MHSA), the Department's partnerships and collaborations with community based organization and

community faith organizations continues to increase and develop. Currently all the MHSA programs and other available resources are included in the Guide to Services, Network of Care, www.riverside.networkofcare.org and the Department's Website.

The Department's Website, http://mentalhealth.co.riverside.ca.us, provides a list of the Mental Health Providers available. Each one of the providers in the Department has immediate access to the list of providers by discipline, location, language specialties, disorder specialties, cultural specialties, etc. Attachment #42 provides the current list available at each provider's desk top and at the Department's Website.

The Peer Specialists in each clinic have a list of services, including self help groups and other community resources at their "Welcoming Desk. The Department is currently working on providing computer accessibility at each one of the clinic's welcoming desks for consumers and family members to have access to Network of Care and Department Website.

B. **Evidence that the County informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the County will include it in their next printing or within one year of the submission of their CCPR.**

The Department Guide to Services currently provide the list of all services provided as well as information on how to obtain more information via the Department's Website and the Network of Care.

The Department hired a FTE Community Resource Educator (CRE) to provide the following:
- Coordinates the data collection for the primary resource data banks related to our service delivery: 211; Network of Care; CARES Website (currently in development); RCDMH website; and Guide to Services.
- Serve as the central point of contact to ensure that Department services are listed accurately in each data bank and are simultaneously updated upon change in services offered.
- The CRE serve as the primary editor for describing community services as they appear in the CARES website; these annotations will describe staff's practical knowledge in utilizing these recourses so that all services staff can best tailor a referral to meet a consumer's needs.
- She will also educate staff, partner agencies, and the people served regarding Department programs as well as community resources.
- Outreach and problem solve with resource providers in order to increase availability and accessibility of resources for consumers and their families.

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

The Department is involved in numerous activities that inform Medi-Cal beneficiaries of available services. In addition to the process described above in item B, the Department provides information, education and linkage under the community outreach activities. The following is a list of the activities used:

- Radio broadcast on local Spanish station. These broadcast topics have included mental health information as well as information on resources.
- Television broadcast on Local Television Station. This Television program provides the community with information on mental health and resources available in the community.
- Ethnic and linguistic specific outreach activities described in criterion 1, section II, item A (page 3).
- Mental health community events: Open houses and May is Mental Health Month activities.
- Community trainings and educational workshops.

D. Evidence that the County has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

1. Location, transportation, hours of operation, or other relevant areas:

Making services as easy as possible to use and as inviting as possible has always been an important factor when planning for services. The accessibility to public transportation routes has always been a major factor in site selection. Currently, special care is taken to ensure consumers and their families are served in a warm and friendly environment and that a diverse ethnic population is represented in posters, signs, magazines, and overall décor. Service centers are spread throughout the County and maintain consistent hours of operation. This month, the Department operations are 4 days a week, 10 hours a day. These hours of operation facilitate the opening of clinics and services to evening hours. Some of the programs are operating 24 hours 7 days a week to ensure immediate access to services are available when needed.

All the facilities have ample free parking available for both staff and consumers.

2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs); and

The Department implemented the Welcoming Program in 2007. This Welcoming Action Plan was developed according to Bruce Anderson "Welcoming" definition. "Welcoming" is creating an environment where interaction encourages a feeling of belonging and willingness to engage. The Welcoming plan addresses the following areas:
- Storefront and interior (site)
- How we engage and interact initially, ongoing and at exit
- How we support staff

Staff, consumers and family members worked on developing the Riverside County Department of Mental Health Statement of Operating Beliefs and Principles (Attachment #1). An example of a Welcoming Plan is provided in Attachment #43 A consumer and family members survey was developed to find out how the clinics are doing in providing a respectful, comfortable and welcoming environment (Attachment # 44).

3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and/or partnerships, such as primary care and in community settings.

The mission of the Mental Health Department, including the Mental Health Services under the MHSA is that the residents of Riverside County facing challenges of severe mental illness and in need of Prevention and Early Intervention Programs have a quality of life that includes a reduction or absence of symptoms, meaningful relationships, housing, employment and activities in supportive communities free of stigma. Many of the County and Contract programs are co-located in community settings such as schools, social services offices, community centers and community based organizations that promote empowerment and recovery environment. Attachment #45 provides a list of Riverside County Department of Mental Health Lease Building Management that illustrates the hours of operation, if the program is located by a bus or train line, if the program is ADA accessible, multilingual capability and décor.

III. Quality of Care: Contract Providers

A. Evidence of how a contractor's ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.

Riverside County Department of Mental Health Policy #121 emphasizes the importance of each executed contract with the Department of Mental Health for the provision of mental health, substance abuse, managed care services by an outside agency being monitored and evaluated to verify contract compliance and satisfactory performance. In the last contract preamble revision it is included the Cultural Competency Plan Requirements and the need for the contracts to adhere to the Plan.

Attachment #9 provides a list of Contract Agencies that illustrates the cultural and linguistic capacity, ADA accessibility, and type of services they provide.

IV. Quality Assurance

The Riverside County Department of Mental Health strives to establish and maintain provider and client satisfaction by continuously evaluating services and implementing quality improvement initiatives.

A. Outcome measures, identification, and descriptions of any culturally relevant consumer outcome measures used by the county.

There are several consumer outcome measures that are cultural specific. The Mental Health Statistical Improvement Program Survey has been developed to give an assessment of consumer satisfaction and contains components that measure cultural competency specifically. There are also instruments such as Penetration/Retention Rates and the Unmet Needs study that give a view of where our services are being utilized and among which cultures and languages our services are needed (Attachment # 46).

The California Department of Mental Health requires each county to survey consumers of mental health services for a two-week period during the months of May and November to monitor the effectiveness of mental health services. For culturally relevant consumer outcomes the Department has the Consumer Perception Survey, which is a sample of clients completed twice a year and in that survey are the three cultural and linguistic relevant questions: "Staff were sensitive to my cultural background (race, religion, language, etc.)." "Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer?" "Were the services you received provided in the language you prefer? Riverside County Department of Mental Health presents a report divided into four primary sections for each age group of Youth, Parents/caregivers, Adults, Older adults. All reported findings are based solely on data provided by respondents who chose a valid response. Missing data was excluded from analysis. RCDMH Research and Evaluation Report November 2008 (Attachment #41).

In addition, in 2007 some Managed Care phone surveys were completed (separate report). These were consumers that were served not in the clinics

but were served by Managed Care and in that phone survey the items on that survey include:

Do you feel that your provider was sensitive to your cultural background? For example, were you comfortable talking about your family traditions? What language do you prefer to speak and read? Would an interpreter have been helpful to you in treatment? If so, was one provided to you? The Managed Care Phone survey report is attached but it is a small sample size and we have not updated the data for awhile since we just did not have the staff to make the calls (Attachment #41).

B. Staff Satisfaction

The Cultural Competency Program Organization and Community Assessment project (described in criterion 1) provided the opportunity for staff at all levels of the organization to express their perception of the Department's ability to value cultural diversity in the workforce and the value of culturally and linguistically competent services. During year '08-'09 a total of 32 staff focus groups were conducted. 358 staff participated in the focus groups representing direct service staff, supervisors and program managers.

The focus group questions were developed and analyzed using Indicators of Cultural Competence in Health Care Delivery Organization: HRSA Domains: Organization Values, Governance, Planning and Monitoring, Communication, Staff Development, Organization Infrastructure, and Service Interventions (Attachment #19).

C. Grievances and Complaints

The grievance and complaints system is an important component of quality assurance and measuring whether the needs of cultural and linguistically diverse consumers are met. Wherever possible, the Department wants to ensure that any trends in the system that portray a tendency towards one particular group or another are addressed.

Attachment #47 presents the last two Problem Resolution Reports. The data is not broken out by ethnicity of complainant.

In one report 1st half of year 08-09 there was none related to culture/language and in 2nd half of year 08-09 there were 2.

ATTACHMENTS

Attachment 1 - Operating Beliefs and Principles

Attachment 2 - Cultural Competency Policy #162

Attachment 3 - Consumer Brochures and Posters Policy #290

Attachment 4 - Client and Family Involvement Policy #291

Attachment 5 - 20/20 Upgrade Training Program Policy #342

Attachment 6 - Translation of Documents Policy #123-0

Attachment 7 - Workforce Needs Assessment

Attachment 8 - Contractor Agreement Renewal FY 2010/2011

Attachment 9 - List of County Clinics Cultural Competency Capacity

Attachment 10 - Cultural Competency Outreach and Engagement Events

Attachment 11 - Achieving Cultural Competent Mental Health Services for LGBTQ

Attachment 12 - LGBT Outreach and Engagement Plan

Attachment 13 - Deaf and Hard of Hearing Outreach and Engagement Plan

Attachment 14 - Asian American/Pacific Islander Outreach and Engagement Plan

Attachment 15 - Native American Outreach and Engagement Plan

Attachment 16 - African American Outreach and Engagement Plan

Attachment 17 - Spirituality as Part of Mental Health Recovery

Attachment 18 - List of Informational Materials

Attachment 19 - Cultural Competency Focus Groups & Logic Model Development

Attachment 20 - Community Capacity Building Initiative

Attachment 21 - Bilingual List

Attachment 22 - Riverside County General Population

Attachment 23 - Cultural Competency/Reducing Disparities Committee Description

Attachment 24 - Cultural Competency/Reducing Disparities Committee Flow Chart

Attachment 25 - Administration Flow Chart

Attachment 26 - Cultural Competency/Reducing Disparities Membership

Attachment 27 - Cultural Competency Goals and Objectives 2007-2008

Attachment 28 - Cultural Competency Committee Assessment

Attachment 29 - Cultural Competency Committee Training

ATTACHMENTS

Attachment 30 - Cultural Competency Committee's Recommendations for PEI

Attachment 31 - Cultural Competency/Reducing Disparities Committee's Minutes 2009-2010

Attachment 32- California Brief Multicultural Competency (CBMCS) Training Program Evaluation

Attachment 33 - Training Unit Evaluation Example

Attachment 34 - Recovery Management

Attachment 35 - Parent Support Training Report

Attachment 36 - List of Stipend Students

Attachment 37 - Interpretation Services Posters

Attachment 38 - Interpretation Services Memo

Attachment 39 - Providing Interpretation Services PowerPoint

Attachment 40 - List of Translations 2009-2010

Attachment 41 - Performance Outcomes Quality Improvement Report & Managed Care Client Satisfaction Survey

Attachment 42- Providers' List on Computer Desktops

Attachment 43 - Welcoming Plan Example

Attachment 44 - Consumers' Feedback Survey

Attachment 45 - List of Building Locations and Hours of Operation

Attachment 46 - Service Disparities Report

Attachment 47 - Problem Resolution Report

Attachment 48 - Prevention and Early Intervention Implementation Report

Attachment 49 - WET Implementation Report

ATTACHMENT #1

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH
STATEMENT OF OPERATING BELIEFS AND PRINCIPLES

OPERATING BELIEFS

We believe

- that everyone has hopes and dreams for their lives.

- that people we serve know themselves best and that they bring a unique value to us and the community.

- that people can recover from addiction and mental illness to become self sufficient and thrive and that they deserve to be an integral part of the community.

- that people we serve and their families should have choices and be active partners in determining goals and achieving a quality life.

- that people in recovery and their families need and deserve having us actively listen to them with our ears, hearts and minds.

- that people in recovery have strengths to share with others through mentoring and guidance and that they can contribute to program development through sharing of their experience, needs and goals.

- that people in recovery are to be treated with dignity and respected as individuals, as members of families (of their choice) and as members of any expressed culture or group.

- that addiction and mental health problems can be prevented or reduced through preventative efforts and/or early intervention efforts.

PRINCIPLES

We will

- respect client's choices and beliefs and instill hope, promote empowerment and foster resilience.

- celebrate accomplishments both with ourselves and with those who receive services and be truly welcoming to those we serve and to each other.

- provide effective, flexible treatment which we believe facilitates recovery and will deliver services that ensure a person receives the help they ask for, which may include referral, active linkage and follow-up and/or ongoing treatment.

- commit, as staff, to use our expertise and specialized knowledge to provide the most culturally appropriate and current, evidence-based and promising practices and will challenge our leaders and ourselves with new ideas that promote teamwork across the organization to ensure ongoing improvement.

- integrate peer support systems into service delivery and ensure family and consumer involvement in all aspects of the department and will provide a properly trained, supervised and supported workforce that believes in and understands the process of recovery and consumer empowerment.

- provide, in a user friendly format, access to information and to services across the county and across all groups.

- outreach to underserved and unserved seriously mentally ill priority populations and actively address disparities in service utilization and availability.

- actively partner with other agencies for maximum service effectiveness and will focus on consumer outcomes and utilize feedback and evaluation mechanisms to continually improve services/outcomes, thus ensuring accountability.

ATTACHMENT #2

RIVERSIDE COUNTY

DEPARTMENT OF MENTAL HEALTH

POLICY NO.:	162
SUBJECT:	CULTURAL COMPETENCY
REFERENCES:	California Department of Mental Health Information Notice 97-14
FORMS:	None.
EFFECTIVE DATE:	September 18, 2000

I. POLICY

A. Purpose

The purpose of this policy is to establish cultural competency standards and policy requirements for the Department of Mental Health to enhance treatment outcomes for patients.

The intent of this Cultural Competency policy is to develop standards for achieving cultural and linguistic competency in the Riverside County Department of Mental Health. It is the intent that this will assist each mental health program and each mental health contractor to develop and implement an individualized cultural competency plan.

B. Mission

The Cultural Competency policy is designed to improve the quality of patient care.

C. Background

California is one of the most demographically diverse states in the country. This diversity is represented in Riverside County Mental Health facilities. The Department of Mehtal Health has begun several efforts to begin a strategic planning process that will move Riverside County Mental Health's system towards addressing the diversity of the patient population we are responsible to serve in a

more effective manner. In 1997, the State Department of Mental Health added an addendum to the consolidation of Medi-Cal Specialty Mental Health Services requiring each local Mental Health Plan (MHP) to submit a Cultural Competence Plan in response to the requirements identified in State Department of Mental Health Information Notice 97-14. Riverside County's Cultural Competency plan has been submitted and approved by the State and continues to be updated annually as part of and in compliance with the State's overall compliance review protocols.

II.   PROCEDURE

A.   Language Accessibility

The Department of Mental Health will take the following actions to increase the availability of services at key points of contact to Medi-Cal eligible clients who do and do not meet the threshold language requirements.

1.   Threshold Language

The State Department of Mental Health has designated the threshold language as that language spoken by 2% of the county population. Following this state rule, DMH has identified Spanish as the threshold language.

2.   Meeting Consumer Language Needs

DMH prohibits the expectations that families will serve as interpreters. To help meet the needs of threshold language speaking clients, DMH will provide the following services to these clients:

a.   AT & T Language Line, a 24-hour phone line

b.   New World Interpretation Agency

c.   Provide clinics with list of available DMH staff and available interpretation service vendors who provide same day services

B. **Training**

DMH will require all trainers address cultural competency in all workshops, conferences, presentations and trainings given by mental health staff.

C. **Evaluations**

Data will be collected and evaluated to include:

1. Language capability

2. Gender

3. Age

4. Ethnicity (when feasible)

D. **Surveys**

Surveys will be taken to collect and evaluate the following data:

1. Client level of satisfaction with mental health services

2. Client primary language

3. Client's gender

4. Client's age

5. Client's ethnicity

6. Client's request for bilingual staff

E. **Brochures and Informational Material**

Consumers will be provided brochures in the threshold language. Brochures are available in all clinic reception and waiting areas, group rooms, and available through staff members. Brochures provide information on the following:

1. DMH regions and programs

2. DMH services

3. Consumer rights

4.   Other county health and or social service programs

5.   Substance abuse services

6.   Legal services

7.   Other free services available by local agencies and or non-profit groups

F.   **Non-Threshold Language Clients**

For Medi-Cal eligible clients who do not meet the language threshold criteria, DMH:

1.   Will continue to improve its referral capability by working and identifying local providers who meet the language needs of these clients.

2.   Will continue to identify local service providers to assist these clients with direct and indirect mental health services.

3.   DMH will require all contractors who provide direct services to Medi-Cal eligible clients to develop a Cultural Competency plan to demonstrate their ability to provide clinically sound services.

Approved by: _____
                     Mental Health Director

ATTACHMENT #3

POLICY: 290

SUBJECT: CONSUMER BROCHURES AND POSTERS

REFERENCE: Title 9, Chapter 11, Section 1810.360
Title 9, Chapter 11, Section 1810.410
Title 9, Chapter 11, Section 1850.205
DMH Information Notice No.: 97-14

FORMS: Informing Material Reorder Form

EFFECTIVE DATE: March 14, 2001

REVISED DATE: April 26, 2010

POLICY:

A. **Background**

Title 9, Chapter 11, Section 1810.360, Notification of Beneficiaries, requires that the Department provide consumers with an informational brochure and a provider list from the Mental Health Plan (MHP) upon request when they initially access services. The Consumer's Guide to Mental Health Services contains a description of services available, the process for obtaining the services including the MHPs statewide toll-free telephone number, a description of the consumer's problem resolution process, and the availability of fair hearings.

Title 9, Chapter 11, Section 1810.410, Cultural and Linguistic Requirements, and DMH Information Notice 97-14, establishes the consumer's right to have services that are culturally and linguistically appropriate services. The consumer also has the right to a listing of specialty mental health services and other Mental Health Plan services available for beneficiaries in their primary language by location of service.

Title 9, Chapter 11, Section 1850.205 requires that the Department have a problem resolution process that includes a complaint resolution process, a grievance process, and the Fair Hearing Process. Consumers have the right to use the grievance process without going through the complaint process first. Medi-

Cal consumers also have the right to have any of their concerns addressed at the Fair Hearing level without going through either the complaint or grievance level of the process.

In addition, Section 1850.205 requires that the consumer have adequate information about the problem resolution process. Posters explaining the process need to be readily available to both the beneficiary and the provider staff. These notices are to be posted at any site owned or operated by this Department and at all contracting provider sites where beneficiaries receive mental health services. Grievance brochures, forms and self-addressed envelopes must be available without having to make a verbal or written request to anyone.

B.   Goal

It is the goal of the Riverside County Department of Mental Health (DMH) to provide services that are consumer-centered and that achieve positive mental health outcomes for culturally diverse populations across all age groups. Consideration will be given to the consumer's choice, cultural and linguistic needs, as well as history of treatment when referring a consumer for services.

PROCEDURE:

A.   Requests for brochures/posters

1. Upon request, consumers will be given a listing of specialty mental health services and other Mental Health Plan services available for beneficiaries in their primary language by location of services.

2. DMH and contract providers will provide consumers with a copy of the Consumer's Guide to Mental Health Services upon request, when they initially access services and annually thereafter as long as they remain in treatment.

   a. This brochure and the Consumer Complaint Resolution and Formal Grievance Procedure brochure are available in English and in Spanish.

   b. The brochures are also available on audiotape in both languages for consumers who are visually impaired or who are unable to read. Consumers will be given the choice of either the brochure or the audiotape.

3. Both of these brochures as well as self-addressed envelopes will be readily available in treatment rooms and waiting areas so that it is unnecessary to request them either verbally or in writing. Posters on the Complaint, Grievance and Fair Hearing process will be prominently posted in lobby and waiting areas where mental health services are provided and in all DMH offices.

B. Compliance

1. Mental health sites will comply with the above policy by maintaining an appropriate supply of brochures to meet consumer needs.

2. DMH clinics may display the brochures in a wall rack attached to a wall high enough to make them available to adults, and yet is handicap accessible.

3. Brochures should not be behind glass; rather they should be readily available.

C. Supplies

Supplies of this material can be ordered through the Provider Relations Section using the Brochure and Poster/Flyer Reorder Form (Attachment 1).

1. Check the box and indicate the amount you need for each item.

2. Fax the reorder form to (909) 358-6868. Allow one week to 10 days for delivery.

Approved by: _____ Date: 4-26-10
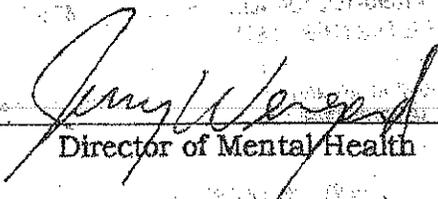
Director of Mental Health

Attachment
Informing Material Reorder Form

RIVERSIDE COUNTY MENTAL HEALTH PLAN
INFORMING MATERIAL REORDER FORM

Please use this form to reorder Riverside County Mental Health Plan brochures and/or poster/flyers that you may need. Place a check mark inside the box next to each item needed. Please put amount requested of English and/or Spanish. Please note that the maximum order per brochure is 50. The maximum per Provider Report (Listing) is 10.

Please check box for items and enter quantity and language of item needed

☐	___ Eng	___ Sp	**Riverside County Guide to Medi-Cal Mental Health Services** – This brochure must be given to each of your Riverside County Medi-Cal beneficiaries during the initial intake. It gives them important information about their treatment in the Mental Health Plan. This brochure is replacing the Consumer's Guide to Mental Health Services and OMBUDSMAN brochures
☐	_____ 10 Max		**Provider Report (Listing).** Consumers must be provided with a copy of the Provider Report (Listing) upon request, when the consumer initially accesses services and annually thereafter as long as the consumer remains in treatment. Mental Health Clinic Sites: Please remember that you will need to print additional Provider Reports (Listings) from the "Shortcut to Report Printing" icon on your OA's desktop. If you do not have this shortcut, please e-mail Mental Health Support and they can add it to the appropriate computer at your site.
☐	___ Eng	___ Sp	**Notice of Privacy Practices.** (HIPAA) Notice of Privacy Practice form describing how the County of Riverside may use and disclose the personal health information of the consumer and how the consumer can obtain access to this information. Packet contains the "Acknowledgement of Receipt" of this information that must be kept in the consumer's chart.

THE FOLLOWING MUST BE DISPLAYED IN AN AREA (WAITING ROOM) THAT IS VISIBLE TO ALL CONSUMERS RECEIVING MENTAL HEALTH SPECIALTY SERVICES:

☐	___ Eng	___ Sp	**Grievance Procedure/Form** – This brochure must be available to all consumers. It provides the consumer with information on their rights and how to proceed if not satisfied with the mental health services being received.
☐	___ Eng	___ Sp	**Appeal Procedure/Form** – This brochure must be available to all consumers. It provides the consumer with information on how to proceed with an appeal.
☐	___ Eng	___ Sp	**Your Right to Make Decisions About Medical Treatment** – Must be given to each consumer at intake.
☐	_____		**Quality Improvement Envelopes.** To mail grievance information.
☐	___ Eng	___ Sp	**Riverside County Medi-Cal Beneficiaries 800 Number Flyer** – MDs ONLY. FOR POSTING ONLY. NOT TO BE DISTRIBUTED.
☐	___ Eng	___ Sp	**Grievance Poster** – Must be posted in an area where consumers can read its content. FOR POSTING ONLY. NOT TO BE DISTRIBUTED.

Please fax your request to 951-358-5352. No telephone orders please.

PROVIDER NAME: _____

PROVIDER ADDRESS: _____

If a Riverside County Mental Health Clinic: Mail Stop Number: _____

ATTACHMENT #4

RIVERSIDE COUNTY

DEPARTMENT OF MENTAL HEALTH POLICY

POLICY NO:	291
SUBJECT:	**CLIENT AND FAMILY INVOLVEMENT WITH ADULT SERVICES**
REFERENCES:	CCR, Title 9, Chapter 11, Section 1810.410(a) MPH Contract with DMH, Attachment C; DMH Information Notice 97-14, pp. 16-17.
FORM:	Client Care Plan
EFFECTIVE DATE:	November 16, 2000 (Revised 10/10/2001)

I. POLICY

It is the policy of Riverside County Department of Mental Health to ensure that all consumers are involved in the planning of their mental health treatment services, as delivered by County-operated and MHP network individual, group and organizational providers. Family members and other advocates can be included in this process as selected by the adult consumer. The conservator/legal guardian of an adult client and the parent/legal guardian of a minor client shall be involved in the client's care, unless such involvement has been deemed inappropriate by the treating professional (e.g., potentially detrimental or harmful to the client).

II. PROCEDURES

A. The client care plan will be developed in collaboration with the client and with the client's family, as appropriate.

B. The clinician and client (and family member(s)as appropriate) will review the client care plan and their participation and agreement will be documented.

C. Participation and agreement with the client care plan will be evidenced by the client's signature (parent/legal guardian's signature in the case of

minor clients under age 12; conservator/guardian's signature in cases of conservatorship if client cannot sign the plan) on the plan. The signature on the care plan will be used as the means by which the MHP determines client and relevant other(s)' participation and agreement. Participation and agreement with the care plan may be additionally referenced in the body of the plan and/or in the progress notes. If parental/legal guardian involvement in the minor client's treatment is deemed inappropriate, this will also be documented on the care plan.

1. In the event that the client (or parent/legal guardian of a minor client under age 12) refuses or is unable to sign the client care plan, written explanation of the refusal or unavailability will be documented on the plan.

D. Family members (as selected by the adult consumer) participation and agreement with the care plan may be documented in the body of the plan, may be evidenced by their signature on the care plan, or may be documented in the progress notes.
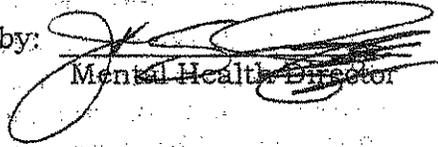
Approved by: _____
Mental Health Director

RIVERSIDE COUNTY

DEPARTMENT OF MENTAL HEALTH POLICY

POLICY NO:	**297**
SUBJECT:	**CLIENT AND FAMILY INVOLVEMENT WITH SERVICE PLANNING FOR MINORS**
REFERENCES:	CCR, Title 9, Chapter 11, Section 1810.410(a) MPH Contract with DMH, Attachment C; DMH Information Notice 97-14, pp. 16-17.
FORMS:	RCDMH Client Care Plan RCMHP Care Plan
EFFECTIVE DATE:	January 12, 2004

POLICY:

The Riverside County Department of Mental Health Children's Services is committed to the goal of an active partnership with families in providing services to minor clients. It is the policy of Riverside County Department of Mental Health (DMH) to ensure that in every possible circumstance, parent(s) or legal guardian(s) and the minor receiving services be involved in the planning of mental health treatment services, whether delivered by County staff, Mental Health Plan (MHP) providers, or contractors. Parents will be included in service planning and in service delivery unless the court has prohibited them, it is clinically inappropriate, or the minor is being served under minor consent Medi-Cal.

PROCEDURE:

A. A client care plan will be developed in collaboration with the client and the client's parent(s) or legal guardian(s). Staff are encouraged to develop a partnership with the client's parents in order to facilitate the exchange of ideas which will assist both the parent(s) or legal guardian(s) and the client in identifying and developing mutually agreed upon goals for the care plan. Appropriate support goals will be included in the care plan. As part of this process, clinicians will discuss the support services

available for families, including parent support services. Clinicians are to also encourage and assist clients and family members in taking advantage of those services and supports.

B. The client and parent(s) or legal guardian(s) are to sign the care plan signifying their participation in and agreement with the plan. Client participation and agreement may be additionally referenced in the body of the plan and/or in the progress notes. In the event that the client and/or parent(s) or legal guardian(s) refuses or are unable to sign the client care plan, or are otherwise not permitted, a written explanation of the reason will be documented in the plan.

C. Clinicians are to maintain contact with the family on a regular basis even in cases where there seems to be little interest on the family's part. Except for MHP providers and/or other exceptions noted above, this will be accomplished through monthly face-to-face meetings with client's parents or legal guardian(s) and will be documented in the client's progress notes. Telephone consultation will only be substituted for face-to-face visits when a parent(s) or legal guardian(s) refuses to come in or is unable to keep an appointment. No-shows and failed attempts to have meetings will also be documented in the client's progress notes.

D. In all cases, a variety of approaches will be utilized to foster family involvement in the treatment and treatment planning process. The approaches used to foster family involvement in treatment planning and interventions will be documented in the client's progress notes.

Approaches may include, but are not limited to:

1. Clarification of the outcomes the family desires;

2. Mutual identification and utilization of family strengths;

3. Exploration of the barriers the family is experiencing in trying to achieve the above outcomes;

4. With the family's permission, inclusion of a parent representative in meetings with the family;

5. Suggesting and providing a Parent Partner to support, interact with, and assist the family to understand and successfully negotiate within the Mental Health and other associated systems;

6. With the family and client's permission, inclusion of additional interested and supportive family and community members in the treatment planning and treatment process;

7. Maintaining an open posture to family members' ideas and desires and being willing to try unusual approaches and solutions, which a family suggests, that are within legal, ethical, and professional boundaries.

Approved by: _____ Date: /-/2-0Y
            Mental Health Director

ATTACHMENT #5

RIVERSIDE COUNTY

DEPARTMENT OF MENTAL HEALTH

POLICY NO: 342

SUBJECT: 20/20 UPGRADE TRAINING PROGRAM

REFERENCES: None

FORMS: Program Guidelines for MSW and RN, Participant Application Forms for MSW and RN, Participant Agreement Forms for MSW and RN, Selection Criteria for MSW

EFFECTIVE: May 20, 2002 (revision of policy dated November 1, 1993)

POLICY:

It is the Department of Mental Health's Policy to enhance its ability to recruit, promote and retain specified professional positions by offering an agreed upon exchange of training opportunities for an established employment commitment. Qualified regular (permanent) full-time staff would be permitted to divide their working and training hours on a weekly 20/20 hour basis while continuing to be paid as full-time employees. In return, selected employees would agree to a service commitment for a period of time equal to the period to which financial training assistance is granted.

This program is intended to address professional staff positions which:

1. Are difficult to fill because demand exceeds supply of qualified available graduating students and professional staff.

2. Due to high turnover, impact quality and continuity of care and result in high replacement costs.

3. Promote the meeting of consumers' needs for culturally diverse professional mental health services, while allowing for internal advancement opportunities.

PROCEDURE:

1. Establishment of educational programs to be used and the number of employees to be selected for participation in the 20/20 Program.

    A. Department will annually determine which educational programs will be used and the number of employees to be selected for participation in the 20/20 Program.

    B. Department will provide funding for 20/20 Program participant expenses in a central money pool. Program costs will be paid from this pool, not from individual Program/Region budgets.

2. Application and Screening.

    A. Department will recruit/accept applications (see attached) from all interested regular (regular) full-time DOMH employees and hold informational meetings for these employees.

    B. Applications will be reviewed and ranked by a joint committee of DOMH staff based on the following primary criteria:

        1. Job Performance Appraisal and Attendance
        2. Academic Achievement and Initiative
        3. Seniority, Consumer Need
        4. Personal Goals
        5. Related community work and Ethnicity in relation to the funding sources program goals.

3. Selection and notification.

    A. Applicants must agree to the terms of the Participant Agreement (see attached).

    B. Selected participants will sign and comply with the terms of the Participant Agreement.

4. Program Participation.

A.   Employee participants must comply with attendance and performance standards on the job and in the educational program to continue.

B.   Employee participants having family (or other), emergencies that prohibit continuation in the 20/20 Program must present their case in writing to a committee member or orally to a joint committee of DOMH staff to request approval for suspension of their 20/20 Program participation. If approved, their eligibility for 20/20 Program participation will be placed in abeyance until they are able to participate in and complete the program within the university's time line. Employee participants not complying with this policy will be considered to have dropped out of the program and will be responsible for payment of tuition, book, supplies and county time costs.

C.   Employee participants must work a minimum of 20 hours a week. Overtime hours worked in excess of daily schedule will be paid subject to provisions of the applicable Memorandum of Understanding.

D.   Employee participants and their immediate supervisor are required to attend and complete a mandatory information meeting with representatives of the 20/20 committee prior to the beginning of the academic year.

5.   Employee participant progress will be monitored by the Department.

A.   Employee participants are obligated to return to work status during summer and other vacation periods when school is not in session.

B.   Employee participants are obligated to provide attendance and performance verification from training institution on a regular basis.

C.   The Department is committed to providing flexible work hours for the 20/20 program participants for the purpose of completing the approved academic program.

6. Program Termination.

A. If for some unforeseen reason an individual is unable to maintain satisfactory progress in the program they would be allowed to return to their regular full-time position without penalty of disciplinary action related to participation in the 20/20 Program.

B. Successful 20/20 program participants who terminate prior to completing the service obligation, shall be subject to paycheck or retirement contribution withholding in an amount equivalent to the payroll cost of the educational assignment time plus fifty (50) percent of salary earned while they were a 20/20 Program participant.

7. Program Completion.

A. Following the completion of the 20/20 Program, employee participant shall have a legally binding commitment to work for the Department for a period of time equal to the period to which financial training assistance has been granted (i.e., hour for hour).

B. Following the completion of the 20/20 Program, the Department will make every effort to provide career promotional opportunities to successful participants.

C. If, following the completion of the 20/20 Program, the employee participant terminates employment with the Department before completion of the required work commitment period, they shall repay the portion of the amount paid by the Department which is proportionate to the uncompleted term of his employment obligation plus fifty (50) percent of salary earned while they were a 20/20 Program participant.
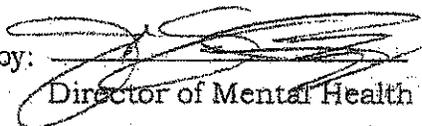
Approved by: _____
Director of Mental Health

Attachments: Participant Application Form MSW (2); RN (5)
                Participant Agreement-MSW (2); RN (6)
                Selection Criteria-MSW (3)
                Program Guidelines-MSW (1)
                Program Guidelines-RN (4)

RIVERSIDE COUNTY MENTAL HEALTH DEPARTMENT

Career Ladder Program Guidelines

20/20 Master of Social Work

Upgrade Training

Application Procedures:

1.   Complete the application attached Please - Type or print requested information
     - Read each page carefully
     - Fill in each item

2.   Please attach a written Goals Statement indicating your particular interest in
     the 20/20 Program. Topics to address include:

     - Reasons for wanting to get a MSW degree.
     - Particular circumstances that demonstrate your need for 20/20 Program
       support.
     - Qualities and characteristics about yourself that would make you a successful
       trainee in the 20/20 Program.

3.   Submit transcripts of all related coursework to date.

4.   Deliver or send - Application
                       Goals Statement
                       Transcripts

by_____ to MENTAL HEALTH PROGRAM ADVANCEMENT
UNIT, STAFF DEVELOPMENT UNIT, Stop 3790 OR P.O. Box 7549, Riverside, CA
92513

5.   Incomplete applications will NOT be considered.

RIVERSIDE COUNTY

DEPARTMENT OF MENTAL HEALTH

POLICY NO: 348

SUBJECT: CASE MANAGEMENT CERTIFICATE PROGRAM

REFERENCES: DOMH Policy 342 - 20/20 Upgrade Training Program

FORMS: Case Management Certificate Program Guidelines,
        Case Management Certificate Program Application,
        Case Management Certificate Selection Criteria,
        Case Management Certificate Program Participant Agreement

EFFECTIVE: February 3, 2000

I.   POLICY:

Cultural Competency is a State mandate to the Mental Health Managed Care Plan and in all other services provided by the department. The Case Management Certificate Program has been developed to support the Department of Mental Health's Policy to enhance quality consumer directed services and augmentation of staff knowledge and skills including but not limited to cultural competency by offering an agreed upon exchange of training opportunities for an established employment commitment. Qualified regular full-time staff that are selected to participate may receive tuition support and would be permitted to work 34 hours per week and attend Case Management Certificate courses 6 hours per week while continuing to be paid as a full time employee. In return, selected employees would agree to a service commitment for a period of time equal to the period financial assistance and time for training was granted; (i.e. selected employees would commit to working 12 months in the Department of Mental Health for each academic year the department granted assistance).

This program is intended to address the quality of care provided by Bachelor degree level quasi-professional staff:

A.   that work with culturally, socially, and spiritually diverse consumers, community groups, agencies, organizations,

individuals and family members; interpret mental health programs, policies, and procedures to consumers, community groups, agencies and organizations; apply laws, rules, and regulations governing a public mental health agency in specific situations;

B.   to improve knowledge of the methods and techniques of social work interviewing, individual and group counseling, intervention and documentation, the principles of individual and group behavior, the principles and practices involved in improving mental health, recognize and obtain relevant and significant psychosocial factual information, and take appropriate action pertaining to mental health needs, and maintain accurate case work documentation;

C.   to establish and maintain effective working relationships with consumers, and to communicate effectively and appropriately in verbal and written form.

II.   PROCEDURE:

A.   Establishment of educational programs to be used and the number of employees to be selected for participation in the Case Management Certificate Program.

1.   Department will annually determine which educational programs will be used and the number of employees to be selected for participation in the Case Management Certificate Program, or more frequently depending on business and clinical need.

2.   Department will provide funding for Case Management Certificate Program participant expenses in a central money pool, not from individual Program/Region budgets.

B.   Application and Screening

1.   Department will recruit/accept applications from all interested regular full-time DOMH employees who have passed initial probation within Riverside County and hold informational meetings for these employees (See Attachments 1 & 2).

2.   Applications will be reviewed and ranked by a joint committee of DOMH staff based on the following primary criteria: Job Performance and Attendance, Academic Achievement and Initiative, Seniority, Need, Personal Goals, Related

Community Work, and Ethnicity in relation to the consumer population and business and clinical needs (See Attachment 3).

C.   Selection and Notification

1.   Applicants must agree to the terms of the Case Management Certificate Program Participant Agreement (Attachment 4).

2.   Selected participants will sign and comply with the terms of the Case Management Certificate Program Participant Agreement (Attachment 4).

D.   Program Participation

1.   Employee participants must comply with attendance and performance expectations on the job and in the educational program to continue.

2.   Employee participants having family (or other), emergencies that prohibit continuation in the Case Management Certificate Program, must present their case to a joint committee of DOMH staff to request approval for suspension of their participation. If approved, their eligibility for the Case Management Certificate Program participation will be placed in abeyance until they are able to participate in and complete the program. Employee participants not complying with this policy will be considered to have dropped out of the program and will be responsible for payment of tuition, paid time costs and any other associated costs.

3.   While the approved school program is in session, employee participants must work a minimum of 34 hours per week. Any time beyond the agreed 6 hours necessary to attend required courses, or completing homework/projects/assignments are the responsibility of the participant, not the department. Overtime hours worked in excess of daily schedule will be paid subject to provisions of County Salary Ordinance 440 and Memorandum of Understanding. Any time, beyond the allowed 6 hours, necessary to attend required program courses or completing homework/projects/assignments are the responsibility of the participant not the department.

E. Employee participant progress will be monitored by the Department.

  1. Employee participants are obligated to return to work status during vacation or holiday periods when school program is not in session.

  2. Employee participants are obligated to provide attendance and performance verification from training institution to their supervisor on a regular basis. If a problem arises the supervisor is to contact the Personnel Officer.

  3. The supervisor is committed to providing flexible work hours for the Case Management Certificate program participants to allow completing the approved academic program.

F. Program Termination.

  1. If for some unforeseen reason an individual is unable to maintain satisfactory progress in the program they would be allowed to return to their regular full-time position without penalty of disciplinary action related to participation in the Case Management Certificate Program.

  2. Case Management Certificate Program participants who terminate or drop out of the program prior to completing the program course work, shall be liable for repayment of any and all amounts equivalent to the paid time, and any monetary support provided by the Department while they were a Case Management Certificate Program participant plus interest at the legal rate. The repayment liability shall be deducted from their pay and/or retirement, or upon such terms as may be agreed upon in writing.

G. Program Completion.

  1. Following the completion of the Case Management Certificate Program, employee participant shall have a legally binding commitment to work for the Department for a period of time equal to the period to which educational time, and in some cases, financial assistance was granted (one academic year for one calendar year).

  2. Following the completion of the Case Management Certificate Program, the Department will make every effort to provide career promotional opportunities to successful participants.

3.   If following the successful completion of the Case Management Certificate Program, the employee participant terminates employment with the Department before completion of the required work commitment period, they shall repay upon demand or upon such terms as may be agreed upon in writing, an amount of the paid time and monetary support provided by the Department which is proportionate to the uncompleted term of the participant's employment obligation, with interest at the legal rate.

Approved by: _____
Mental Health Director

Attachments:
Case Management Certificate Program Guidelines (Attachment 1)
Case Management Certificate Program Application Form (Attachment 2)
Case Management Certificate Program Ranking Criteria (Attachment 3)
Case Management Certificate Program Participant Agreement (Attachment 4)

ATTACHMENT #6

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH

POLICY NO:	123-0
SUBJECT:	**TRANSLATION OF DOCUMENTS**
REFERENCES:	DMH Policy #123 – "Producing and Printing Department Publications for Public Dissemination"
FORMS:	Translation Request Form
EFFECTIVE DATE:	August 24, 2009

POLICY:

It is the policy of the Riverside County Department of Mental Health (RCDMH) that the following procedures be followed to provide standards and guidelines for translating documents, as well as ensure the quality, distribution and availability of translated informational materials, forms and any other written documents.

Translation is defined as the transmission of written communication from one language to another. All written information, forms, and documents created for consumers must be translated into Spanish, which is the state established threshold language for the county. All translated written information must follow translation standards.

PROCEDURES:

A. Processing Document(s) for Translation

    1. Clinic/Program staff develops or identifies material(s) to be translated.

    2. Research the Translation Drive (X: drive) to determine if the document has previously been translated for your use.

    3. The Clinic/Program bilingual staff shall complete the first translation if it is not available on the Translation Drive (X: drive).

Note: All RCDMH computer users have access to the translation Drive (X:drive). Contact Mental Health Support if you have difficulties accessing the X:drive.

4. Clinic/Program staff completes the Translation Request Form (Attachment A) and obtains supervisory approval.

5. Supervisors need to be aware of the following:

   a. Brochures/Pamphlets/Publications: All new or revised brochure(s), pamphlet(s), or publication(s) developed by the Riverside County Department of Mental Health and designed for distribution to the public shall be reviewed and approved by the Mental Health Director, and shall display the logo and name of the Riverside County Department of Mental Health and the name and title of the Mental Health Director.

   b. Individual consumer's letters that are written by program staff do not need to follow this translation procedure.

   c. The approved Translation Request Form is to be sent to the Cultural Competency Program with a copy of the English version of the document, and the first translation completed. A copy of the approved Translation Request Form shall also be provided to the authorizing supervisor/manager.

B. Timeframe for Processing Request

   1. The translation process will be completed within one month after the request has been received.

   2. Any flyers, small posters or one page documents will be translated or reviewed for proper translation, within five working days.

   3. Please indicate in the lower portion of the Translation Request Form the date the document is needed, if it is time sensitive.

   4. Expediting your request is top priority. The program supervisor/manager will be notified of any difficulties in completing the translation within the requested time frame.

C. Distribution of Translated Material(s)

   1. The final version of the translated material(s) will be provided to the requester, clinic or program, with a copy to the program manager.

2. A copy of all translated material(s) will be housed in the Translation Drive (X: drive), except for documents that contain confidential information.

Approved by: _____ Date: 8-24-01
                Mental Health Director
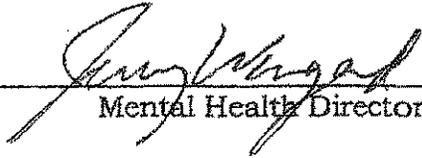
Attachment
Translation Request Form, Attachment A

TRANSLATION REQUEST FORM
(All translation request forms are to be sent electronically)

Date: _____

Requestor: _____

Worksite/Clinic/Program: _____ Telephone: _____

Title of Document: _____

Description of Translation Requested:

- ☐ Letter
- ☐ Informational Material
- ☐ Form (approved by the Forms Committee)
- ☐ Brochure (approved by the Mental Health Director)
- ☐ Other _____

Language Requested:

- ☐ English
- ☐ Spanish
- ☐ Other _____

Document Attached:

- ☐ English Version
- ☐ First Translation Draft Completed

For Supervisor's Only:

If this document is time sensitive, how soon do you need the translation? _____

Supervisor's Name: _____

Supervisor's Approval Date: _____

E-mail the authorized form, the document to be translated and the first translation to alrodriguez@rcmhd.org at the Cultural Competency Program, with a copy to the authorizing Manager/Supervisor.

ATTACHMENT #7

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT
By Occupational Category - page 1

Major Group and Positions (1)	Estimated # FTE authorized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)							# FTE filled (5)+(6)+(7)+(8)+(9)+(10) (11)
				White/Cau-casian (5)	His-panic/Latino (6)	African-Ameri-can/Black (7)	Asian/Pacific Islander (8)	Native Ameri-can (9)	Multi Race or Other (10)	Un-known	
Unlicensed Mental Health Direct Service Staff											
Mental Health Rehabilitation Specialist	158	0	235								
Case Manager/Service Coordinator	5.0	0	7								
Employment Services Staff	1	0	12								
Housing Services Staff	30	1	45								
Consumer Support Staff	41	1	61								
Family Member Support Staff											
Benefits/Eligibility Specialist	67	0	100								
Other *Unlicensed* MH Direct Service Staff											
Sub-total, A (County)	**302**	**2**	**460**	**48**	**71**	**26**	**2**	**3**	**72**		**222**
				(Unlicensed Mental Health Direct Service Staff, Sub-Totals Only)							
Mental Health Rehabilitation Specialist	220.5	0									
Case Manager/Service Coordinator	27	0									
Employment Services Staff	8	0									
Housing Services Staff	2.5	0									
Consumer Support Staff	16	0									
Family Member Support Staff	11.5	1									
Benefits/Eligibility Specialist	0.0	0									
Other *Unlicensed* MH Direct Service Staff	88	0									
Sub-total, A (All Other)	**373.5**	**1**		**123.4**	**95**	**80**	**25.3**	**4**	**14**	**7.5**	**349.1**
				(Unlicensed Mental Health Direct Service Staff, Sub-Totals and Total Only)							
Total, A (County & All Other):	**675.5**	**3**	**460**	**171.4**	**166**	**106**	**27.3**	**7**	**86**	**7.5**	**571.1**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

Major Group and Positions (1)	Esti-mated # FTE author-ized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce – Col. (11)							# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10) (11)
				White/ Cau-casian (5)	His-panic/ Latino (6)	African-Ameri-can/ Black (7)	Asian/ Pacific Islander (8)	Native Ameri-can (9)	Multi Race or Other (10)	Un-known	
B. Licensed Mental Health Staff (direct service)											
Psychiatrist, general	73.8	1	40								
Psychiatrist, child/adolescent	2	1	50								
Psychiatrist, geriatric		1	17								
Psychiatric or Family Nurse Practitioner		0									
Clinical Nurse Specialist		0									
Licensed Psychiatric Technician	3	0	4								
Licensed Clinical Psychologist	13	0	19								
Psychologist, registered intern (or waivered)		0									
Licensed Clinical Social Worker (LCSW)	54	1	80								
MSW, registered intern (or waivered)	33	0	49								
Marriage and Family Therapist (MFT)	52	1	77								
MFT registered intern (or waivered)	50	0	75								
Other *Licensed MH Staff (direct service)*		0		*(Licensed Mental Health Direct Service Staff, Sub-Totals Only)*							
Sub-total, B (County)	280.8	5	411	124.5	33.9	16	30.2	2.0	55.2		261.7
Psychiatrist, general	51.5	1									
Psychiatrist, child/adolescent		0									
Psychiatrist, geriatric		0									
Psychiatric or Family Nurse Practitioner		0									
Clinical Nurse Specialist		0									
Licensed Psychiatric Technician	33.8	0									
Licensed Clinical Psychologist	36	1	5								
Psychologist, registered intern (or waivered)	8	0									
Licensed Clinical Social Worker (LCSW)	35.5	1									
MSW, registered intern (or waivered)	26	0									
Marriage and Family Therapist (MFT)	81	1	2								
MFT registered intern (or waivered)	69.8	0									
Other *Licensed MH Staff (direct service)*		0		*(Licensed Mental Health Direct Service Staff, Sub-Totals and Total Only)*							
Sub-total, B (All Other)	341.5	4	7	137	23.3	39.5	4.5	0.0	3.5	106.5	314.3
Total, B (County & All Other):	622.3	9	418	261.5	57.1	55.5	34.7	2.0	58.7	106.5	576

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

Major Group and Positions (1)	Esti-mated # FTE author-ized (2)	Position hard to fill? 1=Yes' 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)							# FTE filled (5)+(6)+(7)+(8)+(9)+(10) (11)
				White/Cau-casian (5)	His-panic/Latino (6)	African-Ameri-can/Black (7)	Asian/Pacific Islander (8)	Native Ameri-can (9)	Multi Race or Other (10)	Un-known	
Other Health Care Staff (Direct Service)											
Physician	.5	0	1								
Registered Nurse	46	1	68.5								
Licensed Vocational Nurse	5	0	7.5								
Physician Assistant		0									
Occupational Therapist	2	0	3								
Other Therapist (e.g., physical, recreation, art, dance)		0									
Other Health Care Staff (direct service, to include traditional cultural healers)	3	0	4.5	(Other Health Care Staff, Direct Service; Sub-Totals Only)							
Sub-total, C (County)	56.5	1	84.5	14	2	4	2		24		46
Physician	2	1									
Registered Nurse	141.5	1									
Licensed Vocational Nurse	98	1									
Physician Assistant	1.2	1									
Occupational Therapist	5	1									
Other Therapist (e.g., physical, recreation, art, dance)	2	1									
Other Health Care Staff (direct service, to include traditional cultural healers)	88.5	1		(Other Health Care Staff, Direct Service; Sub-Totals and Total Only)							
Sub-total, C (All Other)	338.2	7	84.5	36.5	19.3	34.8	12.5		7	199.5	309.5
Total, C (County & All Other):	394.7	8	84.5	50.5	21.3	38.8	14.5		31	199.5	355.5

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions (1)	Esti-mated # FTE author-ized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	White/ Cau-casian (5)	Hispanic/ Latino (6)	African-Ameri-can/ Black (7)	Asian/ Pacific Islander (8)	Native Ameri-can (9)	Multi Race or Other (10)	Un-known	# FTE filled ((5)+(6)+(7)+(8)+(9)+(10)) (11)
D. Managerial and Supervisory											
CEO or manager above direct supervisor	22	1	7								
Supervising psychiatrist (or other physician)	1	1	2								
Licensed supervising clinician	56	1	59					(Managerial and Supervisory; Sub-Totals Only) ➡			
Other managers and supervisors	21	1	10								
Sub-total, D (County)	100	4	78	54	17	4	3		15		93
CEO or manager above direct supervisor	19	1									
Supervising psychiatrist (or other physician)		0									
Licensed supervising clinician	36.8	1						(Managerial and Supervisory; Sub-Totals and Total Only) ➡			
Other managers and supervisors	45	1									
Sub-total, D (All Other)	100.7	3		47.3	10	11			1.5	25.5	95.2
Total, D (County & All Other):	200.7	7	78	101.3	27	15	3		16.5	25.5	188.2
E. Support Staff (non-direct services)											
Analysts, tech support, quality assurance	42	1	62.6								
Education, training, research	9	1	13.4								
Clerical, secretary, administrative assistants	209	0	63.5					(Support Staff, Sub-Totals Only) ➡			
Other support staff (non-direct services)	6	0	8.9								
Sub-total, E (County)	266	2	148.4	70	76	34	9	2	50		241
Analysts, tech support, quality assurance	6	0									
Education, training, research		0									
Clerical, secretary, administrative assistants	105.6	1						(Support Staff, Sub-Totals and Total Only) ➡			
Other support staff (non-direct services)	80	0									
Sub-total, E (All Other)	191.6	1		38	45.8	11.5	1		1.5	81	178.8
Total, E (County & All Other):	457.6	3	148.4	108	121.8	45.5	10	2	51.5	81	419.8

Race/ethnicity of FTEs currently in the workforce — Col. (11)

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT
I. By Occupational Category - page 5

GRAND TOTAL WORKFORCE (A+B+C+D+E)

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	Race/ethnicity of FTEs currently in the workforce -- Col. (11)							# FTE filled ((5)+(6)+ (7)+(8)+ (9)+(10))
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	Un-known	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)		(11)
	1005.3	14	1181.9	310.5	199.9	84	46.2	7	216.2		863.7
	1345.5	16	7	382.1	193.3	176.8	43.3	4.0	27.5	420	1246.8
	2350.7	30	1189.9	692.5	393.1	260.8	89.5	11	243.7	420	2110.5

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						All individuals (5)+(6)+ (7)+(8)+ (9)+(10)
				White/ Cau-casion	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	Leave Col. 2, 3, & 4 blank			44.5%	33.8%	11.6%	2.2%	.6%	7.3%	100.0%

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. Positions Specifically Designated for Individuals with Consumer and Family Member Experience:

Major Group and Positions (1)	# FTE authorized and to be filled by clients or family members Estimated (2)	Position hard to fill with clients or family members? (1=Yes; 0=No) (3)	# additional client or family member FTEs estimated to meet need (4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff	30	1	45
Family Member Support Staff	41	1	61
Other *Unlicensed* MH Direct Service Staff			
Sub-Total, A:	71	2	106
B. *Licensed* Mental Health Staff (direct service)			
C. Other Health Care Staff (direct service)			
D. Managerial and Supervisory	3	1	4.5
E. Support Staff (non-direct services)			
GRAND TOTAL (A+B+C+D+E)	74	3	110.5

III. LANGUAGE PROFICIENCY

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the language, (3) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3):

Language, other than English (1)	Number who are proficient (2)	Additional number who need to be proficient (3)	TOTAL (2)+(3) (4)
1. Spanish	Direct Service Staff 275 Others 111	Direct Service Staff 13 Others _____	Direct Service Staff 288 Others 111
2. Vietnamese	Direct Service Staff 5 Others 2	Direct Service Staff _____ Others _____	Direct Service Staff 5 Others 2
3. Tagalog	Direct Service Staff 26 Others 4	Direct Service Staff _____ Others _____	Direct Service Staff 26 Others 4
4. Chinese	Direct Service Staff 5 Others _____	Direct Service Staff _____ Others _____	Direct Service Staff 5 Others _____
5. Korean	Direct Service Staff 2 Others 1	Direct Service Staff _____ Others _____	Direct Service Staff 2 Others 1

IV. REMARKS: Provide a brief listing of any significant shortfalls that have surfaced in the analysis of data provided in sections I, II, and/or III. Include any sub-sets of shortfalls or disparities that are not apparent in the categories listed, such as sub-sets within occupations, racial/ethnic groups, special populations, and unserved or underserved communities.

Riverside County Demographics (United States Census Data, 2006)

Total Population: 2,026,803

Caucasian/European Origin: 43%   Latino/Hispanic: 42%   African-American/Black: 6%

Asian/Pacific Islander: 5%   Native American: .5%   Other: 4%

Exhibit 3 Methodology Described Below:

RCDMH Personnel: Existing Human Resources data was utilized to ascertain: (1) employees' voluntary ethnic identity report at time of hire, and (2) staff linguistic skill as indicated by number of employees receiving bilingual pay. This data was augmented using a brief, electronic survey of all Department staff. This staff survey response was 80%.

Network Providers: Network providers are a combination of individual and small group providers. RCDMH maintains data on our network providers reported ethnicities and linguistic skills. This existing system data was augmented using a paper survey and telephone follow-up.

Contract Providers: These providers were surveyed by standard mail, electronic mail, and telephone. Our contract providers were grouped into three categories: (1) IMD/Acute Care – 4 providers; (2) Therapeutic Behavioral Service – 5 providers; and, (3) Community Based Organizations that provide direct service – 8 providers. We received responses from all contractors.

Summary: The Grand Total Workforce is located on page 9. It is noted that some Network and Contract Provider staff declined to provide ethnicity for the survey. These provider staff ethnicities were recorded in an additional 7th race/ethnicity category called "Unknown". Column 4, "# FTE estimated to meet need in addition to # FTE authorized," was obtained by looking at the prevalence of acute mental illness of persons who are at 200% of poverty line and below. We applied current caseload standards to these estimated numbers to determine the estimated number of additional staff needed. Contractors were asked how many additional staff they anticipate needing. Their responses are recorded on Workforce Needs Assessment.

IV. REMARKS (continued)

A. Shortages by occupational category:

In *Unlicensed Mental Health Direct Service Staff* positions, we have shortages in Peer Support Specialist and Parent Partner positions as indicated by a high turnover rate. Family Advocate positions are difficult to recruit. In *Licensed Mental Health Staff (direct service)* positions, we have found it difficult to recruit psychiatrists in our Mid-County and Desert Regions. The difficulty increases county-wide when we recruit for psychiatrists who are certified to treat children/adolescents and older adults. We also experience difficulty in recruiting and retaining LCSW and MFT therapists across the county. This is the highest category of vacant positions. This difficulty is more pronounced in our Mid-County and Desert Regions. Our shortage is exacerbated by the potential retirement of our aging workforce. Thirty-nine percent of our staff is over the age of 50.

In *Support Staff (non-direct Service)*, we have difficulty in recruiting and retaining Analysts, Accountants, and Research staff.

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services:

RCDMH's current client population served is: 44% Caucasian/European origin; 34% Latino/Hispanic; 12% African-American/Black; and, 7.3 identified as "other." All other ethnic groups are 2% or less of our current population served. Our total professional clinical staff (Clinical Therapist I and II) is 55% Caucasian/European origin, 17% Latino/Hispanic, and 7% African-American/Black. Greater diversity is seen in our licensed-waivered (Clinical Therapist I) staff: 44% Caucasian/European origin; 27% Latino/Hispanic; and, 9% African-American/Black. We need to continue to support our licensed-waivered staff to become licensed to build the diversity of our workforce. This is especially important when considering the anticipated retirement of our aging workforce.

Our paraprofessional direct service staff is 18% Caucasian/European origin, 30% Latino/Hispanic, and 14% African-American/Black.

C. Positions designated for individuals with consumer and/or family member experience:

RCDMH currently has 71 authorized positions designated for consumers and family members. These positions are classified as Mental Health Peer Support Specialists and serve as consumer peers, parent partners, and family advocates. There is a designated career track for this classification that begins in a trainee position and advances through to a managerial peer planning position. The number of staff in these positions is expected to grow with further program development under MHSA. It is also important to note that we have employees who have consumer and family member experience within our department staff in positions that are not specifically designated for consumers or family members.

Two of our Contract Providers report having designated positions for consumers and family members. The remainder has none. It is an area that requires continued work.

IV. REMARKS (continued)

D. Language proficiency:

Our threshold language is Spanish. According to a 3-year average of the American Community Survey United States Census statistics on languages spoken in Riverside County, 15% of Riverside County's total population reported they speak Spanish and either do not speak English or do not speak English very well. RCDMH has made concerted efforts to increase the capacity of our bilingual staff. The percentage of our direct and support staff with Bilingual/Spanish proficiency is: 31% Support staff; 38% Paraprofessional staff; 30% Clinical Therapist I (licensed-waivered) staff; and, 9% Clinical Therapist II (licensed) staff. We need to continue to support our licensed-waivered staff to become licensed and to nurture our paraprofessional and support staff into pathways that lead to licensure.

E. Other, miscellaneous:

It is noted that our professional workforce is primarily female. There is a need to encourage and recruit men into our professional positions.

ATTACHMENT #8

FY 2010/2011
AGREEMENT RENEWAL
BETWEEN
COUNTY OF RIVERSIDE AND
(MENTAL HEALTH CONTRACTOR NAME)

That certain agreement between the County of Riverside (COUNTY) and

_____ (CONTRACTOR) originally approved by the Board of Supervisors on

_____, Agenda Item _____ for FY _____; renewed by the Riverside

County Purchasing Agent (or **Board of Supervisors if applicable**) on _____ for FY

2008/2009; renewed by the Purchasing Agent on _____ for FY 2009/2010; is hereby

renewed again for FY 2010/2011, effective July 1, 2010 and shall continue to June 30, 2011.

That certain agreement is modified as follows:

1. Section VI-ADMINISTRATIVE CHANGE STATUS is modified as follows:

Add lettering system to paragraphs and current paragraph now becomes paragraph "a".

Add subparagraph "b." as follows:

"b. CONTRACTOR is responsible for providing to the COUNTY, annually, at the beginning of

each fiscal year and upon execution of the CONTRACTOR'S agreement, emergency and/or after

hour contact information for the CONTRACTOR'S organization. CONTRACTOR emergency

and/or after hour contact information shall include, but is not limited to, first and last name of

emergency and/or after hour contact, telephone number, cellular phone number, and applicable

address(s). CONTRACTOR shall provide this information to the COUNTY at the same time the

CONTRACTOR provides the COUNTY with annual insurance renewals and/or changes to

insurance coverage."

Add subparagraph "c" as follows:

"c. CONTRACTOR shall be responsible for updating this information, immediately and in

writing, when changes in CONTRACTOR'S emergency and/or after contact information happens

during the fiscal year or prior to the end of the fiscal year. Written CONTRACTOR updates of

this information shall be provided to the COUNTY in accordance with Section XXXIII-Notices

of this agreement."

-1-

2. Section XVI-REPORTS is modified as follows:

Delete existing paragraph "B." and replace with the new paragraph "B." as follows:

"B. CONTRACTOR shall provide the COUNTY with applicable reporting documentation as specified and/or required by the COUNTY, State Department of Mental Health and Federal guidelines. COUNTY may provide additional instructions on reporting requirements.

3. Section XX-STAFFING is modified as follows:

Add paragraph "H." as follows:

"H. CONTRACTOR shall follow all Federal, State and County policies, laws and regulations regarding Staffing and/or Employee compensation. CONTRACTOR shall not pay or compensate any of its Staff, Personnel or Employees by means of cash. All payments or compensation made to CONTRACTOR Staff, Personnel and/or Employees in association with the fulfillment of this agreement shall be made by means of Staff, Personnel and/or Employee Certified Payroll only.

4. Section XXI-CULTURAL COMPENTENCY

Add new subparagraph "1." to paragraph A. as follows:

"1. CONTRACTOR agrees to comply with the COUNTY'S Cultural Competency Plan as set forth in the Board of Supervisors approved Cultural Competency Plan. The Cultural Competency Plan may be obtained from the COUNTY'S website at www.mentalhealth.co.riverside.us or by contacting the COUNTY'S Cultural Competency Manager or designee upon written request via certified mail or facsimile to:

Riverside County Department of Mental Health Cultural Competency Program

P.O. Box 7549

Riverside, California 92513

Attention: Cultural Competency Manager

Fax: 951-358-4792"

Add new subparagraph "2." to paragraph A. as follows:

"2. CONTRACTOR agrees to meet with COUNTY'S Cultural Competency Program Manager, as needed by the CONTRACTOR and as coordinated by the COUNTY, to determine and implement cultural competency activities that shall include, but is not limited to, compliance with the

cultural competency requirements outlined in Section XXI of this agreement."

Add new subparagraph "3." to paragraph A. as follows:

"3. COUNTY will provide technical assistance to CONTRACTOR in the areas of cultural competency as needed and requested by CONTRACTOR."

Add new subparagraph "4." to paragraph A. as follows:

"4. CONTRACTOR will be responsible for participating in cultural competency trainings as required by the COUNTY'S Cultural Competency Plan. The following is a partial list of annual cultural competency trainings and topics that may be available through the COUNTY to assist CONTRACTORS with meeting training requirements though capacity will be limited: Cultural Formulation; Multicultural Knowledge; Cultural Sensitivity; Cultural Awareness; Social/Cultural Diversity; Mental Health Interpreter Training; Training Staff in the use of Mental Health Interpreters; Training in the Use of Interpreters in the Mental Health Setting. In order to attend the COUNTY offered trainings, CONTRACTOR must contact the Cultural Competency Manager at the contact information location in subparagraph 1 of paragraph A. in Section XXI-CULTURAL COMPENTENCY."

Add subparagraph "5." to paragraph A. as follows:

"5. CONTRACTOR will be responsible for reporting back to the COUNTY annually in writing all cultural competency related trainings that staff members have taken. The following format is recommended:

Name of Training Event	Description of Training	How long and how often attended	Attendance by Service Function	No. of Attendees and Total	Date of Training	Name of Presenter
Example: Cultural Competence Introduction	Overview of cultural competence issues in mental health treatment settings.	Four hours annually	*Direct Services *Direct Services Contractors *Administration *Interpreters	15 20 4 2 Total: 41	1/21/10	John Doe

CONTRACTOR training information shall be submitted via facsimile to 951-358-6924 to the attention of the COUNTY Cultural Competency Program Manager on or before June 30 of each fiscal year."

-3-

Add subparagraph "6." to paragraph A. as follows:

"6. CONTRACTOR is responsible for notifying the COUNTY Cultural Competency Program Manager in writing if the June 30th deadline can not be met. CONTRACTOR will be responsible for requesting an extension from the COUNTY'S Cultural Competency Program Manager. All requests for extensions must be put in writing and mailed or faxed to the COUNTY'S Cultural Competency Program Manager at the contact information listed herein."

5. Section XXIX-TERMINATION PROVISIONS: is modified as follows:

Re-letter paragraph "I" to read paragraph "J".

Add a new paragraph "I" as follows:

"I. In instances where the CONTRACTOR agreement is terminated and/or allowed to expire by the COUNTY and not renewed for a subsequent fiscal year, COUNTY reserves the right to enter into settlement talks with the CONTRACTOR in order to resolve any remaining and/or outstanding contractual issues, including but not limited to, financials, services, billing, cost report, etc. In such instances of settlement and/or litigation, CONTRACTOR will be solely responsible for associated costs for their organizations legal process pertaining to these matters including, but not limited to, legal fees, documentation copies, and legal representatives. CONTRACTOR further understands that if settlement agreements are entered into in association with this agreement, the COUNTY reserves the right to collect interest on any outstanding amount that is owed by the CONTRACTOR back to the COUNTY at a rate of no less than 5% of the balance."

6. Rescind the previous Exhibit C in its entirety and replace it with the new, attached Exhibit C in which the COUNTY'S Maximum Obligation to the CONTRACTOR is (increased or decreased) from _____ to _____ for FY 2010/2011.

7. Rescind the previous Schedule I in its entirety and replace it with the new, attached Schedule I for FY 2010/2011.

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1   All other provisions of this entire Agreement shall remain unchanged and in full force and effect.

2   **IN WITNESS WHEREOF**, the Parties hereto have caused their duly authorized representatives

3   to execute this amendment.

4   <u>COUNTY ADDRESS:</u>   <u>INFORMATION COPY:</u>

5   County of Riverside   County of Riverside

     Board of Supervisors   Department of Mental Health

6   4080 Lemon Street, 5th Floor   P.O. Box 7549

7   Riverside, CA 92501   Riverside, CA 92503-7549

8   **CONTRACTOR:**   **COUNTY OF RIVERSIDE:**

9

10   Signed:_____

11   Purchasing Agent

    Date:_____   County of Riverside

12

13   Title:_____   Date:_____

    Address:

14

15   **COUNTY COUNSEL:**

16   Pamela J. Walls

    Approved as to Form

17

18   By:_____

        Deputy County Counsel

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20   Rev. 05/17/10 stl

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<u>Training</u>

— Introduce CCPR

— Review Contract Responsibility
Section XXI.

-5-

ATTACHMENT #9

WESTERN CHILDREN

AGENCY	MAIL ADDRESS	OFFICE ADDRESS	PHONE	FAX	CONTACT	TYPES OF SERVICE PROVIDED
CAROLYN E. WYLIE CENTER	4164 Brockton Ave., 1st Floor Riverside, CA 92501	4164 Brockton Ave., 1st Floor Riverside, CA 92501	951-683-5193	951-683-4819	Melody Auvenal, CEO	Provide therapeutic services for children with exceptional needs who have emotional/ behavioral problems and may also have developmentally delayed. The Wylie Center also provides in-home outpatient services to emotionally disturbed children, ages 2 - 5, one-on-one and one-on-one supervision.
FSA - MORENO VALLEY	21250 Box Springs Road, Ste 212 Moreno Valley, CA 92557	21250 Box Springs Road, Ste 212 Moreno Valley, CA 92557	951-686-3706	951-686-5382	Maria Martin Contract Manager	Provides outpatient services to indigent and Medi-Cal eligible clients. Collateral services are performed in person or by telephone. Therapeutic telephone contacts are reportable for Collateral and individual therapy are Medi-Cal reimbursed if the client needs medical necessity.
FSA - La Sierra	11200 Pierce St Riverside, CA 92505	11200 Pierce St Riverside, CA 92505	951-685-1096	951-685-5392	Susan Mela	Provides outpatient services to indigent and Medi-Cal eligible clients. Collateral services are performed in person or by telephone. Therapeutic telephone contacts are reportable for Collateral and individual therapy are Medi-Cal reimbursed if the client needs medical necessity.
OLIVECREST (FREDDY HANDLING) (Wraparound)	3050 Chicago Ave Riverside, CA 92507	3050 Chicago Ave Riverside, CA 92507	951-686-4500	951-686-8565	Jeanne Smith	Provides Education, Foster care Services, Emergency Shelter Care, Intensive Treatment Foster Care, Wraparound
VICTOR COMMUNITY SUPPORT - FAST	1996 Business Center Dr San Bernardino, CA 92408	13351 Riverside Drive Ste. I Lake Elsinore CA 92507	530-230-1230	951-600-6630	Paula Quijano, Executive Director	Provides intensive, short-term in-home mental health interventions for children with severe emotional disturbances and their families with recent psychiatric hospitalization or at-risk of institutional care. All recipients of services are Medi-Cal eligible, and services include intake, evaluation, diagnosis, crisis intervention, case management, treatment planning, therapy, medication and discharge planning
VICTOR COMMUNITY LAKE ELSINORE	P.O.Box 5381 Chico, CA 95927	13351 Riverside Drive Ste. I Lake Elsinore CA 92507	530-230-1230	951-600-5854	Paula Quijano, Executive Director	Provides intensive, short-term in-home mental health interventions for children with severe emotional disturbances and their families with recent psychiatric hospitalization or at-risk of institutional care. All recipients of services are Medi-Cal eligible, and services include intake, evaluation, diagnosis, crisis intervention, case management, treatment planning, therapy, medication and discharge planning
VICTOR TREATMENT CENTER (Group Home)	P.O.Box 1361 Chico, CA 95927	3164 Condo Court Santa Rosa, CA 95401	707-360-1824	707-360-1805	Kris Roozen	RCL 14 Program Services and Structure, Psychiatric Care & Evaluations,Medication Therapy Psychotherapy (Individual, Family & Group) Vocational Programs

MID-COUNTY

ORGANIZATION	MAILING ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT	0-5	YOUTH	CHILDREN	TEEN	AFRICAN AMERICAN	TAGALOG	HISPANIC	ASIAN PACIFIC ISLAND	GAY	BISEXUAL	LGBT	HANDICAP ACCESSIBLE	OTHER	TYPE OF SERVICES PROVIDED	SERVICES
AMERICAN INDIAN HEALTH AND SERVICES (PHOENIX COUNCIL)	1850 Gateway Blvd, Suite # 300, Concord, CA 94520	1215 Buena Vista, San Jacinto CA 92583	925-825-1730	925-674-9109	Christopher Wilcox, Director of Operations	X	X	X	X	X	X	X	X	X	X	X	X		Student Volunteering, Prison Pen network, Holiday Program, The Week of Caring, Disaster Response, Welcome Infrastructure
VICTOR COMMUNITY SUPPORT SERVICES, INC	2351 California Park Drive Chico CA 95928	31631 Riverside Drive, Suite L, Lake Elsinore CA 92530	951-674-9243	951-674-9535	Paula Cuperus, Executive Director				X	X	X	X	X	X	X	X			Provide full service partnership to Transition Age Youth Mid Co
VIP Inc	41915 Acacia Ave, Hemet, CA 92544	41915 Acacia Ave, Hemet CA 92544	951-929-8565	951-925-0268	Jason Hermsmeier, Executive Director			X		X	X	X	X	X	X		X		Provide therapeutic services for children aged 0-5 with exceptions, needs who are not eligible to receive services from the Regional Center or public schools. VIP also provides In-Home support services for emotionally disturbed minors and one-on-one supervision services, including those who have emotional/behavioral problems

DESERT

CONTRACTOR	MAILING ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT	MEN	WOMEN	CHILDREN	TEENS	AFRICAN AMERICAN	CAUCASIAN	HISPANIC	ASIAN PACIFIC ISLAND	DEAF	BILINGUAL	LGBT	HANDICAP ACCESSIBLE	OTHER	TYPES OF SERVICES PROVIDED
Aztra Behavioral Health, CRT	1850 Gateway Blvd Suite #300 Concord, CA 94520	47-815 Oasis St Indio, CA 92201	925-825-4700	831-663-6624	Dan Cox Vice President	x	x			x	x	x	x		o	x	x		15 Day Crisis Residential Treatment - MHSA Funded
Desert Morning Glory, Inc.	82-465 Miles Ave. Indio, CA 92201	82-465 Miles Ave. Indio, CA 92201	760-347-4347	760-342-7839	Tom Fee	x	x			x	x	x	x		o	x	x		Adult Board And Care Will Not Have Prof Service Agreement in FY FD11
Oasis Rehabilitation Center, TAY	7677 Oakport St Suite 1010 Oakland, CA 94621	47-815 Oasis St Indio, CA 94621	510-836-8700	510-555-8718 760-863-6803	Mary Jane Gross Administrator				x	x	x	x	x		o	x	x		Full Service Partnership - MHSA Funded

HOUSING

CONTRACTOR	MAILING ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT											CLIENTS	TYPE OF SERVICE PROVIDED
JEFFERSON TRANSITIONAL - SAFEHAVEN RIVERSIDE	3839 Brockton Ave Riverside, CA 92501	16531 McLand Street Palm Springs, CA 92262	951-686-5484	951-686-8830	Sue Moreland CEO	x	x			x	x	x	x	x	x	Homeless	Drop In / Permanent Shelter
JEFFERSON TRANSITIONAL - SAFEHAVEN DESERT	3839 Brockton Ave Riverside, CA 92501	16531 McLand Street Palm Springs, CA 92262	951-686-5484	951-686-8830	Sue Moreland CEO	x	x			x	x	x	x	x	x	Homeless	Drop In / Permanent Shelter

ADMINISTRATION

CONTRACTOR	MAILING ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT															TYPE OF SERVICES RENDERED
CLAREMONT GRADUATE SCHOOL	160 E. Tenth Street Claremont, CA 91711	160 E. Tenth Street Claremont, CA 91711	909-621-8085	909-621-8390	Dean Gerstein PHD															Research and Consultation Services.
ECHO CONSULTING	P.O. Box 2150 Conway, NH 03818	519 17th St. Suite 400 Oakland, CA 94612	510-238-2727	510-447-8680	David Allen	Not Applicable														IT Consulting
INFOSEC	101 W. Elm Street, Ste. G10 Conshohocken, PA 19428	101 W. Elm Street, Ste. G10 Conshohocken, PA 19428	484-530-0100	484-530-0111	Angela Madisera															IT Consulting
Havenstick Foster Family	P.O.Box 1168 Moreno Valley, CA 92556	13800 Heacock St, Suite D-117 Moreno Valley, CA 92553	951-488-8064	951-185-0278	Bronson Rees															Not in Administration contract.

CRISIS HOSPITAL

CONTRACTOR	MAILING ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT	MEN	WOMEN	CHILDREN	TEENS	SPOKEN/WRITTEN VIETNAMESE	CAMBODIAN	HISPANIC	ASIAN PACIFIC ISLAND	DEAF	BILINGUAL	LGBT	HANDICAP ACCESSIBLE	OTHER	TYPE OF SERVICE PROVIDED
Area Sprl Clinic	2467 Euclid Street, Los Angeles, CA 90002	2467 Euclid Street, Los Angeles, CA 90002	323-721-5177	323-721-5692	Chris Birchak, Treatment Director	x	x			x	x	x	x	x	x		x		Board & Care – Schizophrenia
Area Behavioral Health – ART	1860 Gateway Blvd., Suite #500, Concord, CA 94520	2100 South Gate Blvd., Merced, CA 92343	925-825-4700	925-818-3810	Chris Weiner	x	x			x	x	x	x	x	x		x		Adult Residential Treatment (ART)
Area Behavioral Health – CRT	1860 Gateway Blvd., Suite #500, Concord, CA 94520	2650 Pacific Ave, Riverside, CA 92503	925-825-4700	925-825-3810	Paul Carwell, VP Program Services	x	x			x	x	x	x	x	x		x		Crisis Residential Treatment (CRT)
Casady Vista	4541 Palm Avenue, Riverside, CA 92501	4541 Palm Avenue, Riverside, CA 92501	951-684-4701	951-684-2029	Anne Mankelow, Administrator	x	x			x	x	x	x	x	x		x		Institution for Mental Disease (IMD)
Crestwood Behavioral Health	520 Capitol Mall, Suite #800, Sacramento, CA 95814	520 Capitol Mall, Suite #800, Sacramento, CA 95814	916-471-2244	916-471-2272	Gary Zeyen, Controller	x	x			x	x	x	x	x	x		x		Mental Health Rehabilitation Center (MHRC) & Adult Residential Treatment (ART)
Canonica Medical Services	3200 North Garey Ave, Pomona, CA 91767	3200 North Garey Ave, Pomona, CA 91767	909-593-2895	909-593-4130	Rosemary Clemons Way, Administrator	x	x			x	x	x	x	x	x		x		Institution for Mental Disease (IMD)
National Council on Crime & Delinquency	426 South Yellowstone Drive, Suite #250, Madison, WI 53719	426 South Yellowstone Drive, Suite #250, Madison, WI 53719	608-831-8882	608-831-6446	Dan Pauline	x	x		x	x	x	x	x	x	x		x		Research & Training
Quail Rehabilitation Center	7677 Oakport Street, Suite #1040, Oakland, CA 94621	47 815 Oasis Street, Indio, CA 92201	510-808-9705	510-615-9166	Stephen Klimara	x	x			x	x	x	x	x	x		x		Psychiatric Health Facility (PHF) & Crisis Stabilization (CSU)
Sharon Hts Rehabilitation	4184 North 4th Avenue, San Bernardino, CA 92407	4184 North 4th Avenue, San Bernardino, CA 92407	909-886-6706	909-886-0963	Mila Gozzia	x	x			x	x	x	x	x	x		x		Institution for Mental Disease (IMD)
Sunny Vista	16601 Von Karman Ave, Suite 640, Irvine, CA 92612	3425 E. Raymond Ave, Highland, CA 92346	800-627-1021	909-862-6474	Michael Olesla	x	x			x	x	x	x	x	x		x		Institution for Mental Disease (IMD)
Sylmar Health & Rehabilitation Center	12209 Foothill Blvd, Sylmar, CA 91342	12209 Foothill Blvd, Sylmar, CA 91342	818-834-5882	818-834-5881	Dan Getakol, Program Director	x	x			x	x	x	x	x	x		x		Skilled Nursing Facility
Telecare Corporation	1080 Marina Village Parkway, Suite 100, Alameda, CA 94501	11546 Greenwood Drive, Riverside, CA 92505	800-977-7771	510-337-7950	Faye G. Paterson, Vice President of Development	x	x			x	x	x	x	x	x		x		Adult Residential Treatment (ART)
Valueto Workforce	5216 South Marina Pacifica Drive, Bldg #16, Long Beach, CA 90803	5216 South Marina Pacifica Drive, Bldg #16, Long Beach, CA 90803	562-598-9905	562-919-8060	Veronica Mortensen	x	x			x	x	x	x	x	x		x		Consulting, Research & Program Management
Vista Point Rehabilitation Center	3000 Westwood Blvd, Vista, CA 92083	3000 Westwood Blvd, Vista, CA 92083	760-630-2273	760-631-4913	Ana Cook, Executive Director	x	x			x	x	x	x	x	x		x		Skilled Nursing Facility
Vista Pacifica Enterprises, Inc	2674 Pacific Avenue, Riverside, CA 92509	2674 Pacific Avenue, Riverside, CA 92509	951-682-4833	951-682-1570	Deborah Davis, Administrator	x	x			x	x	x	x	x	x		x		Institution for Mental Disease (IMD)

CHILDRENS

CONTRACTOR	MAILING ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT	...	TYPE OF SERVICE PROVIDED
Chestnut, Inc.	205 South 24th Street, Quincy, IL 62301	205 South 24th Street, Quincy, IL 62301	217-222-0094	217-223-3625	Ardyth Friley, Director of Development Marketing		Group Home/Residential
CHARLEE Family Care	135 E. Sixth Street, Beaumont, CA 92223	135 E. Sixth Street, Beaumont, CA 92223	951-845-1036	951-845-3544	Richard Rice		TBS
Citrus Youth Center	714 West Main Street, Grass Valley, CA 95949	10071 Commute Rd, Grass Valley, CA 95949	530-477-1800	530-477-0800	Sidney Houston		Group Home/Residential
Clearwood Hill	770 East George Blvd, St. George, UT 84770	770 East George Blvd, St. George, UT 84770	435-674-1394	435-674-0114	Amber Abdis, Administration Director		Group Home/Residential
Colorado Boys Ranch	P.O. Box 681, La Junta, CO 81050	28071 Highway 109, La Junta, CO 81050	719-384-0021	719-341-0470	Charles Thompson, President		Group Home/Residential
Devereux Residents	3038 Butler Road, Malvern, TX 77578	3038 Butler Road, Malvern, TX 77578	281-489-0977 ext 045	281-489-0167	C.M. Beck		Group Home/Residential
Devereux Treatment Florida	5900 J.G. Lee Blvd, Orlando, FL 32822	8000 Devereux Drive, Viera, FL 32940	407-354-4034	407-251-1267	Karie Bonati		Group Home/Residential
Devereux Texas Network	1150 Devereux Drive, League City, TX 77573	1150 Devereux Drive, League City, TX 77573	281-335-1000	281-332-2301	Penny Albrex, Contract Specialist		Group Home/Residential
Excelsior	1501 E. Oxford Ave, Aurora, CO 80014	1501 E. Oxford Ave, Aurora, CO 80014	303-726-0700	303-693-8008	Tracy Hoffman, Admissions Director		Group Home/Residential
Families First, Inc.	2100 Fifth Street, Davis, CA 95618	2100 Fifth Street, Davis, CA 95618	530-753-0188	530-746-4372	Sharmon Bellencourt, Program Manager		Group Home/Residential
Family & West	426 Bryant Circle, Ste. C, Ojai, CA 93023	426 Bryant Circle, Ste. C, Ojai, CA 93023	805-640-2240	805-640-3340	Sharon Vela		LEGAL
Hillview Acres, Inc.	3880 Chino Avenue, Chino, CA 91710-4719	3880 Chino Avenue, Chino, CA 91710-4719	909-628-1772	909-627-1040	Rod Stone, Executive Director		TBS
Koinonia Foundation - Highlands	950 "O" S. Santa Fe 950, Vista, CA 92084	30031 County Farm Road, Riverside, CA 92531	951-342-2536	951-729-3003	Michele Richey, Administrator		Group Home/Residential
Milhous Children Services, Inc.	24037 State Hwy 49, Nevada City, CA 95959	24037 State Hwy 49, Nevada City, CA 95959	530-265-9057	530-292-3820	Dan Petre		Group Home/Residential
New Haven Youth & Family	216 N. Los Angeles Drive, Vista, CA 92083	216 N. Los Angeles Drive, Vista, CA 92083	760-630-4125	760-630-4025	Donna Oldan, Director		TBS
Oasis Rehabilitation Center	7677 Oakport Street, Suite 1040, Oakland, CA 94621	51840 Avenue 46 Ste. 201, Oakland, CA 94621	510-635-5705	510-635-0745	Stephen Albrecht, Administrator		Marketing
Pacific Clinics	800 S. Santa Anita Avenue, Arcadia, CA 91006-4000	603 S. El Cino #1, Palm Springs, CA 92262-9757	626-254-5000	626-254-1077	Susan Mandel, CEO		TBS
Providence Behavioral Health	1475 N Palm Ave, Suite 107, Fresno, CA 93711	63 E. Shaw Ave, Suite 50, Fresno, CA 93711	559-490-1437	559-490-0539	Lisa Reagan, CEO		TBS
Rose Oak Center for Children, Inc.	5030 El Camino Ave, Carmichael, CA 95608	5030 El Camino Ave, Carmichael, CA 95608	916-609-5147	916-609-5167	Kelly Schiele, Division Director		TBS
San Diego Center for Children	3002 Armstrong Street, San Diego, CA 92111	3002 Armstrong Street, San Diego, CA 92111	858-277-9550	858-279-3253	Pamela Harman, Director		Group Home/Residential
Seneca Center	2275 Arlington Drive, San Leandro, CA 94578	1034 Oak Grove Road, Concord, CA 94518	510-317-1444	510-317-1443	Katherine West, Executive Director		Group Home/Residential
Star View Adolescent Center	1501 Hopper Way, Ste. 160, Long Beach, CA 90810	4025 W. 226th Street, Torrance, CA 90505	310-537-4556	310-925-2984	Kurt Dunlap, VP of Operations		Group Home/Residential
Stanbridge Residential Rehabilitation Center	420 W. 14th Street, Long Beach, CA 90013	5030 E. 14th Street, Long Beach, CA 90013	562-981-4384	562-981-4352	Dan Theone, Director		Group Home/Residential
TLC Consultants, Inc.	1163 Olive St, Eugene, CA 97401	1163 Olive St, Eugene, CA 97401	541-345-2395 ext. 234	541-345-2794	Gerald Bowman		Training/Staff
United Advocates for Children of CA	2035 Hurley Way, Suite 290, Sacramento, CA 95825	2035 Hurley Way, Suite 290, Sacramento, CA 95825	916-543-1530	916-543-1524	Oscar Wright, CEO		Training/Conference for Parents
Unity Care Group, Inc.	297 Rock Street, San Jose, CA 95126	897 Hamilton Road, Selma, CA 93607	408-510-3240	408-421-6800	Andre Chapman, Executive Director		Group Home/Residential
Vista Community Support Services, Inc.	1908 Business Center Drive, San Bernardino, CA 92408	2201 California Park Drive, Chino, CA 92253	530-720-1235	951-680-5056	Paula Gilbert, Executive Director		TBS
Vista Treatment Center	P.O. Box 381, Chino, CA 92627	2661 California Park Drive, Chino, CA 92505	530-883-0235	530-883-0202	David Moreno, Controller		Group Home/Residential
Vista Del Mar Child and Family Services	3200 Motor Avenue, Los Angeles, CA 90034	3200 Motor Avenue, Los Angeles, CA 90034	310-836-1227 ext. 458	310-836-1431	Amy Jefe, Senior VP Operations		Group Home/Residential

MHSA

Contractor	Mailing Address	Site Address	Phone	Fax	Contact													Other	Types of Services Provided
Aces Biobehavioral Health - ART	1850 Gateway Blvd, Suite #900 Concord, CA 94520	2100 South State Street Hemet, CA 92543	925-825-4700	925-825-2610	Chris Wayne	x	x					x	x	x	x	x	x		Acute Residential Treatment (ART)
Aces Biobehavioral Health - CRT	1850 Gateway Blvd, Suite #900 Concord, CA 94520	3686 Pacific Ave Riverside, CA 92509	925-825-4700	925-825-2610	Paul Carretti VP Program Services/I	x	x				x	x	x	x	x	x	x		Crisis Residential Treatment (CRT)
California Institute of Mental Health (CiMH)	2125 19th Street, 2nd Floor Sacramento, CA 95818	2125 19th Street, 2nd Floor Sacramento, CA 95818	916-556-3480	916-446-4519	Sandra Goodwin CEO	x	x				x	x	x	x	x	x	x		Training, Technical Assistance, Conferences mostly for Mental Health Programs and Professionals
Carnegie Charities	1450 North D Street San Bernardino, CA 92405	1450 North D Street San Bernardino, CA 92405	760-388-5101	909-384-1130	Devon Singh Department Director	x	x				x	x	x	x	x	x	x	Faith Based Groups	Caregiver Training
Jefferson Transl. Program Western Peer Ctr/Riv Mtl County	2031 N 5th St, Suite 216 Phoenix, AZ 85006	3686 Brockton Avenue Riverside, CA 92501	951-686-5484	951-686-5630	Sue Moreland CEO	x	x				x	x	x	x	x	x	x		Peer Support and Resource Service Centers
Jefferson Transl. Program - Workforce & Education TA	3636 Brockton Avenue Riverside, CA 92501	3636 Brockton Avenue Riverside, CA 92501	951-686-5484	951-686-5630	Sue Moreland	x	x				x	x	x	x	x	x	x		Peer Employment Training, WRAP Training, Consumer Input Into Mtl System
Oasis - Peer Center	7637 Oakport Street, Suite 1010 Oakland, CA 94621	7637 Oakport St Indio, CA 92201	760-863-8500	760-863-8509	Stephen Albrecht	x	x				x	x	x	x	x	x	x		Peer Support and Resource Service Centers
Riverside Volunteer Center	2060 University Avenue Riverside, CA 92507	2060 University Avenue Riverside, CA 92507	951-686-4402	951-686-7417	Roberta Neil	x	x		x		x	x	x	x	x	x	x		Crisis House
TFC Consultant, Inc	1163 Olive St Eugene, OR 97401	1163 Olive St Eugene, OR 97401	541-343-2308	541-343-2788	Gerard J Bouwman	x	x				x	x	x	x	x	x	x		Training and Technical Assistance for Mtl Direct Service Staff in Evidence Based Practice
Trilogy Integrated Resources	1195 5th Avenue, Ste. 250 San Rafael, CA 94901	1195 5th Avenue, Ste. 250 San Rafael, CA 94901	415-456-9500	415-256-9005	Bruce Bronzan, President									x	x	x	x		Website Maintenance of Network of Care
Tellcare Corporation	1100 Marina Village Parkway, Suite 100 Alameda, CA 94501	11545 Cottonwood Drive Riverside, CA 92505	800-977-7471	510-337-7963	Robin L. Peterson Vice President of	x	x				x	x	x	x	x	x	x		Adult Residential Treatment (ART)
Via Language	309 SW 6th Ave, Ste. 1200 Portland, OR 97204	309 SW 6th Ave, Ste. 1200 Portland, OR 97204	1800-737-8481 x299 (Oregon)	503-243-1980	Cheryl Selcuk, CEO	x	x				x	x	x	x	x	x	x		Written Translation Services for Mtl Department

SUBSTANCE ABUSE

ORGANIZATION	MAIN ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT													OTHER	TYPE of SERVICE PROVIDED
ABC RECOVERY	44074 Palm Avenue, Indio, CA 92201	44074 Palm Avenue, Indio, CA 92201	760-347-9616	760-347-8276	David Liberti, Chief Executive Director	x	x				x	x	x	x	x	x	x	Sober living, Parenting, Anger Management, AA and NA Mtg svcs available	RES DETOX/RES PERINATAL
CALIFORNIA RECOVERY CLINICS	740 South Rimpau Ave, Ste 102, Corona, CA 92879	740 South Rimpau Ave, Ste 102, Corona, CA 92879	951-549-8888	951-549-8888	Luke Oyelela, Executive Director	x	x		x		x	x	x	x	x	x	x	Domestic Violence, Anger Management, Parenting and 12 step services for teens	ODF SVCS
CAROLYNE WYNE CENTER	4194 Brockton, Riverside, CA 92501	7317 Potomac St, Riverside, CA 92504-2825	951-681-6193	951-683-6019	Melody Annad, Chief Executive Officer				x		x	x	x	x	x	x	x		ODF SVCS
DESERT AIDS PROJECT	1695 North Sunrise Way, Palm Springs, CA 92262	1695 North Sunrise Way, Palm Springs, CA 92262	760-323-2118	760-323-9865	David Brinkman, Executive Director	x	x				x	x	x	x	x	x	x		HIV
IMMACULATE CARE CENTER INC	24384 Sunnymead Blvd Ste 240, Moreno Valley, CA 92553	24384 Sunnymead Blvd Ste 240, Moreno Valley, CA 92553	951-243-0303	951-243-3866	Olany Jagbat Bejaku, Executive Director	x	x		x		x	x	x	x	x	x	x		ODF SVCS
INLAND AIDS	3757 Elizabeth Street, Riverside, CA 92506-2357	3757 Elizabeth Street, Riverside, CA 92506-2357	951-346-1310	951-784-0416	D Jay Gould, CEO	x	x		x		x	x	x	x	x	x	x		HIV
LA VISTA, INC	P.O. Box 1411, San Jacinto, CA 92583	2220 Grand St, San Jacinto, CA 92583	909-925-8450	909-925-4686	Jane Fenner, Executive Director	x	x				x	x	x	x	x	x	x	SENIOR PROGRAM	RES DETOX/RES PERINATAL
LOPEZ & ASSOCIATES CSA (BEAR-VALLEY)	101 S. Sunrise Way #123, Palm Springs, CA 92262	101 S. Sunrise Way #123, Palm Springs, CA 92262	760-329-4457	760-329-7803	Jo Ann Lopez, Executive Director	x	x				x	x	x	x	x	x	x		HIV
M2 RECOVERY	5670 Arlington Ave Suite 103, Riverside, CA 92504	P.O.Box H97, Riverside, CA 92504	951-683-4598	951-683-4239	Craig Lansden, Executive Director	x	x		x	x	x	x	x	x	x	x	x	prevention and svc counseling svcs available	RES PERINATAL/ODF ADULTS AND ADOLESCENT
MENTAL HEALTH SYSTEMS INC (DRUG COURT)	9465 Farnham St, San Diego, CA 92123	3075 Arlington Ave Suite 100, Riverside, CA 92506	909-509-3391 x 216	909-573-2980	Kim Bond, President	x	x				x	x	x	x	x	x	x	HIV, DDC parenting and NA	drug court svcs
MENTAL HEALTH SYSTEMS, INC	9465 Farnham St, San Diego, CA 92123	2075 Arlington Ave, Suite 1, Riverside, CA 92506	909-573-3300	909-573-2902	Kim Bond, President	x	x			x	x	x	x	x	x	x	x	HIV, DDC parenting and NA	ODF SVCS
PERRIS VALLEY RECOVERY	235 E. Third St Suite B, Perris, CA 92570	235 E. Third St Suite B, Perris, CA 92570	951-657-2960	951-940-4600	Tanya Hull, Executive Director	x	x			x	x	x	x	x	x	x	x	Anger mgmt, Parenting, psychotherapy, and na mtg svcs.	ODF SVCS
Ranch Recovery Center	7885 Annandale Ave, Desert Hot Springs, CA 92240	12890 Quinta Way, Desert Hot Springs, CA 92240	760-329-2924	760-329-0169	Rick Mass, Executive Director	x	x			x	x	x	x	x	x	x	x		RESIDENTIAL DETOX, RESIDENTIAL TREATMENT
RIVERSIDE RECOVERY RESOURCES	P.O.Box 569, Lake Elsinore, CA 92531-0569	500 Third Street, Lake Elsinore, CA 92530	909-674-3354	909-674-3227	Derrick Bruce Harvey, Executive Director	x	x			x	x	x	x	x	x	x	x	parenting/family counseling	ODF case mgmt, res detox, secondary prevention
SOCIAL HEALTH SERVICES	P.O.Box 2325, O'Neal, CA 91761	1455 Spruce St, Riverside, CA 91761	951-682-5979		Tim Ejiorfu, Executive Director	x	x		x	x	x	x	x	x	x	x	x		ODF AND DCR
SOCIAL SCIENCE SERVICES (CEDAR HOUSE)	P.O. Box 607, Bloomington, CA 92316	18612 Santa Ana Ave, Bloomington, CA 92316	909-421-7120	909-421-7124	Greg Durel, CEO	x	x				x	x	x	x	x	x	x		RES DETOX/SECONDARY PREVENTION
SOCIAL SCIENCE SERVICES (CEDAR HOUSE) (DUAL DIAG)	P.O. Box 607, Bloomington, CA 92316	18612 Santa Ana Ave, Bloomington, CA 92316	909-421-7120	909-421-7120	Greg Durel, CEO	x					x	x	x	x	x	x	x	Anger mgmt, parenting, AA and NA, co-occurring	DUAL DX
STEP UP(OMM) HOUSE OF HOPE	679 South 3rd St, Banning, CA 92220	687 E. Cabullo Ave, Desert Hot Springs, CA 92240	760-251-1676	951-489-6067	Cindy Grey, Director		x				x	x	x	x	x	x	x	HIV, anger mgmt, domestic violence, parenting and AA mtg	RES
SUN RAY ADDICTIONS	890 N. State St, Suite B, Hemet, CA 92543	890 N. State St, Suite B, Hemet, CA 92543	951-842-3560	951-923-3260	Lydeen Haughto, Executive Director	x	x		x	x	x	x	x	x	x	x	x	Domestic Violence, Parenting and Family Counseling	ODF ADULT AND ADOL
THE RANCH RECOVERY CENTER (DESERT REHAB)	12890 Annandale Ave, Desert Hot Springs, CA 92240	12890 Quinta Way, Desert Hot Springs, CA 92240	760-329-2924	760-329-0169	Rick Mass	x	x				x	x	x	x	x	x	x		RES
VMRP	1101 Marie "D" St, San Bernardino, CA 92415	1101 Marie "D" St, San Bernardino, CA 92415	909-381-3774	909-381-6845	Bobby Cope, Executive Director	x	x			x	x	x	x	x	x	x	x		RES
WCHS	20303 Stevens Creek Blvd. Suite 200, Cupertino, CA 95014	1251 W. Co Center, Indio, CA 92201	619-283-7728	619-283-0813	Paula Fatz	x	x			x	x	x	x	x	x	x	x	co occurring available	RES
WHITESIDE MANOR	2743 Orange St, Riverside, CA 92501	2743 Magnolia Ave, Riverside, CA 92501	909-656-9454	909-652-0614	Ron Vervick, Executive Director	x	x			x	x	x	x	x	x	x	x	co occurring available	RES
YWCA	9172 Magnolia Ave, Riverside, CA 92504	9172 Magnolia Ave, Riverside, CA 92504	951-687-9322	951-688-0270	Rebecca Goldware, Board President	x	x				x	x	x	x	x	x	x	PARENTING	RES PERINATAL

SUBSTANCE ABUSE PSA

CONTRACTOR	MAIL ADDRESS	SITE ADDRESS	SITE ADDRESS 2	SITE ADDRESS 3	PHONE	FAX	CONTACT	MEN	WOMEN	CHILDREN	TEENS	AFRICAN AMERICANS	CAUCASIAN	HISPANICS	ASIAN PACIFIC ISLAND	DEAF	BILINGUAL	LBT	OTHER	TYPES OF SERVICES PROVIDED
Ewbank, Leo	43421 Benjamin Street, Hemet, CA 92544	43421 Benjamin Street, Hemet, CA 92544			951-652-8249	951-658-6629	Leo Ewbank			x	x	x	x	x	x	x	x	x		Alcohol/substance
Ericberp, Inc	18505 Aston Parkway, Suite 450	18505 Aston Parkway, Suite 450			949-453-4300	949-681-4370	Brindan Donovan	x			x	x	x	x	x	x	x	x		Prevention/CA
Psya Regency Irvine	17300 Jamboree Blvd, Irvine, CA 92614	17300 Jamboree Blvd, Irvine, CA 92614			949-675-1231	949-724-6785	Jessica Rancohler	x		x	x	x	x	x	x	x	x	x		Alcohol/substance counseling
WENDAY BATES- FNL PROFESSIONAL SVCS. AGREEMENT	600 Highland Drive, Los Gatos, CA 94032	600 Highland Drive, Los Gatos, CA 94032			805-901-3301	805-730-2459	Jeremy Ward			x	x	x	x	x	x	x	x	x		Prevention
KERRI SHOORT (OAKLAND)- FNL PROFESSIONAL SVCS. AGREEMENT	11800 Sycamore Parkway, City of Industry, CA 91746	9131 Sheridan Avenue, Riverside, CA 92507	300 Aztec Road, Perris, CA 92571	15570 Saturn Avsch Blvd, Compton, CA 90220	1800-309-6584	714-367-6401	Wallace Anow			x	x	x	x	x	x	x	x	x		Transportation
RICK MANNEFIELD-FNL PROFESSIONAL SVCS. AGREEMENT	3632 Wallace Drive, Fontana, CA 92336	3632 Wallace Drive, Fontana, CA 92336			909-426-6166	909-426-0003	Rick Mannefield			x	x	x	x	x	x	x	x	x		Prevention
RODNEY ANDERSON-FNL PROFESSIONAL SVCS. AGREEMENT	5000 Larchmore Drive #115, Riverside, CA 92507	5000 Larchmore Drive #115, Riverside, CA 92507			951-662-2295	951-682-2796	Rodney Anderson			x	x	x	x	x	x	x	x	x		Prevention/Substance Prevention
BIOCLEAN RESOURCES-FNL PROFESSIONAL SVCS. AGREEMENT	13465 E. Verbena Drive, Palm Springs, CA 92262	13465 E. Verbena Drive, Palm Springs, CA 92262			760-324-5545	760-320-0345	Joe Bioclean	x	x	x	x	x	x	x	x	x	x	x		Alcohol prevention/counseling
ALPH SILVA-FNL PROFESSIONAL SVCS. AGREEMENT	431 Vista Court Circle, Sacramento, CA 95835	431 Vista Court Circle, Sacramento, CA 95835			916-417-3443	916-417-3443	Alan Silva			x	x	x	x	x	x	x	x	x		Prevention services

PREVENTION

CONTRACTOR	MAIL ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACTS	MEN	WOMEN	CHILDREN	TEENS	AFRICAN AMERICANS	CAUCASIANS	HISPANICS	ASIAN PACIFIC ISLAND	DEAF	BILINGUAL	LBT	OTHER	TYPES OF SERVICES PROVIDED
California Recovery Center	716 South Rampose Ave, Suite 102 Corona, CA 92879	716 South Rampose Ave, Suite 102 Corona, CA 92879	951-549-0688	951-549-0688	Luis Oyolado Executive Director	X	X				X	X	X	X	X	X	X	atod prevention
Coachella Valley Recovery Coalition	43990 Cook Street, Suite 105 Palm Desert, CA 92211	43990 Cook Street, Suite 105 Palm Desert, CA 92211	760-778-0575	760-342-2928	Scott Findlay Executive Director	X	X	X	X	X	X	X	X	X	X	X	X	atod prevention
La Vida McGrief A Drug Recovery Program	P.O. Box 1461 San Jacinto, CA 92583	2225 Grand Blvd San Jacinto, CA 92583	909-929-9460	909-929-9469	Jose Farias Executive Director	X	X			X	X	X	X	X	X	X	X	atod prevention
Perris Valley Program	295 E. 71st St, Suite 3 Perris, CA 92570	295 E. 71st St, Suite 3 Perris, CA 92570	951-657-2690	951-940-4620	Steve Hiti Executive Director	X	X			X	X	X	X	X	X	X	X	atod prevention

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CONTRACTOR	MAIL ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT	TEEN	WOMEN	CHILDREN	TEENS	AFRICAN AMERICANS	CAUCASIAN	HISPANICS	ASIAN PACIFIC ISLAND	DEAF	BILINGUAL	LBT	OTHER	TYPES OF SERVICES PROVIDED
ABC Recovery Center, Inc.	11471 Palm Street Indio, CA 92201	11471 Palm Street Indio, CA 92201	760-342-6616	760-347-3375	Daniel Leard Program Director	x	x			x	x	x	x	x	x	x	x	Sober living, Parenting, Anger Management, AA and NA Meetings available
Adeeno Counseling Team	6887 Magnolia Ave Riverside, CA 92506	6887 Magnolia Ave Riverside, CA 92506	909-369-5040	909-787-0552	Steven Ward Executive Director	x	x			x	x	x	x	x	x	x	x	Anger Management
The Redeemers Program	4545th Grove Street Indio, CA 92201	4545th Grove Street Indio, CA 92201	760-342-1203	760-342-4303	Concepcion Riley Executive Director	x	x			x	x	x	x	x	x	x	x	Domestic Violence, Anger Management, Parenting and 12 step services for Men
California Recovery Clinics	710 S. Ringold Ave. Suite 102 Corona, CA 92879	710 S. Ringold Ave. Suite 102 Corona, CA 92879	951-549-5695	951-549-5695	Lisa Spickok Executive Director	x	x			x	x	x	x	x	x	x	x	Domestic Violence, Anger Management, Parenting and 12 step services for Teens
The High Road Program	25775 Arlington, Suite 300 Riverside, CA 92555	25775 Arlington, Suite 300 Riverside, CA 92555	909-731-6262	909-731-6245	Gloria Gallen Program Director	x	x	OPT		x		x	x	x	x	x	x	DUI Counseling and Education, Misdemeanor Drug Diversion Counseling, Domestic Violence Counseling, Anger Management, Counseling, Drug Testing, SARDA Treatment and Rehabilitation Services, PC1000 Substance Abuse Treatment Services, Outpatient Alcohol and Drug Counseling for Individuals and Families
Four Hills Los Mujeres	P.O. Box 890341 Temecula, CA 92589	35430 Rangecats Road Hemet, CA 92543	909-767-6376	951-767-0530	Jerry Thornton Administrative Director	x	x			x	x	x	x	x	x	x	x	Anger Mgmt, AA meetings, and sober living
La Vida Inc	2220 Girard St San Andreas, CA 95383	2220 Girard St San Andreas, CA 95383	951-925-5460	951-638-6082	Jane Fariane Executive Director		x			x	x	x	x	x	x	x	x	Sober Program
ABC Recovery Center Inc	6970 Magnolia Ave Riverside, CA 92501	6970 Magnolia Ave Riverside, CA 92501	951-682-5026	951-682-4026	Craig Landholm	x	x			x	x	x	x	x	x	x	x	prevention and safe counseling also available
Perris Valley Recovery Program	230 East Third St. Suite 5 Perris, CA 92570	230 East Third St. Suite 5 Perris, CA 92570	951-657-4600	951-943-4600	Floyd Hall Executive Director	x	x			x	x	x	x	x	x	x	x	Anger mgmt, Parenting, psychotherapy, and NA meetings
Ranch Recovery	7095 Armadillo Ave Desert Hot Springs, CA 92240	12890 Quinta Way Desert Hot Springs, CA 92240	760-329-2584	760-329-2158	Rick Maas Executive Director	x	x			x	x	x	x	x	x	x	x	
Riverside Co. Latino Commission	8570 Limonite Ave Mira Loma, CA 92509	8570 Limonite Ave Mira Loma, CA 92509	760-347-6442	760-347-4622	Lionel Cothran Executive Director	x	x			x	x	x	x	x	x	x	x	Domestic Violence, Anger Management, AA and HIV AIDS HIV Services available
Phoenix Recovery Resources	600 Inlet St Lake Elsinore, CA 92530	600 Chaney St Lake Elsinore, CA 92530	951-674-6204	951-674-6227	Dennis Feavey Executive Director	x	x			x	x	x	x	x	x	x	x	parenting and family counseling
Sun Ray Adventures	950 North State Street Suite B Hemet, CA 92543	950 North State Street Suite B Hemet, CA 92543	951-655-5001	951-600-3780	Lyford Hughes Executive Director	x	x			x	x	x	x	x	x	x	x	Domestic Violence, Parenting and Family Counseling
VARP, Inc	1400 North "D" Street San Bernardino, CA 92410	1400 North "D" Street San Bernardino, CA 92410	951-361-3774	951-361-4845	Bobby Hope	x	x			x	x	x	x	x	x	x	x	Non-12 Step Drug Rehab Program, 2 Cal Locations, Intensive Hospital Intervention Program for Immediate Drug Addiction Treatment
Village Counseling	73332 Highway 111 Palm Desert, CA 92260	73332 Highway 111 Palm Desert, CA 92260	760-346-0066	760-773-0246	Dr. Jerry Mello	x	x			x	x	x	x	x	x	x	x	Domestic Violence and Anger Management
M QHS	26540 Sierras Crest Blvd Suite 600 Corona, CA 92801	26540 Sierras Crest Blvd Suite 600 Corona, CA 92801	949-257-7229	619-263-1510	Paula Fiera CEO	x	x			x	x	x	x	x	x	x	x	Latino and Prevention Svcs
Wellness Matters	2743 Orange Street Riverside, CA 92501	2743 Orange Street Riverside, CA 92501	951-686-5004	951-686-5300	Roni Woods Executive Director	x	x			x	x	x	x	x	x	x	x	co occurring available
YMCA	9572 Magnolia Ave Riverside, CA 92504	9572 Magnolia Ave Riverside, CA 92504	951-689-0122	951-689-0270	Rebecca Gobreno Board President	x	x			x	x	x	x	x	x	x	x	parenting svcs available

MANAGED CARE INDIVIDUALS

NAME	MAILING ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT	MEN	WOMEN	CHILDREN	TEENS	AFRICAN AMERICAN	CAUCASIAN	HISPANICS	ASIAN PACIFIC ISLAND	DEAF	BRAILLE	LIT	OTHER	HANDICAP ACCESSIBLE	TYPES OF SERVICE PROVIDED

Name	Address 1	Address 2	Phone	Phone	Phone																Services
Beverly Garippo						x	x	x	x	x	x	x	x	x	x	x	x	x	x		Family Therapy, Individual Counseling, Assessment
Nadia Garon						x	x	x	x	x	x	x	x	x		x	x	x	x	x	Medical Evaluations
William Glasgow						x	x	x	x	x	x	x	x	x	x	x	x		x	x	Individual Counseling, Medication Support, Assessment
Jerry Gubrud						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluation
Rachelle Gravel						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Individual Counseling, Medication Services, Medication Support, Assessment, Family Therapy, Group Therapy
Raghavendra Guddgundi						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Family Therapy, Assessment, Individual Counseling, Medication Support
Kimberly Hall						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluations
Robert Hamilton						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluations
LaKeisha Hardy-Davis						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Family Therapy, Group Therapy, Individual Counseling
Tony Harden						x		x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluating
Sharon Hazelton						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluation
Elizabeth Hernandez Felix						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Family Therapy
Henrietta Stephens K						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluations
Peter Hiland						x	x	x	x	x	x	x	x	x	x	x	x		x	x	Medical Evaluations
Tanya Holt						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluations
Rodney Hospal						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Evaluations
Walter Hunt						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Referral for Medical Evaluation
Kenneth Hutchins						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Individual Counseling
Linda Hyman						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluations
Geoffrey Ikejiofor						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluations
Michael Inn						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluations
Sita Jacob						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medication Support, Assessment, Individual Counseling
Dwyann Jamal						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Individual Counseling, Medication Services, Medication Support
Danielle Johnson						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Individual Counseling, Family Therapy
Leonard Jones						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Assessment, Medication Services, Individual Counseling, Medication Support
William Jones						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Referral Medical Evaluation
Jerome Josie						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Individual Counseling, Assessment, Family Therapy
Edmond Kramer						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluations
Radislav Kozelny						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluations
Samuel Kastner						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Evaluations
Maria Kitchinson						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Evaluations
Wolfgang Mond						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medical Evaluations
Karl Kaiana						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medication Evaluations
Philip Lesley						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medication Evaluations

Name	Address 1	Address 2	Phone 1	Phone 2	Contact															Services
Gabriela Roberts	9916 Glenhaven Avenue, Riverside, CA 92506	1629 E. Cooley Dr., Suite 206-S, Colton, CA 92324	909-340-4963	909-424-4222	Gabriela Roberts	X		X		X	X	X	X	X	X	X	X		X	Medication Evaluations
Buris Rodisan	72-100 Highway 111, Palm Desert, CA 92260	72-100 Highway 111, Palm Desert, CA 92260	760-773-0593	760-773-0593	Buris Rodisan	X	X	X		X	X	X	X	X	X	X		X	X	Individual Counseling
Edward Ryan	P.O. Box 3045, Riverside, CA 92515	17241 Van Buren Blvd, Riverside, CA 92504	951-224-4007	689-401-8650	Edward Ryan	X		X		X	X	X	X	X	X	X	X	X	X	Medication Evaluations
Ronald Ryan	23630 Cielo Mendoza, Temecula, CA 92591	29451 Rancho California Rd., Suite 205-A, Temecula, CA 92591	951-971-4529	951-600-0849	Ronald Ryan	X		X		X	X	X	X	X	X	X	X	X	X	Medication Evaluations
Sanjel Sharma	3 Corporate Plaza Drive, Suite 140, Newport Beach, CA 92660	3 Corporate Plaza Drive, Suite 140, Newport Beach, CA 92660	949-642-7757	949-642-5331	Sanjel Sharma	X		X		X	X	X	X	X	X	X		X	X	Individual Counseling, Medication Support, Medication Service
Carla Sardana	22811 Washington Ave., Ste 110-223, Murrieta, CA 92562	22811 Washington Avenue, Suite K, Murrieta, CA 92562	951-197-7147	951-877-9850	Carla Sardana	X		X		X	X	X	X	X	X	X		X	X	Medication Evaluations
Robert Stankly	Pkwd Cywy 111, Ste B-494, La Quinta, CA 92253	1216 N. Mountain Ave #B294, Upland, CA 91786	509-345-4400	909-945-4400	Robert Stankly	X	X	X		X	X	X	X	X	X	X		X	X	Assessment
Michael Schwartz	421 East 17th Street #226, Costa Mesa, CA 92627	501 Victoria St, Costa Mesa, CA 92627	949-209-7936	949-753-7743	Michael Schwartz	X	X			X	X	X	X	X	X	X	X	X	X	Individual Counseling, Medication Support, Medication Service
Nancy Stranson	73-255 El Paseo #15, Palm Desert, CA 92260	73-255 El Paseo #15, Palm Desert, CA 92260	760-424-5354	760-436-5656	Nancy Stranson	X	X	X		X	X	X	X	X	X	X	X	X	X	Family Therapy, Individual Counseling
Aurora Silva	45-680 Golf Center Parkway, Bldg B, Ste H, Indio, CA 92201	45-680 Golf Center Parkway, Bldg B, Ste H, Indio, CA 92201	760-342-6344	760-342-6345	Aurora Silva	X	X	X		X	X	X	X	X	X		X	X	X	Family Therapy
Shirley Sizemore	1816 E. Royal Ridge Drive, Riverside, CA 92533	3638 University Ave., Suite 247, Riverside, CA 92501	951-742-6200	951-742-6572	Shirley Sizemore	X	X	X		X	X	X	X	X	X	X	X	X	X	Medication Evaluations
Ramandar Singh	12565 Garden Grove Blvd. #202, Garden Grove, CA 92843	12565 Garden Grove Blvd. #202, Garden Grove, CA 92843	714-537-4722	714-537-7713	Ramandar Singh	X	X	X		X		X	X	X	X	X	X		X	Medication Service, Individual Counseling
Michael Sloan	241 N. Highland Springs Bldg. 1, Suite C, Banning, CA 92220	241 N. Highland Springs Bldg. 1, Suite C, Banning, CA 92220	951-485-8224	951-485-5458	Michael Sloan	X		X		X	X	X	X	X	X	X			X	Assessment, Medication Counseling, Family Therapy, Group Home
Melissa Snyder	PO Box 4165, Palm Springs, CA 92263	73-333 El Paseo #13, Palm Desert, CA 92260	760-567-9259	760-327-1247	Melissa Snyder	X		X		X		X	X	X	X	X	X		X	Group Therapy, Family Therapy, Individual Counseling
Vera Stone Ferek	P.O. Box 1145, Riverside, CA 92514	4225 Market Street, Suite 2, Riverside, CA 92501	951-583-8522	951-683-8500	Vera Stone Ferek	X	X	X		X	X	X	X	X	X	X	X	X	X	Medication Evaluations
Jan Standfield	4315 Central Avenue, Suite 204, Riverside, CA 92506	4315 Central Avenue, Suite 204, Riverside, CA 92506	951-424-3202	951-726-1555	Jan Standfield	X	X	X		X	X	X	X	X	X	X	X	X	X	Medication Evaluations
Robert Suter	5617 Brockton Avenue, Suite 207, Riverside, CA 92506	5617 Brockton Avenue, Suite 207, Riverside, CA 92506	951-276-0245	951-276-4759	Robert Suter	X		X		X	X	X	X	X	X	X	X	X	X	Medication Evaluations
Clara Todorotd	11-601 Reserve Road #21, Bermuda Dunes, CA 92241	11-601 Reserve Road #21, Bermuda Dunes, CA 92241	760-324-5226	760-345-6433	Clara Todorotd	X		X		X	X	X	X	X	X	X	X	X	X	Removal Re Medication Evaluations
Leland Techno	23570 Glenwood Place Ste 3 & 1143, Moreno Valley, CA 92553	23570 Glenwood Place Ste 3 & 1143, Moreno Valley, CA 92553	951-242-6699	951-242-6214	Leland Techno	X		X		X	X	X	X	X	X	X	X	X	X	Medication Evaluations
Brent Thompson	2692 Atrington Suite J, Riverside, CA 92506	2692 Atrington Suite J, Riverside, CA 92506	951-202-2134	951-202-2134	Brent Thompson	X		X		X	X	X	X	X	X	X	X	X	X	Medication Evaluations
Craig Tacker	47 First Street Office A, Redlands, CA 92373	47 First Street Office A, Redlands, CA 92373	909-375-2211	909-733-3444	Craig Tacker	X		X		X	X	X	X	X	X	X	X	X	X	Medication Evaluations
Lawrence Tucker, MD	3381 Central Avenue, Los Angeles, CA 90008	3265 Coolidge Blvd., Suite 120, Torrance, CA 90503	800-670-9127	800-888-9357	Lawrence Tucker, MD	X		X		X	X	X	X	X	X	X	X	X	X	Individual Counseling
Penelope Underwood	3072 Aviation Rd, Suite C302-375, Winchester, CA 92596	3072 Aviation Rd, Suite C302-375, Winchester, CA 92596	951-532-3596	951-926-1927	Penelope Underwood	X		X	X	X	X	X	X	X	X	X	X	X	X	Multidisciplinary Counseling Group, Psychological Testing, Group Therapy
Michele Visweit	27925 Puerto Road, Ste 100-223, Mission Viejo, CA 92691	27925 Puerto Road, Ste 100-223, Mission Viejo, CA 92691	949-682-6900	714-389-6992	Michele Visweit	X				X	X	X	X	X	X	X	X	X	X	Group Therapy, Psychological Testing
David Watson	73-562 Fred Waring Dr, Palm Desert, CA 92260	73-562 Fred Waring Dr, Palm Desert, CA 92260	760-862-1128	760-340-1913	David Watson	X		X		X	X	X	X	X	X	X		X	X	Individual Counseling
Amanda Washington	404 W. 17th St, San Bernardino, CA 92405	404 W. 17th St, San Bernardino, CA 92405	909-475-1777	909-475-1777	Amanda Washington	X		X		X	X	X	X	X	X	X		X	X	Medication Evaluations
Gail Wation	1421 N. Sunrise Way #20, Palm Springs, CA 92262	1421 N. Sunrise Way #20, Palm Springs, CA 92262	760-778-0344	760-778-0366	Gail Wation	X	X	X		X	X	X	X	X	X	X	X	X	X	Group Therapy, Individual Counseling, Group
Alfred Wahner	P.O. Box 390068, Anza, CA 92539	53491 Cove Road 1 Road, Anza, CA 92539	951-224-5762	951-541-4166	Alfred Wahner	X	X	X		X	X	X	X	X	X	X	X	X	X	Group, Family Therapy, Process Counseling
Gail York	10630 Town Center Dr., Suite 120, Rancho Cucamonga, CA 91730	10630 Town Center Dr., Suite 120, Rancho Cucamonga, CA 91730	909-980-6801	909-944-4097	Gail York	X		X		X	X	X	X	X	X	X	X	X	X	Medical Evaluations

MANAGED CARE AGENCIES

FRIDAY NIGHT LIVE

CONTRACTOR	MAIL ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT	MEN	WOMEN	CHILDREN	TEENS	AFRICAN AMERICANS	CAUCASIANS	HISPANICS	ASIAN PACIFIC ISLAND	DEAF	BILINGUAL	LBT	OTHER	TYPES OF SERVICES PROVIDED
Alvord Unified School District	10330 Keller Avenue Riverside, CA 92505	10330 Keller Avenue Riverside, CA 92505	951-351-2307	951-354-2116	Paul Jessup			x	x	x	x	x	x	x	x	x		alcohol prevention
BEAUMONT UNIFIED SCHOOL DISTRICT	500 Grace Ave Beaumont, CA 92223	500 Grace Ave Beaumont, CA 92223	951-845-1631	951-845-1319	Dr. Frank Pascarella			x	x	x	x	x	x	x	x	x		alcohol prevention
Banning Unified School District	161 West Williams St Banning, CA 92220	161 West Williams St Banning, CA 92220	951-922-0261	951-922-3227	Gaylord Fidler, Coordinator			x	x	x	x	x	x	x	x	x		alcohol prevention
Coachella Valley Unified School District	87-225 Church St Thermal, CA 92274	87-225 Church St Thermal, CA 92274	760-399-5137	760-399-1052	David J. Gibbons			x	x	x	x	x	x	x	x	x		alcohol prevention
Corona-Norco Unified School District	2820 Clark Ave Norco, CA 92860	2820 Clark Ave Norco, CA 92860	909-736-5104	909-736-3315	Lee V. Pollard			x	x	x	x	x	x	x	x	x		alcohol prevention
Desert Center Unified School District	P.O. Box 106 Desert Center, CA 92239	P.O. Box 106 Desert Center, CA 92239	760-366-4297	760-366-4316	Dr. Norman Scott			x	x	x	x	x	x	x	x	x		alcohol prevention
Desert Sands Unified School District	47-950 Dune Palms Road La Quinta, CA 92253	47-950 Dune Palms Road La Quinta, CA 92253	760-771-8500	760-771-8515	Dr. Doris L. Wilson			x	x	x	x	x	x	x	x	x		alcohol prevention
Hemet Unified School District	1791 W. Acacia Ave Hemet, CA 92545	1791 W. Acacia Ave Hemet, CA 92545	951-765-5100	951-765-5165	Dr. Phillip O. Pendley			x	x	x	x	x	x	x	x	x		alcohol prevention
Jurupa Unified School District	4850 Pedley Road Riverside, CA 92509	4850 Pedley Road Riverside, CA 92509	951-360-4191	951-360-4162	Terri Rodriguez SUFSC Coordinator			x	x	x	x	x	x	x	x	x		alcohol prevention
Menifee Union School District	30205 Menifee Road Menifee, CA 92584	30205 Menifee Road Menifee, CA 92584	951-672-1851	951-672-6447	Dr. Gary Cangen			x	x	x	x	x	x	x	x	x		alcohol prevention
Murrieta Valley Unified School District	24624 Alexandro Blvd Murrieta Valley, CA 92562	24624 Alexandro Blvd Murrieta Valley, CA 92562	951-696-1600	951-696-1503	Dr. Chet M. Francisco			x	x	x	x	x	x	x	x	x		alcohol prevention
Perris Union School District	155 East Fourth Street Perris, CA 92570	155 East Fourth Street Perris, CA 92570	951-943-6369	951-657-3638	Jonathan Greenberg			x	x	x	x	x	x	x	x	x		alcohol prevention
San Jacinto Unified School District	2045 San Jacinto Avenue San Jacinto, CA 92583-6865	2045 San Jacinto Avenue San Jacinto, CA 92583-6865	951-654-1700	951-655-2574	Dr. Peter Dongros			x	x	x	x	x	x	x	x	x		alcohol prevention
Val Verde Unified School District	975 West Morgan Street Perris, CA 92571	975 West Morgan Street Perris, CA 92571	951-940-6100	951-943-8124	York Pedernal-Shelf Contractor			x	x	x	x	x	x	x	x	x		alcohol prevention

PUBLIC GUARDIAN

CONTRACTOR	MAIL ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT	MEN	WOMEN	CHILDREN	TEENS	AFRICAN AMERICANS	CAUCASIANS	HISPANICS	ASIAN PACIFIC ISLAND	DEAF	BILINGUAL	LBT	OTHER	TYPES OF SERVICES PROVIDED
Premier Medical Transportation	P.O. Box 650 Colton, CA 92324	1012 E. Cooley Dr., Suite G Colton, CA 92324	909-433-3808	909-433-3353	Courtney Miller	x	x	x	x	x	x	x	x	x	x	x	x	Ambulance Transportation

OLDER ADULTS

CONTRACTOR	MAIL ADDRESS	SITE ADDRESS	PHONE	FAX	CONTACT	MEN	WOMEN	CHILDREN	TEENS	AFRICAN AMERICANS	CAUCASIANS	HISPANICS	ASIAN PACIFIC ISLAND	DEAF	BILINGUAL	LBT	OTHER	TYPES OF SERVICES PROVIDED
Maxim Health Care Services Inc.	7227 Lee Deforest Drive Columbia, MD 21046	4240 Latham Street, Suite D Riverside, CA 92501	951-684-4445	951-369-0831	Diana Hai		x			x	x	x	x	x	x	x		In Home Respite care for older adults (61 + years)

ATTACHMENT #10

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY OUTREACH AND ENGAGEMENT EVENT *

Calendar of Events for 2009: 162 total
Calendar of Events for 2010: 52 total

Grand Total for both years: 214

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH CULTURAL COMPETENCY OUTREACH AND ENGAGEMENT EVENT *

2010

No.	Date of Event	Event Title	Event Location	Contact Numbers	Assigned Person(s)
1.	Monday 01/04/10	Community MH Outreach	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
2.	Monday 01/04/10	SEPAC Executive Committee Mtg.	Indio, Ca	Huerta_A@co.riverside.ca.us	Alfredo Huerta
3.	Thursday 01/07/10	Community Resource Network	Cps 4 Kids Bldg., 12805 Buena Vista St., San Jacinto, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
4.	Monday 01/11/10	Community MH Outreach	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
5.	Wednesday 01/13/10	FSA Planning Meeting	Family Services Moreno Valley, Box Springs Rd and 215Fwy.	Ponce_M@co.riverside.ca.us	Moises Ponce
6.	Thursday 01/14/10	Mental Health Outreach	Coachella Valley High School, Thermal, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
7.	Thursday 01/14/10	Community MH Outreach	Mecca, Ca	Huerta_A@co.riverside.ca.us	Alfredo Huerta
8.	Tuesday 01/19/10	SELPA Meeting	1000 Taquhitz Canyon, Palm Desert	Huerta_A@co.riverside.ca.us	Alfredo Huerta
9.	Wednesday 1/20/2010	Desert Sands Unified Spcl. Education Advisory Committee & Support Group	Desert Sands Unified School District	Aguilar_E@co.riverside.ca.us	Elizabeth Aguilar & Alfredo Huerta
10.	Wednesday 01/20/10	Coachella Valley Teachers Training	Desert Mirage High School	Huerta_A@co.riverside.ca.us	Alfredo Huerta
11.	Wednesday 01/20/10	Teacher Development	Desert Mirage High School	Huerta_A@co.riverside.ca.ua	Alfredo Huerta
12.	Wednesday 01/20/10	Parent Advisory Meeging	La Quinta, CA	Huerta_A@co.riverside.ca.ua	Alfredo Huerta
13.	Wednesday 01/20/10	Los Colores del Liderazgo, Vision & Compromiso Promotores de Salud,	Kaiser, Fontana, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
14.	Friday 01/22/10	Southwest Riverside Violence Prevention Steering Committee	Murrieta Unified School District	Ponce_M@co.riverside.ca.us	Moises Ponce

15.	Saturday 01/23/2010	College & Career Health Expo. Riverside Community Health Foundation	Bobby Bonds Park (Kansas & University) Riverside, CA	909/809-9986	Moises Ponce
16.	Wednesday 01/25/2010	DMH Information Night – Community Event	Banning MH Clinic	Aguilar_E@co.riverside.ca.us	Elizabeth Aguilar Alfredo Huerta Shannon Mc-Cleerey (Sr. Peer)
17.	Wednesday 01/25/2010	Family to Family Group Mtg.	Banning MH Clinic, Banning, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
18.	Wednesday 01/27/10	ELAC Meeting	Rancho Verde High School, 17750 LaSalle St., Moreno Valley, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
19.	Wednesday 01/27/10	Diagnostic Differences	University of California, Riverside, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
20.	Thursday 01/28/2010 3:00 pm	Rededication – Jerry C. Rummonds Community & Senior Center	87-299 Church St., Thermal, CA	Lreisner @ Rivcoeda.org	Alfredo Huerta
21.	Saturday 01/30/10	1st. Annual Health Fair on Planned Parenthood	Santa Rosa Episcopal Church, 20 Monterrey Ave., Desert Shores, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
22.	Tuesday 02/02/10	Interfaith Council Meeting	First Christian Church, Hemet	Ponce_M@co.riverside.ca.us	Moises Ponce
23.	Wednesday 02/03/10	COY	Valley Wide Counseling Services, San Jacinto	Ponce_M@co.riverside.ca.us	Moises Ponce
24.	Saturday, 02/06/2010	Chinese New Year	Mission Inn Museum Riverside	909/809-9986	Moises Ponce Suzanna Luu
25.	Monday 02/08/10	Community Mental Health Outreach	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
26.	Wednesday 02/10/10	Grupo Comunitario de Educacion de Salud Mental	Coachella, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
27.	Thursday 02/11/10	Linking Hearts to Community Resources	Desert Hot Springs Family Resource Ctr. 14-201 Palm Dr., Desert Hot Springs, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta

28.	Friday 02/12/10	Community Health and Wellness Fair	Arlanza Family Community Center, 8856 Arlington Ave., Riverside, CA	909/809-9986	Moises Ponce
29.	Tuesday 02/13/10	Mental Health Presentation	Cristian Church, 2058 Iowa Ave., Ste 102, Riverside	Ponce_M@co.riverside.ca.us	Moises Ponce
30.	Tuesday 02/16/10	Event: Teach the Teachers	Riverside CO. Office of Education, 47-336 Oasis St., Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
31.	Wednesday 02/17/10	Grupo Communitario de Educacion de Salud Mental	Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
32.	Thursday 02/18/10	Community Mental Health Outreach	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
33.	Wednesday 02/24/10	Spirituality Conference by Catholic Charities	Univ. of Phoenix – Palm Desert Campus 75153 Merle Dr., Palm Desert	Aguilar_E@co.riverside.ca.us	Elizabeth Aguilar Alfredo Huerta
34.	Wednesday 02/24/10	Grupo de Educacion de Salud Mental	Coachella, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
35.	Wednesday 02/24/10	Cahtolic Charities Call to Care Event	University of Phoenix, 75153 Merle Dr., Palm Desert	Huerta_A@co.riverside.ca.us	Alfredo Huerta
36.	Monday 03/01/10	LGBT Seminar	LGBT Tristar Palm Springs	Huerta_A@co.riverside.ca.us	Alfredo Huerta
37.	Wednesday 03/03/10	Grupo Comunitario de Education de Salud Mental en Schizophrenia	Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
38.	Saturday 03/06/2010 1PM - 4:30PM	Community Forum on Hate & Violence	Pilgrim Congregational Church, 41861 Acacia Ave., Hemet, CA	909/809-9986	Moises Ponce
39.	Saturday 03/06/10	19th Annual Migrant Health Conference	Riverside Co. Office of Education, 47-330 Oasis St., Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
40.	Wednesday 03/10/10	Alcance Comunitario	Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
41.	Wednesday 03/10/10	Gilda's Club Desert Cities	Thermal, Ca	Huerta_A@co.riverside.ca.us	Alfredo Huerta
42.	Saturday 03/13/10	Dare to Be Aware	Palo Verde College, Blythe, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta

43.	Tuesday 03/16/10	Classes for the Community	Nuestra Señora de Guadalupe Catholic Church, Perris, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
44.	Wednesday 03/17/10	Gilda's Club Desert Cities Presentation	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
45.	Wednesday 03/17/10	Informacion de Salud Mental Comunitario	Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
46.	Wednesday 03/17/10	Catholic Charities – Call to Care	Palm Desert, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
47.	Thursday 03/18/10	Technical Assistance Seminar	CIMH San Bernardino, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
48.	Saturday 03/20/10	Day of Spiritual Understanding	Communications Relations Council, Mount San Jacinto College, Menifee	Ponce_M@co.riverside.ca.us	Moises Ponce
49.	Sunday 03/21/10	ELAC Meeting	Lake Land Village Middle School, Wildomar	Ponce_M@co.riverside.ca.us	Moises Ponce
50.	Wednesday 03/24/10	Informacion de Salud Mental Comunitario	Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
51.	Saturday 03/27/2010 10AM 2:00 PM	Feria Comunitaria Y Busqueda de Huevos	Centro Comunitario Cesar Chavez 2060 University Avenue, Riverside	909/809-9986 Ponce_M@co.riverside.ca.us	Moisés Ponce
52.	Monday 03/29/10	Southwest Riverside Violence Prevention Steering Committee	Murrieta Unified School District, 41870 McCalby Rd., Murrieta	Ponce_M@co.riverside.ca.us	Moises Ponce

* FOR MORE INFORMATION OR TO PARTICIPATE, PLEASE CONTACT CULTURAL COMPETENCY UNIT AT (951) 358-7259

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY OUTREACH AND ENGAGEMENT EVENT *

2009

No	Date of Event	Event Title	Event Location	Contact Numbers	Assigned Person(s)
1.	01/07/09 6PM-8PM	Quarterly Mtg. of Desert Sands Unified School District	47-950 Dune Palms Rd., La Quinta, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
2.	01/09/09	KERU Radio Presentation	KERU Studios Blythe, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
3.	01/08/09	ELAC	Mead Valley Community Ctr.	Ponce_M@riverside.ca.us	Moises Ponce
4.	01/10/09	AA General Meeting	Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
5.	01/13/09	Cultural Competency Focus Group	Indio MH	Huerta_A@co.riverside.ca.us	Alfredo Huerta
6.	01/20/09	MECCA Outreach	MECCA, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
7.	01/22/09	Coffee Shop Club	Mead Valley Community Ctr	Ponce_M@co.riverside.ca.us	Moises Ponce
8.	01/29/09 12:00PM – 2:00PM	Cultural Competence Desert Region Consumers & Family Members Focus Group	Indio Mental Health Clinic, 47-825 Oasis	Huerta_A@co.riverside.ca.us	Alfredo Huerta
9.	01/30/09	Latino Health Collaborative Mtg.	Latino Health Community Ctr.	Ponce_M@co.riverside.ca.us	Moises Ponce
10.	02/09/09	ELAC Mtg	David A. Brown Middle School	Ponce_M@co.riverside.ca.us	Moises Ponce
11.	02/17/09	MECCA Outreach	MECCA, CA	Huerta_A@riverside.ca.us	Alfredo Huerta
12.	02/27/09	Radio Presentation	Blythe, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
13.	Saturday 02/28/09 9:00 AM 2:30 PM	18th Annual Migrant Health Conference	Office of Education Oasis St. in Indio	Myra Sanchez or Nelly Fine (760) 863-3353 mqsanchez@rcoe.us	Alfredo Huerta
14.	02/28/09 8:30AM – 1:10P	Migrant Conference Health Fair	San Bernardino Museum, S. Bernardino	Huerta_A@co.riverside.ca.us Ponce_M@riverside.ca.us	Alfredo Huerta Moises Ponce

15.	03/03/09	Spirituality in Care Giving	Catholic Charities	Ponce_M@co.riverside.ca.us	Moises Ponce
16.	03/03/09	Non-Profit Executives Network	Bi-National Hlth Initiative of Inland Empire, S. Bernardino Museum	Ponce_M@co.riverside.ca.us	Moises Ponce
17.	03/10/09	MECCA Outreach	MECCA, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
18.	03/10/09	MH Board	Indio MH	Huerta_A@co.riverside.ca.us	Alfredo Huerta
19.	03/16/09 6PM-7PM	Junta de la Lianza del Valle de Coachella	Alliance Mtg. Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
20.	03/22/09	AA General Mtg.	Fe & Esperanza Grp., Mecca, CA	Huerta_A@riverside.ca.us	Alfredo Huerta
21.	Saturday 03/28/09 11:00AM 2:00 PM	"Day of the Child" (Fair)	Foss Field Park Perris	Susan Johnson susanjohnson@perris.K12ca.us Felix Minjares feminjar@riverside.edpss.org	Moisés Ponce
22.	04/03/09	MECCA outreach	MECCA, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
23.	04/15/09	Educación Popular Salud Comunitaria	El Sol Community Agency, S. Bernardio, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
24.	04/25/09 8AM-3PM	Parent Resource Fair	La Quinta, CA	Huerta_A@riverside.ca.us	Alfredo Huerta
25.	Saturday 04/25/09	Riverside County Special Education Local Plan Area-A Workshop	Desert Sands Unified School District in La Quinta	Alfredo Huerta (760) 863-8661 ahuerta@co.riverside.ca.us	Alfredo Huerta
26.	Wednesday 04/29/09	Dia Del Nino	Mecca Family Service Center in Mecca	Alfredo Huerta (760) 863-8661 ahuerta@co.riverside.ca.us	Alfredo Huerta
27.	05/01/09	KERU Radio Blythe MH Outreach	KERU 88.5FM, Blythe, CA	Huerta_A@riverside.ca.us	Alfredo Huerta
28.	05/01/09	WorkForce Development Staff Mtg.	Indio Workforce Development Ctr., Indio	Huerta_A@riverside.ca.us	Alfredo Huerta
29	Saturday 05/02/09	"know Limits" Teen Health Challenge – Fair	Hemet Valley Mall	Valley Wide Counseling Services (951) 654-2026	Moises Ponce
30.	Saturday 05/09/09 10:00 AM 4:00 PM	California Association of The Deaf "Building Bridges"	Valley Wide Center 901 W. Esplanade San Jacinto	Roberta Smith 9951) 654-8240 robertaesmith@msn.com	Moisés Ponce
31.	Saturday 05/09/09	"Deaf and hard of Hearing Awareness Day"	San Jacinto Valley Wide	Valley Wide Counseling Services (951) 654-2026	Moisés Ponce

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH CULTURAL COMPETENCY OUTREACH AND ENGAGEMENT EVENT *

2009

No.	Date of Event	Event Title	Event Location	Contact Numbers	Assigned Person(s)
32.	Saturday 05/16/09	1ST Annual Health Fair by Planned Parenthood	49-111 HWY 111 in Indio	Alfredo Huerta (760) 863-8661 ahuerta@co.riverside.ca.us	Alfredo Huerta
33.	05/18/09	Pastors Alliance	Fuente de La Vida, 66101 Hammond Mecca, Ca	Huerta_A@riverside.ca.us	Alfredo Huerta
34.	Tuesday 05/19/09 3:00 PM 7:00 PM	Mental Health Fair	Administration	Ponce_M@co.riverside.ca.us	Moisés Ponce
35.	05/20/09	Special Education Parent Advisory Committee	Val Verde Unified School District, 975 W. Morgan St., Perris, CA	Huerta_A@riverside.ca.us	Alfredo Huerta
36.	05/21/09	MECCA Outreach	Mecca, CA	Huerta_A@riverside.ca.us	Alfredo Huerta
37.	Thursday 05/21/09 8:30 AM 4:30 PM	Training on Foster Care Accessing Communities	Cal Baptist	Ponce_M@co.riverside.ca.us	Moisés Ponce
38.	Thursday 05/21/09 6:00 PM 8:00 PM	Community Forum--with concerned parents	Lake Elsinore	Ponce_M@co.riverside.ca.us	Moisés Ponce
39.	Thursday 05/21/09	Romero Association of Lake Elsinore	Romero Assoc. of Lake Elsinore, 369 Ave 4th, Lake Elsinore, CA	Ponce_M@co.riverside.ca.us	Moisés Ponce
40.	Friday 05/22/09	Padres Como Maestros	Rubidoux Community Resource Ctr.	Ponce_M@co.riverside.ca.us	Moisés Ponce
41.	Wednesday 05/27/09 11:30 AM 1:00 PM	Cultural Celebration For Asian/Pacific Islanders	Hemet Clinic	Guest speaker Father Arturo Balagatt Ponce_M@co.riverside.ca.us	Moisés Ponce
42.	Wednesday 05/27/09	Open House	Valley Wide Community Center	Ponce_M@co.riverside.ca.us	Moisés Ponce

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY OUTREACH AND ENGAGEMENT EVENT *

<u>2009</u>

No.	Date of Event	Event Title	Event Location	Contact Numbers	Assigned Person(s)
43.	Wednesday 05/27/09	Cultural Celebration for Pacific Islanders & Asian	RCDMH Hemet MH Clinic	Ponce_M@co.riverside.ca.us	Moisés Ponce
44.	Thursday 05/28/09 7:15 AM 3:45 PM	12th Annual Latino Conference	San Gabriel CA	Ponce_M@co.riverside.ca.us	Moisés Ponce
45.	05/29/09	Keru Radio – Mental Health Hour	Blythe, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
46.	05/29/09	Padres Como Maestros	First Five of California, Throt St. Elementary School	Ponce_M@co.riverside.ca.us	Moisés Ponce
47.	05/29/09	Latino Annual Conference	Pacific Clinics, 225 W. Valley Blvd., San Gabriel, CA	Ponce_M@co.riverside.ca.us	Moisés Ponce
48.	06/4/09	MECCA Outreach	MECCA Farmer's Center	Huerta_A@co.riverside.ca.us	Alfredo Huerta
49.	06/04/09 & 06/05/09	Spirituality Conference	CIMH – California Endowment Ctr.	Ponce_M@co.riverside.ca.us	Moisés Ponce
50.	06/05/09	MEECA Outreach		Huerta_A@co.riverside.ca.us	Alfredo Huerta
51.	06/09/09 8PM – 10PM	Cirenia Al Mediodia	Cathedral City	Huerta_A@co.riverside.ca.us	Alfredo Huerta
52.	06/10/09 11:45AM- 1:30PM	Annual Joint- East/West Meeting	Betty Ford Center, 39000 Bob Hope Dr., Rancho Mirage, CA 92270	Huerta_A@co.riverside.ca.us	Alfredo Huerta
53.	06/12/09	MECCA Outreach	MECCA, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
54.	06/15/09	Pastor's Alliance	Coachella, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
55.	06/17/09	LOV Luncheon Mtg.	University Baptist Church Palm Desert, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta

56.	Thursday 06/18/09	Romero Association of Lake Elsinore	369 Ave 4th, Lake Elsinore, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
57.	06/19/09	MECCA Outreach	MECCA, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
58.	06/19/09	Padres Como Maestros	Rubidoux Community Resource Ctr., 5473 Mission Blvd., Riverside	Ponce_M@co.riverside.ca.us	Moises Ponce
59.	06/23/09	Round Table – Latter Day Sainst Church	3210 Cypress Perris, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
60.	06/26/09	KERU Radio Training "Promotoras de Salud"	KERU Radio 137 N. Broadway Blythe, CA 92225	Huerta_A@co.riverside.ca.us	Alfredo Huerta
61.	06/30/09	Cultural Competency Focus Group With Community	Indio Mental Health Clinic Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
62.	06/30/09	Community Based Faith Based Focus Group	RCDMH Temecula Clinic	Ponce_M@co.riverside.ca.us	Moises Ponce
63.	06/30/09	Deaf and Hard of Hearing Awareness Brunch	RCDMH San Jacinto Clinic	Ponce_M@co.riverside.ca.us	Moises Ponce
64.	07/07/09	Bi-National Hlth. Initiative for the Inland Empire	Consulado de Mexico S. Bernardino, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
65.	07/11/09	MH Substance Abuse Meeting	Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
66.	07/22/09	Latino Health Collaborative	S. Bernardino Community Hospital	Ponce_M@co.riverside.ca.us	Moises Ponce
67.	0723/09	Movies at the Park	Coachella Valley	Huerta_A@co.riverside.ca.us	Alfredo Huerta
68.	07/24/09	Blythe Event – KERU Radio Station	KERU 88.5FM Blythe, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
69.	0/7/30/09	Planned Parenhood Staff Inservice	Coachella, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
70.	Wednesday 09/3/09	Cirenia al Medio Dia Radio Event	Desert Radio Grp, 1321 No. Gene Autry Trail, Palm Springs, CA 92262	Huerta_A@co.riverside.ca.us	Alfredo Huerta
71.	07/30/09	MECCA "Night at the Movies	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
72.	08/04/09	Bi-National Heath Initiative for the Inland Empire	Mexican Consulate S. Bernardino, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
73.	08/06/09	MECCA "Night at the Movies	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
74.	08/07/09	MECCA Health Fair	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
75.	08/11/09 12PM-12:30PM	Cultural Competency Middle Eastern Culture Event	Banning MH Clinic	Huerta_A@co.riverside.ca.us	Alfredo Huerta

76.	08/12/09	Call to Care	Catholic Charities Palm Desert, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
77.	08/17/09	Spirituality Support Group	S.Bernardino County Dept. Of Behavioral Hlth	Ponce_M@co.riverside.ca.us	Moises Ponce
78.	08/17/09	Caoffee Talk/Focus Group	Mead Valley Community Center	Ponce_M@co.riverside.ca.us	Moises Ponce
79.	08/18/09	Mental Health 101	Oasis Perris	Ponce_M@co.riverside.ca.us	Moises Ponce
80.	08/18/09	Mental Health Presentation	Perris Family Resource Center	Ponce_M@co.riverside.ca.us	Moises Ponce
81.	08/25/09	Focus Group	Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
82.	08/26/09	Radio Presentation Radio 127.0AM	Cathedral City	Huerta_A@co.riverside.ca.us	Alfredo Huerta
83.	08/27/09	KERU Radio Station	KERU 88.5FM Blythe, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
84.	08/27/09	Focus Group	El Sol Neighborhood Moreno Valley Community House	Ponce_M@co.riverside.ca.us	Moises Ponce
85.	09/01/09	Focus Group	Thermal, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
86.	09/02/09	MECCA Outreach	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
87.	09/02/09	Focus Group	Oasis Youth at Risk Oasis, Perris	Ponce_M@co.riverside.ca.us	Moises Ponce
88.	09/02/09	COY	San Jacinto Valley Wide	Ponce_M@co.riverside.ca.us	Moises Ponce
89.	09/03/09	Cirenia Radio Anniversary	70-050 Hwy 111 Rancho Mirage, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
90.	09/08/09	La Esparanza Grp	Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
91.	Wednesday 09/09/09	Nueva Esperanza AA Group Presentation	44510 Jackson St. Indio, CA 92201	Huerta_A@co.riverside.ca.us	Alfredo Huerta
92.	Thursday 09/10/09	Mecca Community Mental Health Outreach	91-275 66th. Avenue, Suite 100 Mecca, CA 92254	Huerta_A@co.riverside.ca.us	Alfredo Huerta
93.	Monday 09/14/09	Special Ed. Advisory Committee MH Consultation	47-950 Dune Palms Road La Quinta, CA 92253	Huerta_A@co.riverside.ca.us	Alfredo Huerta
94.	Tuesday 09/15/09	Focus Group on MH Outreach and Engagement	47-824 Oasis St. Indio, CA 92201	Huerta_A@co.riverside.ca.us	Alfredo Huerta
95.	Tuesday 09/15/09	Cultural Celebration	Hemet MH Clinic	Ponce_M@co.riverside.ca.us	Moises Ponce
96.	Wednesday 09/16/09	Mecca Community Mental Health Outreach	91-275 66th Avenue Suite 100 Mecca, CA 92254	Huerta_A@co.riverside.ca.us	Alfredo Huerta
97.	Wednesday 09/16/09	Recovery Happens	Recovery Happens Fairmont Park, Riverside, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
98.	Wednesday 09/16/09	Focus Group	Jefferson Transitional Program, Riverside,CA	Ponce_M@co.riverside.ca.us	Moises Ponce

99.	Thursday 09/17/09	Mecca Community Mental Health Outreach	91-275 66th Avenue Suite 100 Mecca, CA 92254	Huerta_A@co.riverside.ca.us	Alfredo Huerta
100.	Friday 09/18/09	4th Annual Perris Valley Community Resource Fair	Perris Valley Resource Center, 371 Wilkerson Ave, Perris, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
101.	Sunday 09/20/09	Family Health Fair- Catholic Church	82-450 Bliss Ave. Indio, CA 92201	Huerta_A@co.riverside.ca.us	Alfredo Huerta
102.	Monday 09/21/09	Depression Awareness Day	College of the Desert Palm Desert, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
103.	Monday 09/21/09	TV Taping	News Net TV Station Murrieta, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
104.	Tuesday 09/22/09	Tenemos Voz	Latino Coalition Universal City Hilton	Ponce_M@co.riverside.ca.us	Moises Ponce
105.	Tuesday 09/22/09	MH Awareness Day	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
106.	Wednesday 09/23/09	Latino Health Collaborative	Latino Health Collaborative, S. Bernardino, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
107.	Thursday 09/24/09	Mecca Community Mental Health Outreach	91-275 66th Avenue Suite 100 Mecca, CA 92254	Huerta_A@co.riverside.ca.us	Alfredo Huerta
108.	Saturday 09/26/09	Regional AA Conference Outreach	52-555 Oasis Palms Ave. Coachella, CA 92236	Huerta_A@co.riverside.ca.us	Alfredo Huerta
109.	09/26/09 8:30AM-2PM	Cooperating with the Professional Community, 12 step Program	Coachella, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
110.	09/29/09	Nuevo Amanacer-Planning	88-180 Requa St., Indio, CA 92201	Huerta_A@co.riverside.ca.us	Alfredo Huerta
111.	Tuesday 09/29/09	Alanon Mental Health, Outreach /Presentation	83-180 Requa St. Suite 6 Indio, CA 92201	Huerta_A@co.riverside.ca.us	Alfredo Huerta
112.	Wednesday 9/30/09 11AM-3PM	4th Annual Perris Valley Community Resource Fair- DPSS Children's Services	Perris Valley Resource Center 371 Wilkerson Ave., Suite L, Perris, CA 92570	Ponce_M@co.riverside.ca.us	Moises
113.	Wednesday 09/30/09	Special Ed. Advisory Committee MH Consultation	47-950 Dune Palms Rd.,La Quinta, CA 92253	Huerta_A@co.riverside.ca.us	Alfredo Huerta
114.	Wednesday 09/30/09	Latino Celebration in Blythe	137 N. Broadway Blythe, CA 92225	Huerta_A@co.riverside.ca.us	Alfredo Huerta
115.	Saturday 10/03/09 9AM – 3PM	Health Fair at Consulado de San Bernardino	3rd Street San Bernardino	Ponce_M@co.riverside.ca.us	Moises Anna
116.	Saturday 10/03/09	Health Fair – Bi-National Health Initiative for the Inland Empire	Mexican Consulate in San Bernardino, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
117.	10/04/09	Community Event	1270AM La Voz Radio Station, Cathedral City	Huerta_A@co.riverside.ca.us	Alfredo Huerta

118.	Monday 10/05/09	CV High School Presentations on MH	83-800 Airport Blvd., Thermal, CA 92274	Huerta_A@co.riverside.ca.us	Alfredo Huerta
119.	Monday 10/05/09	Health Window, Bi-National Hlth. Initiave for the Inland Empire	Mexican Consulate in San Benardino, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
120.	Tuesday 10/06/09	Health Window- Bi-National Hlth Initiative for the Inland Empire	Mexican Consulate in San Bernardino, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
121.	Wednesday 10/07/09	Cirenia Al Medio Día – Radio	Desert Radio Group 1321 No. Gene Autry Trail, Palm Springs, CA 92262	Huerta_A@co.riverside.ca.us	Alfredo Huerta
122.	Thursday 10/08/09	Mecca Community Mental Health Outreach	91-275 66th Avenue Suite 100 Mecca, CA 92254	Huerta_A@co.riverside.ca.us	Alfredo Huerta
123.	Thursday 10/08/09	Jefferson Transitional Program (JTP) – Focus Group	JTP Perris Office	Ponce_M@co.riverside.ca.us	Moises Ponce
124.	Friday 10/09/09	Blythe Health Fair	137 N. Broadway Blythe, CA 92225	Huerta_A@co.riverside.ca.us	Alfredo Huerta
125.	Saturday 10/10/09	Blythe Health Fair	137 N. Broadway Blythe, CA 92225	Huerta_A@co.riverside.ca.us	Alfredo Huerta
126.	Sunday 10/11/09	Blythe Health Fair	137 N. Broadway Blythe, CA 92225	Huerta_A@co.riverside.ca.us	Alfredo Huerta
127.	Thursday 10/15/09	Mecca Community Mental Health Outreach	91-275 66th Avenue Suite 100; Mecca, CA 92254	Huerta_A@co.riverside.ca.us	Alfredo Huerta
128.	Thursday 10/15/09	ELAC Meeting	DPSS, Kidd Street Bldg.,Riverside,CA	Ponce_M@co.riverside.ca.us	Moises Ponce
129.	Saturday 10/17/09 9AM-2PM	2nd Annual County of Riverside Code enforcement Neighborhood Conference	Heritage High School 2600 Briggs Blvd., Romoland, CA 92585	Ponce_M@co.riverside.ca.us	Moises
130.	Wednesday 10/21/09	Depression Awareness D-COD	43-500 Monterey Ave., Palm Desert, CA 92260	Huerta_A@co.riverside.ca.us	Alfredo Huerta
131.	Thursday 10/22/09	Mecca Community Mental Health Outreach	91-275 66th Avenue Suite 100 Mecca, CA 92254	Huerta_A@co.riverside.ca.us	Alfredo Huerta
132.	Thursday 10/22/09	ELAC Meeting	Tomas Rivera middle School, Mead Valley	Ponce_M@co.riverside.ca.us	Moises Ponce
133.	Saturday 10/24/09	Health Fair – LGBT	San Bernardino County Behavioral Health	Ponce_M@co.riverside.ca.us	Moises Ponce
134.	Wednesday 10/28/09	Mecca Community Mental Health Outreach	91-275 66th Avenue Suite 100 Mecca, CA 92254	Huerta_A@co.riverside.ca.us	Alfredo Huerta
135.	Thursday 10/29/09	LGBTQI Awareness Day	68-615 Perez Rd., Suite 6A Cathedral City, 92234	Huerta_A@co.riverside.ca.us	Alfredo Huerta

136.	11/04/09	MECCA Outreach & Engagement	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
137.	11/05/09	2nd Annual Conference for Foster Children & Youth	37-500 Cook St. Palm Desert, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
138.	11/07/09	Planned Parenthood 1st Annual Health Fair	49-111 Hwy. 111 Coachella, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
139.	Monday 11/09/09	Catholic Charities Presentation	Rubidoux Resources Ctr. 5475 Mission Riverside	Algarin_M@co.riverside.ca.us	Maria & Claudia
140.	11/09/09	MECCA Outreach & Engagement	91-275 66th St., Mecca, CA	Algarin_M@co.riverside.ca.us	Maria & Claudia
141.	11/12/09	Blythe Outreach	Blythe, CA	Algarin_M@co.riverside.ca.us	Maria & Claudia
142.	11/17/09	SELPA-CAC Business Mtg.	1000 E. Taquitz Palm Springs, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
143.	11/19/09	Parent MH Awareness	Desert Mirage High School, Thermal, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
144.	11/18/09	Call to Care Outreach	Indio, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
145.	11/23/09	MECCA Outreach	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
146.	11/23/09	Family to Famiy Graduation Ceremony	Mead Valley Community Center	Ponce_A@co.riverside.ca.us	Moises Ponce
147.	11/24/09	Centrao Cristiano	Thermal, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
148.	11/25/09	Perris Valley Resource Center	Jefferson Transitional Program (JTP) Perris	Ponce_A@co.riverside.ca.us	Moises Ponce
149.	12/01/09	Mental Health Presentation	Arlanza Family Center Riverside, CA	Ponce_A@co.riverside.ca.us	Moises Ponce
150.	12/02/09	Engagement Meeting Father Ochoa & Staff	Nuestra Señora de Guadalupe Catholic Church	Ponce_A@co.riverside.ca.us	Moises Ponce
151.	12/02/09	Engagement Meeting-Romero Foundation Community Group	Lake Elsinore, CA	Ponce_A@co.riverside.ca.us	Moises Ponce
152.	12/05/09	AA Meeting	Coachella Veteran's Park	Huerta_A@co.riverside.ca.us	Alfredo Huerta
153.	Saturday 12/5/09 9AM-2PM	2nd Annual Holiday Celebration – Moreno Valley Hlth. Center	22676 Alessandro Blvd., Moreno Valley CA 92553	Ponce_M@co.riverside.ca.us	Moises
154.	Saturday 12/07/09	Call to Care	Palm Springs Regional Center	Huerta_A@co.riverside.ca.us	Alfredo Huerta
155.	12/08/09	RCDMH Innovation Phase/Program	DMH 4060-A County Circle Dr., Riverside, CA	Ponce_M@co.riverside.ca.us	Moises

156.	Monday 12/09/09	Grand Opening- Riv.County DMH & Riv. County Latino Commission on Alcohol & Drug Abuse Services	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
157.	Monday 12/09/09	Open House in Mecca	RCDMH and The Latino Commission	Ponce_M@co.riverside.ca.us	Moises Ponce
158.	Thursday 12/12/09	Billy Bob Group Anniversary	Coachella, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
159.	Saturday 12/14/09	MECCA Outreach	Mecca, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta
160.	12/15/09	LGBT Christmas Celebration	Perris MH Clinic Perris, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
161.	12/17/09	Bidders Conference for Promotoras Program	Banning MH Clinic Banning, CA	Ponce_M@co.riverside.ca.us	Moises Ponce
162.	12/24/09	Blythe Radio Talk Show	KERU Radio Station Blythe, CA	Huerta_A@co.riverside.ca.us	Alfredo Huerta

* FOR MORE INFORMATION OR TO PARTICIPATE, PLEASE CONTACT CULTURAL COMPETENCY UNIT AT (951) 358-7259

ATTACHMENT #11
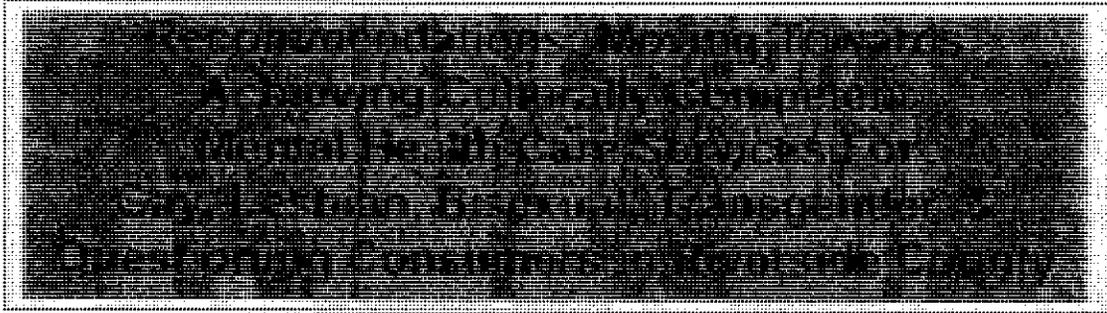
Benita Ramsey
BRMG
3540 North Shore Dr
Ontario, CA 91761
Phone (909) 519-3927

Dear Ms Dahl and Mr. Brennerman,

Please find enclosed final Recommendations to The Riverside County Department of Mental Health designed to aid in your efforts to increase access to Mental Health Services by the Lesbian, Gay, Bisexual, Transgender & Questioning (LGBTQ) Community. This information gathering process has brought together Lesbian, Gay, Bisexual, Transgender Mental Health providers, Consumers, Community Based Organizations, Faith Leaders, Departmental staff and managers to consider how we might address the need of the targeted community.

Our goal when we began was to build relationships within the LGBTQ community, while disseminating basic information about the Department and it services. We have accomplished this goal and bring new partners to the table. To date, fourteen community based organizations have agreed to participate in bimonthly taskforces to examine Mental Health Needs in the LGBTQ Community and Fifteen staff members have agreed to participate in a LGBTQ Cultural Competence Subcommittee.

The following are broad recommendations; many of them will require further research and discussion before specific policies and procedures are developed and implemented. They are intended to set forth in general terms the types of measures Department of Mental Health might take in order to provide a fully inclusive environment for staff, consumers and the community..

The recommendations address both agency administrative practices and service delivery components, including the following areas:

- Staff
- Consumer Rights
- Intake and Assessment
- Service Planning and Delivery
- Confidentiality
- Community Outreach and Health Promotion
- Prevention & Early Intervention
- Training

I am prepared to participate in further discussions and research and to assist affected departments and programs as they develop and implement any of the measures we have recommended.

Sincerely

Rev. Benita Ramsey, MA, J.D., LL.M

1.
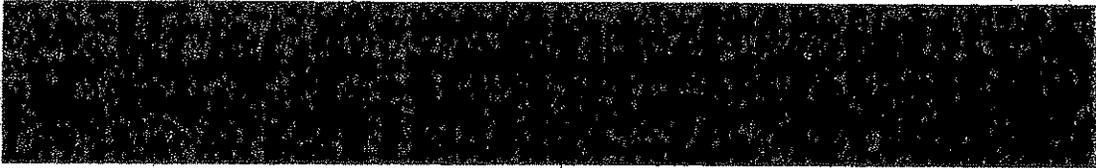
A. Policies and Procedures

1. Review existing policies to ensure that it addresses sexual orientation and gender identity and that those procedures will be effective for dealing with employee complaints of discrimination or harassment based on sexual orientation or gender identity. This includes non-discrimination on the basis of gender identity, sexual orientation, and non-harassment policies that explicitly include gay, lesbian, bisexual and **transgender** employees.

2. Prominent Posting of written non-discrimination policies in all of the department's facilities, services, marketing materials including but not limited to employee handbook, promotional

3. Require all employees to sign off on departmental policies relating to non-discrimination on the basis of gender identity, sexual orientation, diversity and non-harassment which explicitly includes gay, lesbian, bisexual and **Transgender** employees by all employees.

B. Staff

1. *Support* and encourage visibility of gay, lesbian, bisexual and Transgender employees through the establishment and support of a Lesbian Gay Bisexual Transgender Employee Affinity Group.

2. Develop and Initiate an aggressive LGBTQ employee recruitment campaign including targeted outreach to LGBTQ organizations, and advertising in LGBTQ media. (example: include LGBTQ organizations in employment opportunity mailing list).

3. Sponsor internal observances of *National Coming Out Day, World AIDS Day, Transgender Remembrance Day and National LGBTQ Health Week*. The goal of such observances would be to increase awareness of LGBTQ issues and demonstrate public support in a non-threatening manner to staff and consumers. The direct by product of such events is the creation of an atmosphere that supports and affirms employees who are in the "closet" as well as provides non-threatening education for employees who may have questions but have not had a forum to ask their questions.

4. Comprehensive ongoing training of all human resource and other appropriate personnel in sexual orientation and gender identity issues with regard to employee benefits.

5. Promote a "No Tolerance Zone" through a written notice to all employees that discrimination or harassment of other employees on the basis of sexual orientation or gender identification is grounds for appropriate levels of discipline.

6. Consider Knowledge, skills and experience with LGBT persons an asset in all employees and as one criteria for employee hiring and evaluation.

7. Include all staff in training and information, not only front line staff or clinicians, but also administrators, receptionists, nurses, assistants as well.

B. Consumer Rights

1. Examine and Correct if necessary departmental non-discrimination policies in service delivery to include gender identity and expression as protected categories. Explicit sign-off on service related non-discrimination policy by all employees.

2. Examine and correct if necessary housing records, protocols and common practices to reflect the needs of Transgender Consumers in Residential treatment Facilities, board and care, psych evaluation units, shelters or SRO maintained by the Department and/or its contractors.

3. Assess the Feasibility of Providing an Option for Individuals to Identify as Other than Male or Female on Forms . The most common ways to provide for options other than male and female are for forms to read "Gender: M, F, self-identify: _____ " or simply "Gender: _____." Another option may be to have an individual identify his or her birth sex as male or female, and provide another category for gender identity, formatted as above ("Gender Identity:_____).

4. The agency shall ensure that it has comprehensive and easily accessible procedures in place for consumers to file and resolve complaints alleging violations of these policies.

C. Intake and Assessment

1. Review and Revise if necessary, intake and assessment forms to ensure provision for optional self-identification in all categories of gender identity, gender expression, sexual orientation, marital, partnership and family status, and provide consumers with the option and opportunity for further written explanation.

   a *Consumer intake forms should be free of heterosexual assumptions. Include options such as "Living with domestic partner" as well as standard options such as married and single. Instead of "husband/wife" use gender neutral terms such as, "partner."*

   b *Whenever there is a sex or gender question, add a third category for transgender with space that people can elaborate. Do not list transgender as an alternate sexual orientation (like lesbian, bisexual, or heterosexual). Gender identity and sexual orientation are distinct.*

   c *Questions about families should allow for alternative families including two parents of the same sex and more than two parents.*

2. Intake forms need to include an explanation about how confidentiality (HIPPA) will be protected and who has access to medical & Clinical records. Offer the consumer the right to refuse to answer a question on the intake form if they are concerned about confidentiality.

3. Development and implementation of training for all intake and assessment staff to assure medically and culturally appropriate referrals for gay, lesbian, bisexual and transgender consumers and their families to providers within and outside of the agency.

D. Service Planning and Delivery

1. Assume that staff, consumers and other people associating with the Department are of diverse sexual orientations and gender identities.

2. Add LGBTQ subcommittee to the Cultural Competence Committee for review and advise to department as it moves towards integrating cultural competence throughout the department.

3. All agency staff (intake, assessment, supervisory, human resource, case management and direct care)shall have a basic familiarity with gay, lesbian, bisexual and transgender issues as they pertain to services provided by the agency.

   a *Sponsor Department wide HIV 101, LGBTQ 101 and Transgender 101 for all current staff and include as part of Orientation process for new staff to be completed within first 100 days of employment This class will explore basics myths, stigma of LGBTQ community, terminology and special treatment concerns for the LGBTQ community.* (see addendum on Training for Specific training topics)

4. Cultural competency training, specific to LGBTQ populations, should be a standard component of all mental health staff professional training curricula. (For example if we are examining Mental Health Effects of Chronic Illness, LGBTQ special needs should be integrated)

5. Comprehensive ongoing training provided for Clinical/Medical (nurses, psychiatrists) staff to identify and address basic mental health issues within their field of expertise that may particularly or uniquely affect gay, lesbian, bisexual and Transgender consumers.

6. Creation and implementation of mechanism for identification of staff with special expertise in and sensitivity to gay, lesbian, bisexual and transgender issues (including but not limited to Gender Expression or Gender Identity issues, HIV/AIDS, People of Color)

   a. *Create population-specific treatment slots for the lesbian, gay, bisexual, and transgender community*

      i. *LGBTQ Mental Health Clinic – One Night Per Month in each region offer specialized services to the LGBTQ community in conjunction with a LGBTQ Community Center or Organization. This clinic can be offered at a county site or CBO (see model of Women HIV Clinic in Public Health) or*

   b. *Provide Capacity building training for Community Based organizations to be able to provide specialty care or establish paraprofessional support groups.*

c. Develop partnerships with local universities in conjunction with Graduate Social work program or Graduate Psychology program to offer internships to Students to provide Prevention and Early intervention services in conjunction with Community Based Organizations. (Coming Out Support Groups, Identity development Groups, Transgender Support programs).

d. Designate a minimum of at least one staff person per region to serve as the Liaison for LGBTQ care .

e. Designate a minimum of one Parent Partner to attend specialty training to provide services and support to parents of all minors who are dealing with identity development issues.

f. Designate at least one peer advocate to be assigned to work exclusively with Transgender community and LGBTQ community around access, referral and peer support.

7. Development of a comprehensive resource list for appropriate referrals for special gay, lesbian, bisexual and transgender health concerns. (Completed)

8. Outreach to and development of relationships with other agencies and providers with expertise in gay, lesbian, bisexual and transgender mental health issues.

a Creation of LGBTQ Community partners Roundtable to discuss mental health challenges and opportunities, collaboration. As of December 13th 14 providers in the Western and Desert Region have agreed to meet bimonthly with the support of the Cultural Competence Committee.

b Identify opportunities for Cross-training of staffs around HIV/AIDS, & Transgender concerns. (the Desert AIDS Project,. Rainbow Pride Youth Alliance, Brothers United and UCR Queer Resource Center have agreed to serve as a training resource for DMH and would be interested in participating in training sponsored by the Department.

c Leverage County resources to increase funding streams through collaborative mental health grant applications specifically targeting LGBTQ serving agencies.(see Section on Funding in Appendix)

d Recruit and provide capacity building training for LGBTQ community organizations to become contractors or subcontractors in the provision of care services to the LGBTQ community in the community based setting.

e Host panel of LGBTQ community organizations representatives in each regional managers meeting to discuss their services, clientele, special needs and opportunities for partnership.

f Increase agency visibility by encouraging Self-Identified LGBTQ staff along with Community Liaison to participate in special programs and events sponsored by Community groups and by making presentations to staff and constituencies about DMH services and programs.

*1. Establish a Community Mental Health Outreach Workers program.(CMHOW)
CMHOW will go into LGBTQ community to talk one-on-one or to small groups of
people in safe, familiar environments to discuss services and benefits offered by
DMH. If trained this person can also provide Coming Out strategies, provide peer
support around family issues, etc. This is a role easily filled by a Parent Partner or
Paraprofessional with specialty focus on LGBTQ community*

9. Evidence of agreements (MOU) or other appropriate mechanisms to
ensure cooperation with other agencies and providers to whom gay,
lesbian, bisexual and Transgender consumers and their families may be
referred for specialized care and treatment.

E. Confidentiality

1. Examine records protocols and common practices for places where LGBTQ consumers might have reasonable concern about the ramification of sexual orientation/gender identity information being disclosed to insurers, employers and others.

2. Inform Gay, lesbian, bisexual and Transgender consumers about data collection that includes references to sexual orientation and/or gender identity, including in what circumstances such information may be disclosed, whether it may be disclosed as aggregate or individual information whether personal identifiers may be disclosed, and how and by whom such information may be used.

3. Written & posted confidentiality policies which explicitly include sexual orientation and gender identity, indicating that such information is to be considered highly sensitive and treated accordingly.

F. Outreach, Engagement and Health Promotion

Support the inclusion of Lesbian, Gay, Bisexual, Transgender & Questioning people and their families in outreach and health promotion efforts.

1. Conspicuous posting of nondiscrimination policies regarding sexual orientation and gender identification in all Department of Mental Health advertising and promotional materials.

2. Reflect the diversity of Lesbian, Gay, Bisexual, Transgender & Questioning persons and their lives in the program physical space, including artwork, literature, magazines and fliers..

3. Targeted health information delivered to high-risk and hard-to-reach LGBTQ individuals directly in their social contexts, including neighborhoods, churches, internet and socializing spaces.

   a.   Publication of LGBTQ targeted issues specific brochures such as "Coming Out 101, "Relationships 101", I Am A Tweaker" "I Am HIV Positive or Negative, Now What", "I have 2 Moms" The goal of the brochures is to put a department face on the common issues that lead to trauma, stress or psychosocial behavior in the LGBTQ Community and serve as a link for people seeking support. Each brochure will serve simultaneously to offer support, answer basic questions about the topic and include local referrals to peer support groups, community based partners of the department and departmental services. (See Sample Brochure on the next page for the concept.)

   b.   Offer targeted information regarding mental health concerns of the LGBTQ and/or HIV community to the Department website and link the Department's website to the websites of local LGBTQ specific organizations.

   c.   Sponsor a Mental Health Column in a Gay newspaper, community or faith based organization newsletter that offers regular tips for dealing with the stressors of Gay Life. (see sample article attached)

   d.   Sponsor and Participate in Major Events in the LGBTQ community by becoming an exhibitor and by being a financial co-sponsor .(ex. Desert AIDS Walk, Inland AIDS Walk, Desert Pride Festival)

4. Encourage representation from the LGBTQ communities to serve on the Mental Health Board and other community level groups. The process for electing or appointing members of the Mental Health Board and other community forums includes outreach to and inclusion of gay, lesbian, bisexual and Transgender candidates.

G. Early Intervention and Prevention

1. Expand mental health, behavioral health, and harm reduction services and co-locate them with HIV/AIDS care.

   The Reality of this region is that the Desert Region has one of highest populations of people living with HIV/AIDS in the state, Being Gay and male remains one of the highest risk predictors for who will contract HIV, plus we have high rates of Methamphetamine use in Riverside County. All of these combined point to the fact that more work needs to be done in prevention and early intervention directed towards this population and that it cannot be done in isolation. Many people infected with HIV also have mental health and/or substance use disorders. Co-occurrence of HIV, mental illness, and substance use is significantly higher in LGBTQ community and its subpopulation of racial and ethnic minorities and transgender persons. Additional stressors for this population include incarceration and homelessness. Integrated and coordinated service delivery models improve outcomes.

2. Population-specific treatment slots for the lesbian, gay, bisexual, and transgender community within the Substance Abuse program.

3. Targeted outreach to Young Gay Men of Color and LGBTQ youth in general through Friday Night Live Program partnership with Rainbow Pride Youth Alliance, Brothers United, Associated Gay Youth and school based GSA.

4. Develop a pilot program devoted specifically to the treatment of stimulant use (e.g., cocaine, crystal methamphetamine) in Gay men with an emphasis on the impact of stimulant use on Young Black & Latino Gay Men.

5. Develop a central referral registry for LGBTQ community in partnership with Community based organizations.

6. Offer interdisciplinary/cross training to help medical staff and case managers better understand mental health problems, and training for mental health/substance use staff to better understand HIV.

7. Revisit the TAY model of programming and offer a model that will integrate LGBTQ youth from a Prevention and Early Intervention mode.

   a. Take a Tour of the TAY Center in San Bernardino to see how they have integrated youth of all backgrounds in an one stop system of care.

8.   **Trauma:** Recognition of the Trauma associated with the Coming Out and identity development for both the Adult and Youth population within the LGBTQ community.

   a)   *Provide direct funding for paraprofessional Coming Out Groups, and Identity Development groups in partnership with to the Jeffery Owens Community Center, Desert Pride Center, Rainbow Pride Youth Alliance, Associated Gay Youth(Desert) Campus GSA, Brothers United (Gay young men of Color), Bienstar Human Services, and Open and Affirming Congregations.*

   b)   *Partner with Parent Partners Program and Parents, Friends of Gays and Lesbians to provide a support group for parents having difficulty dealing with issues surrounding their child sexual identity.*

   c)   *Provide training for Parent Parents, Peer Advocates and therapist working with LGBTQ youth on the special needs of LGBTQ in identity development, Coming Out/.*

H. Research
Sexual orientation and gender identity should be included, whenever appropriate, in surveys, evaluation studies, and surveillance systems.

I. Suicide

1.   Provide Direct funding to support a Collaboration between the county Department of Mental Health, Teen Line (Riverside Youth Hotline), Trevor Project(LA based LGBTQ Youth Suicide Hotline), Rainbow Pride Youth Alliance, Associated Gay Youth(Desert) Campus GSA and Brothers United(Gay young men of Color) to support a targeted Regional Suicide prevention effort directed to LGBTQ youth/Young Adults in Riverside County.

   a)   *Targeted Suicide Education & Awareness promotional campaign.*

   b)   *Inclusion of Trevor Project/LGBTQ presentation in STIGMA conference.*

   c)   *Development of Regional Website, or other internet presence as a outreach and education tool.*

J.   Stigma

1.   Provide Direct funding to support a Collaboration between the County Department of Mental Health, Jeffery Owens Community Center, Desert Pride Center, Rainbow Pride Youth Alliance, Associated Gay Youth(Desert) Campus GSA, Brothers United (Gay young men of Color), Bienstar Human Services, and Open and Affirming Congregations to support a targeted Anti-Stigma campaign directed at addressing the dual stigma of Mental Illness within the LGBTQ community.

2.   Provide Seed funding for a series of Town Hall or Mini Conferences Focused On Special Topics of Interest to LGBTQ Community. The targeted audience will be consumers, family and the general lay community.

   a)   Transgender Health Conference
   b)   LGBTQ Mental Health
   c)   LGBTQ People of Color
   d)   Crystal Meth and LGBTQ community
   e)   Special Needs of LGBTQ Youth

Recommendations: Vision: Towards Culturally Competent
Medical Health Care Services for Gay, Bisexual, Transgender & Questioning Consumers in Riverside County

14

ATTACHMENT #12

Cultural Competence Activities

Work Plan Outreach and Engagement / Prevention and Early Intervention
July 2010

Cultural Competence Member Responsible	LGBTQ Task Force
Task	Engagement / Prevention and Early Intervention with LGBTQ community

Summary of Task: There are two components to this task: *i)* the implementation of culturally competent community Outreach and Engagement Program with Gay / Lesbian / Bisexual / Transgender / Questioning service organization groups to determine good strategies for engagement and / Prevention and Early intervention activities for individuals in need of services; and *ii)* the promotion of existing and creation of new support groups lead by community volunteers.

Establish collaboration with key community leaders in the LGBTQ community, including those from non-LGBTQ organizations and faith based organizations that serve the LGBTQ population	• Identify key cultural brokers and community leaders that have knowledge, visibility and influence who serve in key positions within the Riverside County LGBTQ community	
	• Conduct 100 hours of consultation with key cultural brokers and LGBTQ community leaders to:	
	1. Identify existing community based services and resources	D 7
	2. Obtain input to compile community concerns and identify specific gaps about the mental health needs of the LGBTQ community	D 8 (a)
	3. Share the knowledge of the existing community organizations and leaders with the greater LGBTQ community	D 7
	4. Assist with formal introductions to community-based LGBTQ organizations and faith based organizations within and outside of the LGBTQ community	D 8 (a), D 8 (e)
	5. Review informational materials and outreach and engagement documents that are currently in use in the Department of Mental Health	
	6. Develop partnership with local universities to promote graduate level internship opportunities and create innovative linkages with campus resources	D 6 (c)
	7. Promote involvement and representation by LGBTQ community on Mental Health Board, Regional Mental Health Boards and other community level groups	F 4

Form and maintain an LGBTQ Task Force to develop and implement LGBTQ community recommendations	• Conduct regular monthly meetings of the Task Force in each of the Department's 3 service delivery regions to establish a dialogue between community based organizations, LGBTQ leaders and faith based organizations and to discuss mental health issues and strategies for promoting greater awareness of mental health in the LGBTQ community. • Develop an Outreach and Engagement Action Plan to achieve these goals: 1. Establish a collaboration between County mental health services, programs and resources and those offered through LGBTQ community based organizations and faith-based organizations 2. Identify specific outreach and engagement activities that promote a linkage to County mental health services, programs and resources and those offered through and LGBTQ based organizations and faith-based organizations 3. Identify existing barriers that discourage LGBTQ participation and inclusion in the mental health system and develop solutions that overcome those barriers 4. Promote stability, independence and self-sufficiency of collaboration among County and LGBTQ and faith-based organizations to strengthen and expand the system of mental health care for the LGBTQ community and to foster ongoing partnership opportunities 5. Create LGBTQ outreach packets with information about mental health services, programs and resources, including how to access those resources, for distribution at community events, festivals, provider sits and other community locations and with linkages between DMH website and providers' websites 6. Regularly assess progress made in executing the Outreach and Engagement Plan and implement corrective action when necessary	D 2 D 8 D 8 (e) D 8 (a) D 8 (d) F 3 (b)

Develop comprehensive resource list of Riverside County organizations / independent therapists / support groups that provide services to the LGBTQ community	D 7 D 7, F 3 (b) F 3 (c) F 3 (d), J 2 G 1, D 6 (a) i	• Compile list of resources and adapt for use by specific populations and audiences from available information and utilize the LGBTQ leadership to verify the resources • Assemble resources into outreach packets for general distribution within and outside the LGBTQ community • Develop community education materials to communicate general information about LGBTQ people, their lives and families • Identify suitable community based partners (LGBTQ or non-LGBTQ) to conduct 3 community events to introduce and establish the collaboration between the Department of Mental Health and various community based organizations • Promote an effort to co-locate mental health services at locations already providing services to LGBTQ community (such as HIV services providers)
Provide support / informational groups / education about mental health issues to the LGBTQ community	D 8 (f) (1) D 6 (b) D 6 (b)	• Conduct 3 training sessions (four hours each) for LGBTQ leaders to introduce collaboration and provide information about mental health services, programs and resources for the LGBTQ community (each four hour training will train up to 20 participants) • Promote and help coordinate the facilitation of 40 support / informational / educational groups by community leaders; provide stipends for volunteer community leaders doing the groups in their communities (4 hours per group, stipend of $180) • Provide snacks and informational materials package for 40 groups (each group will reach approximately 25 people) to reach out to approximately 1,000 unduplicated count of LGBTQ individuals and their families in the community

Develop a training program to increase the sensitivity, knowledge and skills in providing mental health services to the LGBTQ community	• Solicit input from LGBTQ leaders and mental health professionals about shortcomings in existing delivery system of mental health care to LGBTQ people	D 8 (a)
	• Establish relationships with universities to offer graduate level internships through the DMH	D 6 (c)
	• Encourage representation from the LGBTQ community on the Mental Health Board and Regional Mental Health Boards	F 4
	• Evaluate findings and assess alternatives to address shortcomings	
	• Develop format and curriculum to address shortcomings; promote and coordinate trainings	D 6 (b)

Revised July 2010 by the Cultural Competence Program / Outreach and Engagement Prevention and Early Budget Justification

ATTACHMENT #13

Cultural Competence Activities

Work Plan Outreach and Engagement/ Prevention and Early Intervention

March 2009 Budget Justification

CC Member Responsible: Myriam Aragon / Outreach Staff

Task: Deaf and hard of hearing Community

Summary: outreach/ Prevention and Early Intervention will occur with the deaf and Hard of Hearing Community.

Task : Deaf and hard Community Engagement/Prevention and Early Intervention

Consultation with key experts in the community Establishing a Community Task force.	• Identify key cultural brokers, Deaf and Hard of hearing community leaders who serve key roles within the Deaf and Hard of Hearing community. • 100 hours of consultation with key cultural brokers, and community leaders with goal of 1) Identification of existing community based services, community resources, as well as community concerns regarding the mental health need of the Deaf and Hard of Hearing a; 2) Sharing the knowledge of the community organizations and leaders among the Deaf and Hard of Hearing ; 3) Assist with formal introduction to the community based and faith based organizations; and 4) review informational materials, and other outreach and engagement documents.				
Form a Deaf and Hard of Hearing Mental Health Advisory Group	Monthly meetings to engage dialogue between communities based organizations, deaf and hard of hearing leaders, faith based organizations related to mental health care issues and how promotes mental health. The end result of the Advisory group meetings will be an outreach and engagement action plan • with the goal of: 1) Bridge collaboration between county mental health and deaf and hard of hearing, mental health systems and community based and Faith based organizations; 2) Identify outreach and engagement activities that promote linkage to county mental health and deaf and hard of hearing organizations and programs;3) Remove barriers that discourage deaf and hard of hearing participation and inclusion in the mental health system; 4) foster ongoing partnership; 5) determine progress made regarding the outreach action plan and the Prevention and Early Intervention programs, 6) Create an deaf and hard of hearing outreach packets with information on mental health, mental illness, services, and how to access services for distribution at				

Revised March 2009 Cultural Competence Program/ Outreach and Engagement/ Prevention and Early Intervention/ Budget Justification : Deaf and Hard of Hearing

	community events, and other community activities.				
Conduct Support/Informational Groups/ Education about mental health issues in the community.	• Conduct 3 four hours Mental Health Information educational groups facilitation training for Deaf and Hard of Hearing leaders. (Each four hour training will train up to 20 participants) • Coordinate the facilitation of 40 support/informational/educational groups by community leaders. • Provide stipends for volunteer community leaders doing the groups in their communities (4 hours per group $180) • Provide Snacks and informational materials package for 40 groups (each group will reach approximately 25 people) to reach out approximately 1,000 unduplicated count of deaf and hard of hearing individuals and their families in the community.				
Participation in community events targeting the Deaf and Hard of hearing individuals and their families	• Participate on 3 community events targeting the Deaf and hard of Hearing Community • Prepare the information necessary to reach out the Deaf and hard of hearing Community at Community events. Resources including books, pamphlets, audiotapes and packets dealing with a multitude of issues affecting the Deaf and Hard of Hearing Community • Develop Cultural Diverse outreach materials on issues affecting the Deaf and Hard of hearing community.				
Sign Language Interpretation Services	• Provide sign language interpretation services for consultation, information and training.				
MH providers Training Program to increase the sensitivity, knowledge, and skills in providing services to the Deaf and Hard of Hearing Population	• Coordination of Training				
	Total Cost				

Revised March 2009 Cultural Competence Program/ Outreach and Engagement/ Prevention and Early Intervention/ Budget Justification : Deaf and Hard of Hearing

ATTACHMENT #14

Cultural Competence Activities
Work Plan Outreach and Engagement
August 2007

CC Member Responsible: Myriam Aragon/ CCC/Outreach Staff

Task: Asian American Pacific Islander Population Outreach

Summary: Data indicates that the Asian American/ Pacific Islander population is small but has large unmet needs.

Task : Asian American Pacific Islander Population Outreach

Activities	Deliverables	Timelines	Department Responsible		
Create a Cultural Competence Asian American Task force.	• Data analysis to identify priorities among the Asian American/Pacific Islander population and establishment of priorities • Identification of language needs • Create a Asian American outreach package with basic information on mental health problems and how to access services for distribution in most common languages.				
Identify outreach staff needed to implement outreach plan.	• Number of staff need by region • Allocation of funding to hire staff to do the Asian American outreach in each region.				
Develop a collaborative relationship with the Health clinics and low cost Health services providing services to the Asian American/Pacific Islander community	• List of Health clinics and Low cost health services in the community by regions. • List of Asian American Advocacy agencies including legal services and other social and advocacy groups in the community by regions • Creation of and advisory committee with organizations providing services to the Asian American /Pacific Islander population, that will advice the Department on the strategies which will best provide information and outreach to this population in our communities.				
Participation in community events targeting the Asian American Community	• List of events in the community per region • Prepare the information necessary to reach out the Asian American Community at Community events • Allocation of resources for translation and interpretation services necessary to outreach the Asian American Community.				

Develop Cultural Diverse outreach material on issues affecting the Asian American Community	• Mental Health and HIV/AIDS. • Mental health and gender and sexual orientation issues (LGBT)		
MH providers Cultural Competence Training	• Training MH providers on how to provide cultural competent services to the Asian American/Pacific Islander population. • Celebration of the Asian American /Pacific Islander month.		
Evaluation of Efforts and Results	• Number of events per year • Number of clients entering the system. • Increase of penetration rates • Satisfaction surveys • Focus groups		

August 2007, Cultural Competence Program: Outreach and engagement Plan: Asian American Pacific Islander

ATTACHMENT #15

Cultural Competence Activities

CC Member Responsible: Myriam Aragon

Work Plan Outreach and Engagement/Prevention and
Early Intervention
March 2009
Budget Justification

Task: Native American Population Outreach and Engagement.

Summary: The specific goal for the outreach and engagement project is grounded in the principles of community-based participation and community development. Native American Population has unmeet needs and to address cultural barriers specific efforts must be made targeting this group. Riverside County has a large and diverse American Indian population. It is home to 31,948 American Indians, which is 1.4% of the Riverside County population (Census 2000). Approximately 15% of the American Indians are from the 11 local tribes located within Riverside County. These tribes are comprised mostly of Cahuilla, Luiseno and Serrano people. Approximately 85% of the American Indian population are from other areas. *It is recommended that Riverside County Mental Health partner with existing tribal agencies to outreach to the American Indian community.*

Task : Native American Population Outreach and Engagement/Prevention and Early Intervention

Consultation with community experts for Planning and coordination of events and develop of community participation	• Identify key cultural brokers, tribal cultural Specialist, tribal healers who serve key roles within the Native American community. • 100 hours of consultation with key cultural brokers, tribal cultural specialist with goal of: 1) Identification of existing community based services, community resources, as well as community concerns regarding the mental health need of the Native Americans; 2) Sharing the knowledge of the community organizations and leaders among the Native Americans; 3) Assist with formal introduction to the tribal organizations; and 4) review informational materials, and other outreach and engagement documents.			
Establish a Native American Wellness Alliance (NAWA)	Establish a Native American Wellness Alliance (NAWA) within the community to focus on prevention and traditional healing. Partnering with tribal consortiums within Riverside County is critical to outreach efforts, given the diversity or American Indians residing within Riverside Count y, in terms of both tribal affiliation and spread out living locations Monthly meetings to engage dialogue between communities based organizations, Native American leaders, tribal representatives related to mental health care issues and how promote mental			

Revised March 26 2009 Cultural Competence Program: Outreach and Engagement Prevention and Early Intervention Budget
Justification: Native Americans Outreach

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	health. The end result of the Advisory group meetings will be an outreach and engagement action plan with the goal of: 1) Bridge collaboration between county mental health and Native American mental health systems and community based organizations; 2) Identify outreach and engagement activities that promote linkage to county mental health and Native American organizations and programs;3) Remove barriers that discourage Native Americans participation and inclusion in the mental health system; 4) foster ongoing partnership; 5) determine progress made regarding the outreach action plan
Facilitation of prevention and early intervention activities. Support and informational groups/education about mental health issues in a cultural appropriate manner	• Conduct 3 four hours Mental Health Information educational groups facilitation training for the members of the Native American Wellness Alliance (NAWA) (Each four hour training will train up to 20 participants) • Coordinate the facilitation of 40 support/informational/educational groups by community leaders. Provide stipends for volunteer community leaders doing the groups in their communities (4 hours per group $180) • Provide Snacks and informational materials package for 40 groups (each group will reach approximately 25 people)to reach out approximately 1,000 unduplicated count of Native American individuals in the community
Create an distribute Native American outreach package with basic information on mental health problems and how to access services.	• List of resources available in the community • Mental Health Outreach and engagement/ Prevention and Early Intervention Package
MH Providers Cultural Competence Training	• Training Mental Health providers in how to provide cultural competence services to the Native American Community in collaboration with Native American Advisory council • Celebration of Native American Month.
	Total Cost

Revised March 26 2009 Cultural Competence Program: Outreach and Engagement Prevention and Early Intervention Budget
Justification: Native Americans Outreach

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Executive Summary of Native American Survey Results/ January 2009

Presented here for review is a brief executive summary of the results of the survey with several recommendations for consideration.

What has been gleaned from this survey reveals several preliminary conclusions. DMH received 53 completed surveys. Of the 53 responses received, 35 Counties reported that Native American tribes and/or organizations had participated in the County MHSA/CSS planning process and 18 Counties reported that no Native American participation occurred.

Relative to Native American tribal and/or Urban Indian healthcare organizations receiving MHSA funding in the county, 44 counties or 83% of the responses reported that no Native American tribes and/or organizations were receiving MHSA/CSS funding while nine counties or 17% of the responses reported that Native American tribes and/or healthcare organizations were currently receiving MHSA/CSS funding:

- Three of the nine Counties, funded Urban Indian programs.
- Six of the nine Counties, funded rural California Native American tribes.
- $1,386,793 is the approximate total amount of MHSA/CSS funding awarded to Native American Tribes and/or Urban Indian healthcare organizations, statewide:
  - $1,044,883 or approximately 75% of the total was awarded to Urban Indian healthcare programs.
  - $341,910 or approximately 25% of the total was awarded to rural Native American tribes and healthcare organizations.

Barriers/Obstacles:
Some of the barriers and/or obstacles that counties experienced included but were not limited to:
- Outreach efforts were not tailored to Native American values and customs; the county mental health program is not in line with Native American cultural beliefs.
- Lack of county familiarity of Native American contact protocols, e.g. who to contact first, when to contact, who has authority to make tribal decisions, etc.
- Assuming tribal health program was the primary contact was incorrect and offensive to the tribal leadership.
- County and Native American programs staff turnover.
- Geographic size of county.
- Urban Indian communities represent Indian nations throughout the U.S., "one size does not fit all".
- Meaningful participation and integration of Native American communities was limited due to the structure and timeliness of the MHSA/CSS planning process.
- Lack of strategies for outreach into Native American communities.

County Recommendations:
Recommendations to improve the quality of interaction between County Mental Health Departments and Native American communities included but were not limited to:
- Joint planning efforts with more flexible funding guidelines to meet Native American treatment and support activities.
- Have Rancheria representative on advisory council.
- Needs to be a grassroots approach to include elders and leaders.

- Learn tribal protocols.
- Develop county outreach plan with strategies on how to include Native American population, no matter how small.
- Strive to hold meetings at times and locations that are accessible to the largest number of Indian community members.
- Develop informational materials regarding stigma and urge recognized Indian community leaders, both traditional and Indian Christian Churches, to address the issues of stigma as they reach out to their constituents.
- Dialogue in a culturally appropriate manner of Native Americans to find out what it would take to encourage their participation.
- More directives from the State, e.g., mandated funding levels, funding of regional efforts and more DMH involvement working with tribal organizations.

Other Successful Strategies:

Other successful strategies employed by the counties' included:
- Native American participation in county workgroups.
- Native American community training sessions to all county staff.
- Incorporated Native American healing techniques and drumming circles into its treatment options.
- Seeing more collaborative approaches rather than through an RFP. This extends cultural bias.
- The most effective strategy is to be consistent about supporting community activities. We must continue to enhance our understanding of strategies that are inclusive and that foster integration and participation of the Native American communities in all aspects of the MHSA planning and implementation process.

DMH/Office of Multicultural Services (OMS) Recommendations:

Future strategies for your consideration to improve dialogue and interaction between county mental health departments and Native American communities include support for training and technical assistance at the local level for county and Native American program staff; meeting with Tribal Councils, Tribal/Urban consortia and program Board of Directors, at their locations on MHSA programs and processes; and, the development of culturally appropriate outreach and engagement strategies. In an effort to assist county mental health programs develop and implement outreach and engagement strategies. OMS will continue to hold Native American/Mental Health Partnership meetings to support improved dialogue and partnership between state, county and Native American tribes and Urban Indian healthcare organizations in and throughout California.

Needs Assessment: County Mental Health and Riverside County American Indian Population

SUMMARY

Renda Dionne, Ph.D.

Focus Groups and Interview Participants

Six focus groups and three interviews with American Indian adults utilizing services in Riverside County were held on May 2nd, May 6th, and May 13th 2008, June 10th, 2008, July 14th, July 15th, and July 16th 2008, August 4th and August 26th 2008 to solicit information about their experience with Riverside County Mental Health and inquire about mental health needs. The groups and interviews were facilitated by Dr. Renda Dionne, an American Indian Clinical Psychologist who has been working within the local American Indian community for the past 13 years. Four focus groups were held with American Indian parents, participants of two focus groups included the Board of Directors from Indian Child and Family Services and members from the community. The ICFS Board of Directors includes tribal delegates from 8 of the 11 tribes in Riverside County and a board delegate from Riverside San Bernardino Indian Health Incorporated which has board delegates from 8 of the 11 tribes. The Board Chairs of Riverside San Bernardino Indian Health Inc. and Indian Child and Family Services were present at these groups. A focus group was also held with the Torres Martinez Tribal TANF program in Anza. This TANF program serves the Indio, Anza and San Jacinto areas. Interviews were conducted with the Director of Riverside San Bernardino Indian Health Incorporated Behavioral Health Department (a tribal consortium that has clinics on several reservations), The School Counselor for the Noli Indian school serving middle and high school American Indian children located on the Soboba reservation, and the Executive Director of Indian Child and Family Services, an American Indian Child Welfare Consortium that has been serving Riverside County for over 25 years. Below is a synopsis of major findings. Forty-eight participants representing approximately 20 tribes, 29% represented local tribes and 71% represented out of state tribes, 37% were male and 63% were female. Additionally surveys were distributed at American Indian events. Thirty six surveys were completed.

Focus Group Questions centered around the following:

1) What do you know about County Mental Health?

2. What stops you from/ your clients from accessing services to County Mental Health?

3. What kind of Outreach Could County Mental Health do to improve services for American Indians?

4) What mental health services do you wish were available to American Indians?

5. What are your/your clients biggest barriers to seeking mental health treatment?

6. What changes would you recommend that County mental health consider in providing mental health services to American Indians?

Recommendations/themes mentioned by focus group participants:

Participants were asked about their knowledge and impressions of County Mental Health and recommendations for improved services. Six main topics emerged. One was the need for more culturally appropriate terms for mental illness, two was the importance of reducing the stigma associated with mental illness, three was the need for more culturally appropriate services from within the community, four was the need to educate the community about the signs of mental illness, five was the need for information on how to access services before more serious problems develop; six was the need for programs aimed at a) co-morbid disorders (i.e., substance abuse and depression), b) culturally appropriate parenting services, and c) programs supporting early education success for Native American children . The majority of participants felt that services needed to be culturally competent and delivered from within Native programs who have experience working with the local community and addressing similar issues. Major barriers to Native Americans accessing county services was the lack of Native American staff, stigma associated with accessing any type of mental health care, distrust and limited knowledge of the county system. Inconvenient locations and service delivery delays were also listed as a barrier.

1) Need for Culturally Competent Services across all areas

   Provide culturally appropriate services from within the community. Strengthen the existing American Indian mental health/ child welfare programs.

   There is a widespread lack of culturally competent services even within Native American Organizations. One of the issues many participants expressed concern over is historical trauma and the lack of awareness and understanding of the impact of this on Native American Communities. One participant stated, "How do you provide prevention for something that's been happening for 500 years and is still happening today." There are tribal consortiums located within Riverside County that County Mental Health could partner with to better serve the Native American populations. For example, Indian Child and Family Services, a child welfare tribal consortium agency has been providing prevention services to families for over 25 years. They currently use a motivational interviewing tool called the Indian Family Wellness Assessment which takes into account the impact of historical trauma on parenting and family dynamics and parenting. It is a great intervention tool for motivating individuals to follow through with needed services before larger problems emerge. Because ICFS prevention money is grant funded they have limited funds to deliver these services to the large Native

American population residing in Riverside County. Collaborations with agencies like ICFS or Riverside San Bernardino County Indian Health Inc. to supplement the promising existing prevention programs they have is one solution to providing culturally sensitive programs from within the community by Native American providers or from Native American organizations. Other Native American organizations that could apply for grant funding include the Noli School, Sherman Indian School and Torres Martinez, Morongo and Soboba Tribal TANF Programs.

2) Need for School Drop out/Academic Strengthening Programs.

Provide/fund services that identify academic problems early and strengthen academic success.

Participants expressed a strong desire for programs targeting young children for school success. Many American Indian students, particularly in the foster care system get identified as slow learners. The schools provide limited services to these children and they are often passed along into high school where they struggle academically and many drop out. Of those who graduate, many are unprepared for college. Early academic problems lead to a myriad of mental health problems for youth later in development. One example of the community partnering with a Native American Program doing some of this work would be supporting the Native American College Promotion Program with the University of California Riverside (UCR). UCR currently recruits Native American youth to attend it's summer program aimed at academic strengthening. UCR is continually seeking funds to run this program every summer. The county could partner with this program to support more Native American Youth attending these services. Additionally, ICFS has a foster care program under it's umbrella of services,. These children are frequently in need of tutoring services and funds to go to academic summer camps. ICFS also offers academic strengthening groups as part of grant related services. Noli and Sherman Indian School could use supplemental services such as tutoring as well for the middle and high school students they serve.

3) Need for Culturally Competent Parenting Programs

Provide/Fund culturally tailored, evidence based (evaluated from within the community) parenting programs (Incredible Years and Parent Child Interaction Therapy) delivered by BA level case managers and paraprofessionals.

Participants expressed a strong desire to see parenting programs that are culturally sensitive. Early parenting practices are a powerful predictor of youth mental health outcomes. One example of the community partnering with a Native American agency already doing this type of services is supporting the efforts of ICFS which has the only evaluated, culturally tailored evidence based parenting

program 9The Incredible Years and Parent Child Interaction therapy) in the country specifically for Native Americans. Because the SPIRIT program is offered in home, sessions last two hours and participants are so spread out it is an expensive program to run. The county could support such a program which is well received in the community. These programs are covered by insurance and lead by MA level therapists. Within he Native Community BA level cae managers are used and insurance or medi-cal does not pay for this level of training. It is imperative that programs within American Indian communities allow for paraprofessionals to perform service delivery.

4) Provide education about symptoms of mental disorders and how early intervention can decrease more serious problems and reduce stigma associated with accessing services.

Create New Names for County Mental Health that emphasize wellness and resilience; and don't pathologize the client. Frame mental health problems in terms of normal reactions to historical trauma and oppression. Train mental health professions to provide this more culturally appropriate framework.

Participants stated that there is stigma associated with accessing prevention or mental health services and lack of education about early symptoms related to depression and anxiety: what they symptoms are and how they can be addressed to prevent later problems. Providing education and running anti stigma campaigns through Native American organizations would address these concerns. One issue with mainstream mental health issues is the lack of cultural congruence from the community. Furthermore, the labels pathologize American Indians and make it a within person problems as opposed to a problem of history. For example, depression can be framed as sadness resulting fro historical factors that have had a devastating effects on American Indian communities. The problem is not an individual problem, but rather an problem of history. This is more empowering for American Indian individuals to seek help to address the natural sadness resulting from generations of genocide and oppression. To provide this level of service it is important to train mental health professionals about cultural issues in working with American Indians, as well as support existing American Indian programs and provide resources for them to strengthen their communities by providing the service thorough their programs.

5) Transportation to prevention services.

Provide transportation to services; and food and child care when appropriate.

One barrier to accessing prevention services even if stigma is reduced is transportation to group programs. A program funded to transport Native American to services would improve service utilization and could serve as a leveraged resource for programs existing in Native American organization.

6) Ongoing Native American consultation.

Native American leadership should be an ongoing component of continuing to provide more culturally appropriate and effective mental health services to the American Indian population.

Programs should benefit the Native American Community. There was distrust about the county providing something helpful. Native American Consultants involved in planning, interpretation and implementation is an important component for community buy in and program success. A Native American Consultant should be integrally involved in program planning and consulting on conclusions of results and implementation.

7) Contract with Native Providers and American Indian tribal organizations

Strengthen Native American Mental Health, Child Welfare and Education programs to provide services targeting parenting, academic success, and co-morbid problems like depression and substance abuse from within the community through non –competitive grants and contracts.

The majority of American Indians prefer to utilize services through American Indian tribes and organizations. Within Riverside County these organizations include Riverside San Bernardino Indian Health Incorporated and Indian Child and Family Services. Tribal TANF programs at Morongo, Torres Martinez and the Soboba reservation also provide some services to the American Indian community. There are two main schools serving pre-teen and adolescent children which include the Noli school and Sherman Indian boarding school. There is also a Native American Outreach program at the University of California Riverside. The Soboba, Agua Caliente and Morongo tribes have social service departments which serve their members.

8) Make grants viable for Native American Organizations.

Provide grants and contracts to American Indian mental health, tribal welfare and education consortiums within Riverside County through a mechanism that joins these organizations together in a collaborative, non-competitive manner to increase resources and strengthen services for the large and diverse American Indian community within Riverside County.

Because Native American Tribes represent a smaller numbering the population but bigger numbers in terms of mental health disorders it is recommended that grants be offered which are not contingent on size. For example a Native American Organization should not have to compete with a larger County program for grant funds. The State of California Child Abuse Treatment monies make separate RFP's for tribes than mainstream organizations. Also once funded simplify grant reporting procedures. Many larger federal grants don't have the

same administrative needs as some smaller county grants which make them prohibitive to tribes. Because many services to Native Americans are in home, spread over great distances and last 6 months to a year grants between $100,000 and $200,000 are better able to address the population needs. Native American organizations that could apply for grant funding include Indian Child and Family Services, Riverside San Bernardino County Mental Health Incorporated, Noli School, Sherman Indian School and Torres Martinez, Morongo and Soboba Tribal Tanf Programs. Offering the funding in a non-competitive way is also recommended. Conquer and divide has been a strategy used to colonize Indians and further oppression. Setting up a program where American Indian agencies don' t need to complete against each other but can provide services independently thought their organizations under a American Indian Wellness Center that's joined through collaboration meetings with Money distributed through the county to each organization separately, depending on the services thy provide would bring more strength and resources to the community.

9) For County Mental Health Services: have more Native providers and culturally competent providers on staff.

Having American Indian service providers includes providing mechanisms to deliver services in a culturally competent manner and educational avenues for American Indians to pursuer advanced degrees in the mental health field. Intensive cultural competency training providing by American Indian from American Indian programs for staff is also highly recommended.

For the minority of participants that stated they would prefer services outside of Indian country recommendations includes having culturally competent staff and Native providers in visible positions. Mental Health workers need to be well informed about the Native services in their areas. There also needs to be a mechanism to support Native Americans in pursuing degrees in mental health and training by Native Americans on providing mental health services to the Native American community.

10) Community outreach

Community outreach in collaboration with American Indian consortiums and organizations within Riverside County is recommended.

In collaborating with Tribal organizations, it is recommended the county do more listening than leading. Community outreach is critical to reducing stigma and better informing the American Indian Community about RCMH services. Participants stated collaborating and outreaching through American Indian programs was the best approach. Many parents expressed concern and frustration that they are unaware of the services available to them. Survey results indicated there was a high need for services but limited knowledge of county mental health services.

11) Improve logistical issues for county mental health services.

Improve speed of service delivery from time of contact to service provision.

Easier access to services including locations and entry time from the point of client contact/ referral to the time of service provision; and easier access to services involving dual diagnosis with substance abuse.

Working collaboratively with American Indian organizations to establish effective, culturally sensitive programs to address client needs is recommended as a next step in better serving the American Indian population. Because Riverside County includes such a large and diverse American Indian population it is recommended that American Indian organizations with experience serving this diverse group of clients be utilized as a priority.

Needs Assessment: County Mental Health and Riverside County American Indian Population
Focus Group #1 Write-Up
Date: June 10, 2008
Number of Participants 6 (Male 3; Female 3, representing 5 tribes (4 local, 2 out of state)

1) What do you know about County Mental Health?
Participants did not know a lot about Riverside County mental health. One participant reported he had a friend who went their and got locked up without them asking many questions.

2. What stops you from accessing services to County Mental Health?
Participants perceptions were that you had to be really crazy to access these services and they viewed providers as incompetent, racist and lacking cultural sensitivity. Most participants stated Indians like to seek help from Indians and that services from County mental health would be culturally inappropriate. Statements included: "They look down on us because we're native," "They'll treat us worse because we're native," "Indians like to seek help from other Indians."

3. What kind of Outreach Could County Mental Health do to improve services for American Indians?
Some participants stated they would need to show more respect and empathy with American Indian while others felt there were too many cultural differences between natives and non-native providers. They recommended they should contracts with and refer to Native providers and Native organizations at best and have Indians on staff and be culturally educated at worst.

4) What services do you wish were available to?
Participants reported they would like culturally appropriate mental health services through American Indian organizations.

5. What are your biggest barriers to seeking mental health treatment?
Participants stated barriers included the lack of culturally appropriate services within mainstream organizations and limited services offered by Native organizations and tribes.

6. What changes would you recommend that the County consider in providing mental health services to American Indians?
Participants had several recommendations.
1) Contract with Native organizations and providers.
2) For the few participants that stated they would prefer to go to a non Native organization recommendations included having culturally competent staff and native providers in visible positions.

Needs Assessment: County Mental Health and Riverside County American Indian Population

Focus Group #2 Write-Up

Date: June 15, 2008
Number of Participants 12 (Male 4; Female 8, representing 7 tribes (1 local, 11 out of state)

1) What do you know about County Mental Health?

Most participants did not know a lot about Riverside County mental health but they had a general feeling of distrust. The few that had some services were dissatisfied with the services they received.

2. What stops you from accessing services to County Mental Health?

Participants perceptions were that county mental health operated like an inpatient hospital and that they will keep you, they will misdiagnose you for cultural reasons and treat you with a lack of respect. The felt accessing these services would result in a loss of cultural identity and that would be alienated: the only Indian there. A few participants reported they had accessed services and felt services were culturally inappropriate, stigmatizing, that they were rules by white man's rules and that they were talked down to. They also reported they had too many forms, inconvenient locations, too much turn over and were generally ignorant about Indians.

3. What kind of Outreach Could County Mental Health do to improve services for American Indians?

Some participants stated they would need an Indian liasion to reduce some of the stigma associated with mental health services, that they would need to spend more time with the American Indian community, and utilize American Indian organizations for services for Native people.

4) What services do you wish were available to?

Participants reported more services through American Indian organizations and a shelter house just for American Indians.

5. What are your biggest barriers to seeking mental health treatment?

Participants stated barriers included fear of seeking mental health services because of being locked up or stigma, prejudice from non Native providers and preference from Natives for American Indian providers or organizations and a lack of culturally appropriate services including services centered around native conceptions of health and what is normal.

6. What changes would you recommend that the County consider in providing mental health services to American Indians?

Participants had several recommendations.
1) Change the name Mental health it's too stigmatizing.
2) Contract with an Indian liaison for outreach to the community.
3) Support services through Native organizations.
Have more culturally sensitive staff, not just from book knowledge but experience.
4) Operate roe like a private insurance and don't' have so many barriers to accessing services (less forms, access number to make an appointment like private insurance).

Needs Assessment: County Mental Health and Riverside County American Indian Population
Focus Group #3 Write-Up

Date: June 16, 2008
Number of Participants 10 (Male 5; Female 5, representing 6 tribes (3 local, 7 out of state)

1) What do you know about County Mental Health?
Most participants reported that it was a place for people really bad off and that they solely treat you with medication. Several participants reported you would have to be really, really crazy to go there.

2. What stops you from accessing services to County Mental Health?
Participants perceptions were that county mental health was for people that were really crazy and bad off. One participant stated her mother would rather see her go to jail than county mental health. Participants also reported the lack of cultural sensitivity and Native providers. On participant state that drunk and crazy behavior is more acceptable within the community and isn't seen as a need to access services.
operated like an inpatient hospital and that they will keep you, they will misdiagnose you for cultural reasons and treat you with a lack of respect. The felt accessing these services would result in a loss of cultural identity and that would be alienated: the only Indian there. A few participants reported they had accessed services and felt services were culturally inappropriate, stigmatizing, that they were rules by white man's rules and that they were talked down to. They also reported they had too many forms, inconvenient locations, too much turn over and were generally ignorant about Indians.

3. What kind of Outreach Could County Mental Health do to improve services for American Indians?
Some participants stated they would need to work more closely with American Indian organizations and that these organizations could educate their providers to a degree, that providers need to understand Indian history and traditions and that ceremony needs to be incorporated into services.

4) What services do you wish were available to?
Participants reported more services through American Indian organizations and an Indian hospital.

5. What are your biggest barriers to seeking mental health treatment?
Participants stated barriers included stigma associated with accessing services and a taboo about telling people outside the family about your problems. Barriers also included culturally inappropriate services. Participants reported, "There are conflicts with differences in identity, safety and security," "This isn't our society we're just living uin it," "The whole way mainstream mental health looks at things is not Indian.", One participant stated she didn't like the word depression. or prevention. We're sad because of what happened here (genocide) we can't prevent it it already happened."

6. What changes would you recommend that the County consider in providing mental health services to American Indians?
Participants had several recommendations.
1) Money for mental health for American Indians should come straight to Indian organizations.
2) Change the name Mental health it's too stigmatizing.
3) Contract with Indian organizations and providers. Comments included, "We prefer Indian organizations and clinics," "We want American Indian providers,"
4) There was distrust that the county would collaborate with an Indian organization so several participants said have them show us what they're really going to do and then we can tell them the problems with it. There was general distrust that they would take the feedback and user it to the benefit of Indian people.

Needs Assessment: County Mental Health and Riverside County American Indian Population

Focus Group #4 Write-Up

Date: August 4, 2008
Number of Participants 3 (Male 0; Female 2, representing 2 tribes (3 local, 0 out of state)

1) What do you know about County Mental Health?
Participants reported they didn't know anything about county mental health.

2. What stops you from accessing services to County Mental Health?
Participants reported a lack of knowledge and a lack of education on when mental health services would be needed. Participants also reported the lack of cultural sensitivity and Native providers.

3. What kind of Outreach Could County Mental Health do to improve services for American Indians?
Some participants stated they could provide more education about mental health disorder and how to access services through American Indian organizations. Participants felt providing a conference would be a good way to get this information out.

4) What services do you wish were available to?
Participants reported more knowledge about service and when services were indicated like for depression or substance abuse (conferences).

5. What are your biggest barriers to seeking mental health treatment?
Participants stated barriers included stigma and lack of knowledge about the benefits of mental health treatment.

6. What changes would you recommend that the County consider in providing mental health services to American Indians?
Participants had several recommendations.
1) Provide more education about the benefits of mental health services.
2) Reduce the stigma associated with accessing mental health services.
3) Outreach through American Indian organizations and with American Indian providers.

Needs Assessment: County Mental Health and Riverside County American Indian Population

Focus Group #5 Write-Up

Date: July 26, 2008
Number of Participants (6 Male ; 6 Female)

What services are needed for the American Indian community?

Culturally competent parenting programs that incorporate historical trauma and is delivered from within the American Indian community.

Reduce stigma of mental health services

American Indian students to University of California Riverside to decrease high school drop out.

Include services for the whole family.

Outreach to isolated urban elders

Incorporate teaching on traditional things as part of services..

Needs Assessment: County Mental Health and Riverside County American Indian Population

Focus Group #6 Write-Up

Date: September 2008 **Tribal TANF Focus group** (4 people)

What do you know about County mental health and what do you recommend to improve the collaboration between RCMH and the American Indian community.

They don't know about County Mental Health and the name brings up negative images. They recommend more presence in the community.

Needs Assessment: County Mental Health and Riverside County American Indian Population

Interviews

Indian Child and Family Services Executive Director: Luke Madrigal May 13th, 2008
Riverside San Bernardino County Mental Health Inc. Behavior Health Services Director: Herb McMichael May 2, 2008, and Noli School Counselor: Kim Marcus July 14th, 2008

1) What do you think about County Mental health for American Indian's. Interviewees said they either knew little about RCMH or that they had difficulty accessing/utilizing the system if they did know.

2) What are the barriers for American Indians and Tribal organizations in working with RCMH?

Interviewees stated a lack of a relationship, collaboration or knowledge between tribes and RCMH, distrust of American Indians towards the county mental health system, lack of culturally competent providers or services for the American Indian community. Examples of distrust from participants include:

- o Enthnocentrism. Don't understand our culture. History and cultural practices
- o Invisible to them-want to lump us in with other minorities and not really understand us.
- o No collaboration, county has never contacted us, doesn't know about us.
- o No Culturally appropriate services
- o They don't want to give up their money as if we're incompetent to control the funds and serve our people
- o The wait list to get in delays getting client services and then they don't follow through.
- o The money to serve tribes should go to the tribal organizations not the state
- o RSBCIHI is not an insurance company or a health care plan. They should be payer of last resort and the county wants to charge them for services.

3) Would you be interested in a grant from RCMH

Some interviewees reported they would be interested, while others stated they felt too many strings would be attached. Comments included:

- a. If it was set up in right way and offered us something applicable to our people- that meets our needs.
- b. Need prevention money for parenting and treatment money for substance abuse, anxiety, depression, trauma, anger management.

4) How do you outreach to the urban/tribal AI community? Interviewees reported to work through consortiums and add to their recruitment efforts and recruit for each other. Work with tribes through programs already serving them with prevention and treatment services.

5) How could RCMH develop a better relationship with American Indians, tribes and Native organizations?

Interviewees reported there isn't one right answer. That different Native organizations and tribes have different needs.

6) What is the past history of tribes, American Indians using county mental health programs? Interviewees reported court ordered people use their services.

7) How can the county better serve the Indians that do come to them? Interviewees reported using programs that are culturally sensitive. Referring them to AI programs.

8) How can the county best serve the AI population in Riverside County? Interviewees reported contract with AI consortiums and tribes that provide prevention and mental health services for AI people.

9) Any differences in services in for urban versus local tribal people? Interviewees responded that there was a greater outreach for urban population.

10) Main issues that need to be addressed for AI in terms of mental health? Interviewees reported issues were substance abuse, criminal behavior, sexual abuse, child abuse, domestic violence, elder abuse, learning disabilities, depression, anxiety disorders, compulsive eating-obesity-diabetes, suicide. Top three- Child Neglect, Drug/Alcohol Abuse, Depression.

11) What needs to be part of the training for CMH for AI's. Interviewees reported that History, Historical Trauma(genocide, boarding schools, forced adoptions, re-location), Knowledge of tribal programs in the county and who they serve and the referral process, sovereignty and tribes in the area, diversity of tribes in Riverside county urban Indian population, cultural norms for assessments are biased, prejudice, discrimination and harm of stereotypes.

12) Administrators need to know: Give funds to AI programs when possible, in meetings let AI set agenda and listen more than talk, be flexible and try to meet AI needs into what's possible instead of can't work because of the system.

13) Elders and mental health: Many raising their grandchildren, many have extended family care-don't like to board them.

14) Anything else you want to add? Poverty is a huge issue for AI's. Need housing and basic needs to be cared for.

Surveys
26 open ended questions and 10 multiple choice.
September 26th, 27th and 28th Morongo Reservation Pow Wow
September 26th San Manuel Band of Indians California Indian Event at Cal State San Bernardino.

More participants filled out open ended than multiple choice surveys. Surveys indicated there was a high need for services but very little knowledge about county mental health. To improve outreach recommendations included outreaching at American Indian events. Participants stated the biggest barrier was lack of knowledge about County Mental Health services.

ATTACHMENT #16

Cultural Competence Activities
Work Plan Outreach and Engagement
August 2007
Draft

CC Member Responsible: Myriam Aragon/ CCC/Outreach Staff

Task: African American Population Outreach

Summary: The goal of the outreach to African American population is to increase awareness among the African American community about the availability of mental health services and to refer them to existing mental health services

Task : African American Population Outreach

Activity	Deliverables	Due Date(s)	Person(s) Responsible	Status
Create a Cultural Competence African American Task force.	• Data analysis to identify priorities among the African American population and establishment of priorities. • Identification of language needs. • Create an African American outreach packets with basic information on mental health problems and how to access services for distribution • Number of Outreach staff need by region			
Identify outreach staff needed to implement outreach plan.	• Allocation of funding to hire staff to do the African American outreach.			
Develop a collaborative relationship with the Health clinics, churches and low cost Health services providing services to the African American community	• List of Health clinics and Low cost health services in the community by regions. • List of African American Churches in the community by regions • List of African American Advocacy agencies including legal services and other social and advocacy groups in the community by regions • Creation of and advisory committee with organizations providing services to the African American population, that will advice the Department on the strategies which will best provide information and outreach to this population in our communities.			
Develop Cultural Diverse outreach materials on issues affecting the African American community	• Mental Health and HIV/AIDS • Mental Health and gender and sexual orientation issues.			

August 2007. Cultural Competence Program: Outreach and engagement Plan: African American

Participation in community events targeting the African American Community	• List of events in the community per region • Prepare the information necessary to reach out the African American Community at Community events. Resources including books, pamphlets, audiotapes and packets dealing with a multitude of issues affecting the African American Community		
MH providers Cultural Competence Training	• Training MH providers on how to provide cultural competent services to the African American population. • Celebration of the African American/ Black month.		
Evaluation of Efforts and Results	• Number of events per year • Number of clients entering the system • Satisfaction surveys • Focus groups		

Myriam Aragon, MFT
Riverside County Mental Health Department
Manager, Mental Health Cultural Competency
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**PROPOSAL FOR CULTURAL COMPETENCE ACTIVITIES
FOR
COMMUNITY AND FAITH-BASED ORGANIZATIONS**

PURPOSE

Provide Riverside County Mental Health Department with information and input from African-American community leaders and representatives involved with community organizations and congregations in the Western, Mid-County and Desert regions of Riverside County. The work of the consultant will engage these leaders and representatives in four key activities that will increase the communication and understanding of cultural competent mental health services. All activities will be conducted between January 2010 and January 2011. Each proposed activity will be evaluated by participants.

Proposed Activities

African-American community and faith leaders and representatives who serve key roles in the African-American community will be consulted and engaged in activities to increase the awareness that African-American organizations have about the availability of mental health services and increase their knowledge and referrals to existing mental health services. Participants will come from the Western, Mid-County and Desert regions of Riverside County. The consultant will engage these participants in four (4) outreach, prevention and early intervention activities. The activities to be accomplished are:

Consultation With Key African-American Community Leaders

100 hours of consultation will identify 75 existing key African-American community and faith leaders who serve key roles with African-American organizations and communities in Western, Mid-County and Desert regions of Riverside County. Consultant will research and create a list and e-mail data base identifying the names, addresses and

contact person for 75 community and faith organizations in Western, Mid-County and Desert regions of Riverside County. These organizations will be 501 (c) (3) tax-exempt public benefit and religious organizations as well as informal community-based organizations.

(100 hours/$125 per hour/$12,500)
Total - $12,500

The consultant will engage these leaders in identifying existing community based services, services they provide, community resources and the identification of community concerns regarding the mental health needs of African-Americans. The participants will also share their knowledge of community organizations and review informational materials, and other outreach and engagement documents.

Consultant will develop a survey that will incorporate the above referenced information into a data base identifying the services provided by community and faith organizations, identify their knowledge of community resources and identify the mental health needs of African-Americans. A printed document of the data will be used by participants as a tool to assist them become more aware of mental health services, mental health systems and lead to the development of a strong network between project participants. 50 hours will be devoted to the development, printing and distribution of the survey instrument.

50 hours/$75 per hour/$3,750 - Survey.
Total _ $3,750

Formation of African-American Mental Health Advisory Group

The next component of the proposed Cultural Competence activities involve the consultant forming an African-American Mental Health Advisory Group comprised of leaders from community and faith based organizations. The participants will represent the Western, Mid-County and the Desert regions of Riverside County. The purpose of the twelve, two hour meetings will identify mental health issues in the African-American community. The mental health topics to be discussed will be mental health issues identified in the community survey. The appropriate mental health professional will be invited to meetings to discuss issues raised by the advisory group. Each meeting will have an agenda and discuss mental health care issues and ways to promote quality mental health services in the county's African-American community. The discussions will cover the mental health system and increase the participants knowledge of this system. The advisory group will also discuss the removal of barriers that discourage African-Americans from participating in the mental health system. The information obtained through advisory group meetings will foster relationships and partnerships among these groups. Five (5) hours per month will be devoted to preparation, travel and conduct of meetings of the African-American Advisory Group.

Preparation time for the advisory group meetings will include preparing meeting agendas, notifying participants of the meetings, finding a location for meetings, reminder calls for the meeting. A sample agenda would include:

Each group will last two (2) hours. The consultant will serve as facilitator. Enclosed is a sample format for the focus. Input will also come from prospective hosts:

> A. Welcome – Host organization
> B. Introductions/name, organization
> C. Purpose/Background of Project/Ground Rules - Facilitator
> D. Participants share their knowledge of mental health services in their community.
> E. Participants share their perception and attitudes about mental health services in their community.
> F. Mental Health Professional – speaking on topic identified by advisory group.
> G. Participants share culturally relevant mental health services they would like to see in their communities.
> H. Thank You/Wrap up and next step – Facilitator.

(30 hours/ $75 per hour/$2,250).

Monthly meetings will include attendance, preparing room for meeting, guiding members through agendas, facilitating discussions and recording notes

30 hours/$125 per
hour/$3,750)
Total _ $6,000

The consultant will lead the African-American Mental Health Advisory Group in the creation of an Engagement Action Plan. Information obtained from the survey that will be the second activity to be completed will identify specific actions the participating organizations will take to bridge collaboration between the community and faith organizations. It will specifically describe how they will work together, activities they will engage in, who will be responsible and the anticipated outcome. They will identify specific outreach and engagement activities that will connect the African-American participants to county mental health professionals and paraprofessionals.

The Engagement Action Plan will include a mission, vision, priorities, timelines and identification of person(s), organization responsible for carrying out the activity. The work of each group will be presented to the entire advisory group for approval and recommendation to Riverside County Mental Health.

The Engagement and Action Plan will include a list of activities needed to remove barriers that discourage African-American participation in the mental health system.

Priorities and activities will identify ways the advisory group and the county's mental health department can foster and build partnerships.

Once the Engagement and Action Plan is completed, the consultant will create an African-American outreach packet that contains a project logo, printed information on mental health, mental illness, services and how to access services. These materials will be used at community events and activities.

Preparation of Engagement and Action Plan
50 hours/$75 per hour/$3,750
Total - $ 9,750

Support/Informational Groups/Education About Mental Health in the Community

The consultant will conduct 3 four hour Mental Health Information educational groups facilitating training for 20 African-American leaders. One session each will be conducted in the Western, Mid-County and Desert regions of Riverside County. These sessions will include

The consultant will coordinate the facilitation of 40 support/informational/educational groups to increase their knowledge of mental health services, systems and how to engage African-Americans in a discussion on their mental health services needs and their perceptions of mental health services. Volunteers completing groups will be given stipends.

The consultant will plan and conduct a training program to assist congregations and community organizations to connect their constituents. She will use the PEWS (Program for Emotional Wellness and Spirituality) Program developed by the Mental Health Association in New Jersey. The Riverside County version will train representative from the congregations how to use this program in their congregations. The program has educated African-American clergy, lay people and church communities to link parishioners to mental health services when needed and to address negative attitudes surrounding mental illness in the African-American community. The training will include a video created by MHANJ *(Anything But Crazy: African-Americans, Emotional Wellness and Spirituality)* Participants will review the video and then discuss it and how the program can be used in their congregations. In addition the training will include additional sessions that will include discussions and presentations by mental health professionals and community-based organizations to inform congregations of key mental health issues, services that are available and how to access them for their parishioners. To the extent possible, it is recommended that the mental health department staff working with this program be African-American. The consultant will develop a PEWS training manual for congregations to use to implement the program. The consultant will assist congregations set up and introduce the PEWS Program to their congregations. She will monitor their progress and provide technical assistance if needed. Participants will be encouraged to obtain additional information on mental health services by participating in

dialogues when they are scheduled in their community. It is recommended that incentives be used to increase participation in this program. Participants completing the training will receive a certificate. Congregations completing all the required hours of training plus conduct one PEWS meeting will receive a gift card.

Preparation for training -6 hrs./$75/$450
Training – 12 hours training – 12 hrs/$125/$1,500
Printing/training materials - $500
Total - $2,450

Preparation and conduct of facilitation services by consultant – 16 hours/$125/$2,000
Stipends to Volunteers - $5,200

Total - $7,200

Consultant will provide snacks and printed materials to an unduplicated count of approximately 1,000 African-Americans. Identify, prepare and distribute informational materials to project participants.

Total – $10,000

Participation in Community Events Targeting the African-American Community

Consultant will participate in a variety of community events targeting the African-American community. These events will include Black History Week events, Juneteenth Activities, Faith conferences, Community health fairs and other events. Consultant will pay registration fees to obtain display space and distribute materials. Information/materials prepared by mental health advisory group will be distributed, the engagement and action plan will be made available to the public. Consultant will review weekly newspapers directed at the African-American community to locate and identify community events. Advisory group members will be invited to participate in these events. The consultant will utilize community/faith calendars to promote the project and meetings.

4 hours per month/48 hours/ $125 per hour
Total - $6,000

Purchase culturally diverse outreach materials with MHAG logo to be distributed at community events. These events would include pens, pads, buttons, rulers, etc. Consultant will work with the Mental Health Advisory Group to identify and purchase culturally diverse books, audiotapes, pamphlets and other information sources to distribute at community events.

Total – $2,500

Proposal
Riverside County Department of Mental Health
November 2009
Grand Total for all components
$60,150

ATTACHMENT #17

Spirituality
As Part
Of Mental Health
Recovery
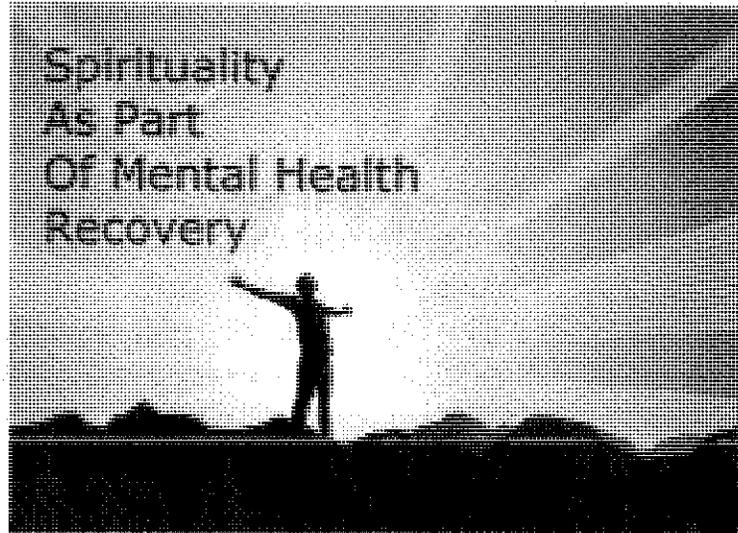
Presented by:

Riverside County
Department of Mental Health,
Cultural Competency Committee

Spirituality as Part of Mental Health Recovery

DISCLAIMER

Riverside County Department of Mental
Health's Cultural Competency Committee
<u>does not</u> endorse any specific faith,
religion/lack of religion and/or spiritual
beliefs, but recognizes the importance of the
role of spirituality in mental health recovery.

Purpose of the Presentation

1. Introduce the Mental Health Spirituality
   Initiative.
2. Create a dialogue, and to increase
   awareness on the importance of Spirituality in
   the Mental Health Recovery.
3. Increase participant's comfort in discussing
   spiritual issues.

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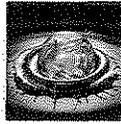
"As long as any of us can remember, Spirituality and Mental Health Services-- like oil and water --did not mix.: (Keyes, 2002)

"Mental Health Professionals kept spirituality out of their practice, while some spiritual people looked at mental health services with skepticism." (Keyes, 2002)

Riverside County Department of Mental Health Cultural Competency Committee in collaboration with spiritual and religious entities are working to break out of traditional ways to adopt innovative approaches to mental health services. We are looking to see what we can learn from one another to better serve people.

Keyes, Cory (2002) Journal of Health and Social Behaviour 43: 207-222

Mental Health & Spirituality Initiative

The State Initiative Summary

The California Mental Health & Spirituality initiative was established in June 2008 at the Center for Multicultural Development of the California Institute for Mental Health. It developed out of a grassroots movement founded in 2006 by Jay Mahler and other consumer, family members, and service providers.

- June 2009 Conference
- Online Annotated Resource Database: www.mhspirit.com
- Survey of Counties
- Survey of Clients & Families

Definition of Terms

let's take a minute to clarify what we mean.

☐ **Spirituality** is an individual's internal sense of meaning, purpose, and connection to something greater than oneself (which could be, for example, family, community, humanity as a whole, or a higher power).

☐ A **religion** is an organization that is guided by shared beliefs and practices, whose members adhere to a particular understanding of the holy and participate in religious rituals.

☐ Some people's **spirituality** is deeply informed by participation in organized **religion**, while others describe themselves as "spiritual but not religious."

☐ So, **spirituality** is a broader term for this aspect of human beings. Most people recognize a spiritual dimension; however, not everyone takes part in organized **religion**

Source: David Lukoff, PhD. CIMH Survey Research Consultant.

Spirituality as Part of Mental Health Recovery

RCDMH The Cultural Competence/Reducing Disparities Committee

In an effort to provide the best spiritual support to people in recovery, shall engage in the following:

1) The formation of Spirituality Taskforce

2) Training

3) Engagement of Spiritual Leaders and organizations

4) Roundtables

Spirituality as Part of Mental Health Recovery (cont)

Training

provide staff with "Spirituality as Part of Mental Health Recovery" training:

- *Obtain knowledge about local spiritual groups, including their traditions and practices and provide it to mental health professionals.*
- *Create a guide for mental health professionals, about the relationship between mental health recovery and spirituality.*
- *be aware of situations in which spiritual beliefs and activities could potentially be harmful, to an individual's recovery.*
- *To facilitate dialogue and to begin establishing guidelines*

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Spirituality as Part of Mental Health Recovery (cont)

Roundtables

invite clergy and other spiritual leaders from many faiths and humanist organizations, to participate in establishing guidelines for successful engagement of consumers, their families and supporters.

- ☐ *Open dialogue*
- ☐ *Encourage crosstraining*

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Spirituality as Part of Mental Health Recovery (cont)

Engagement of Spiritual Leaders and organizations.

☐ *Establish on going relationships with local clergy and faith communities.*

☐ *Building trust*

☐ *Developing a community directory of Spiritual resources available in the community*

Spirituality as Part of Mental Health Recovery (cont)

Spirituality Taskforce

Establishing a Spirituality Taskforce that will be responsible for overseeing the Spirituality as part of Mental Health Recovery for Riverside County Department of Mental Health.

■ *Members will be recognized as key partners who will have active involvement regarding policy recommendations, program review , and activities that address spirituality as part of mental health recovery.*

■ *Members will reach consensus on common priorities and present recommendations regarding implementation of strategies that address spirituality as part of mental health recovery.*

■ *Build a speakers pool*

Emerging Questions

☐ How a person's mental health recovery may be influenced by their spirituality?

☐ How and by what means a person's mental health can be affected by exposure to others that openly practice their faith?

☐ How a person's spirituality may be affected by their mental health?

All mental health professionals, regardless of their own spirituality, will strive to be sensitive, knowledgeable and skillful to spiritual needs.

Keeping in mind that a practitioner also has the right/responsibility to rescue him/herself in the event that the spiritual/religious belief may require their recusal

Regardless of their own view on spirituality, and religion, mental health professionals will proceed with spiritual sensitivity, knowledge and skills toward others .

Common Perceptions of Mental Health Providers

More than 90% of the County Behavioral Health Directors surveyed responded "strongly agree" or "agree" to the following statements:

☐ Spirituality is an important recovery resource in mental health treatment (92%)

☐ Spirituality is an important wellness resource in mental health prevention (94%)

☐ Spirituality is an important element of multicultural competency for mental health providers (91%)

Mental Health and Spirituality Initiative
CIMH

Clergy as a Gatekeeper to Mental Health

- Only 38.9% of those who sought MH help from religious provider were seen by MHP.
- 56% of them were seen only by clergy (Wang et al., 2003)

Data source: NCS (National Comorbidity Survey N=8098. Age 15-54)
Wang, Berglund & Kessier (2003)

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We must keep in mind that for the majority of spiritual people, their spiritual resources are important coping mechanisms that:

- Often help prevent many physical and mental illnesses.
- are linked to a reduction in both symptom severity and relapses.
- can be very influential on the speed of a person's recovery, as well as rendering distress and disability easier to endure.
- enhance recovery by diminishing distress and facilitating resilience in the face of disability

RCDMH Spirituality Initiative Committee 2009

Spirituality and Recovery

- ☐ A Principle of the spiritual approach to healthcare is that, while adversity befalls everyone, it is possible to grow through it.
- ☐ It is believed that people often become stronger emotionally, more resilient, and more mature.
- ☐ People with solid spiritual foundations tend to be healthier and recover better when they are faced with adversity.

Murray & Zentner (1989: p. 259):

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Spirituality has been called:

"a quality that strives for inspiration, reverence, awe, meaning and purpose; even in those who do not believe in a higher power."

Murray & Zentner (1989: p. 259):

A Holistic Approach to Mental Health Recovery.

Curing Symptoms and Helping a Person to Heal.

Both are <u>equally important</u> when working with people in Recovery and their families.

Assessing Spirituality is Ethical Imperative.

Spiritual Assessment Defined

"Spiritual Assessment is the process by which health care providers can identify a consumer's spiritual needs pertaining to their mental health care. The determination of spiritual needs and resources, evaluation of the impact of beliefs on healthcare outcomes and decisions, and discovery of barriers to using spiritual resources are all outcomes of a thorough spiritual assessment". (Dr. David Lukoff, PhD. drlukoff@comcast.net)

Source: Spiritual Competency Resource Center. http://www.spiritualcompetency.com.

Areas of Spiritual Competency for Mental Health Providers When Assessing Spirituality

Attitudes

☐ Awareness of and appreciation for one's own spirituality and religious experiences and their impact on identity and values.

☐ Awareness of one's attitudes towards spiritual and religious experiences and practices.

☐ Awareness of one's possible biases that could influence assessment and therapy.

☐ Empathy, respect, and appreciation for clients from all spiritual and religious backgrounds.

Source: Spiritual Competency Resource Center. http://www.spiritualcompetency.com

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Areas of Spiritual Competency for Mental Health Providers When Assessing Spirituality.

Knowledge	Skills
Defining spirituality and religion, including both their similarities and differences.	Ability to provide culturally competent services with the religions and spiritual problems.
Understanding the impact of spirituality and religion experiences and beliefs on physical and mental health.	Ability to provide culturally competent services with spiritually and religiously committed clients.
Understanding the differential diagnosis among spiritual and religious experiences, and problems, and mental health disorders.	Ability to recognize the differential diagnosis among spiritual and religious experiences, and problems, and mental disorders.

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Areas of Spiritual Competency for Mental Health Providers (cont)

Knowledge	Skills
Understanding the spiritual and religious factors that affect recovery from mental disorders.	Ability to elicit a religious and spiritual history that covers background, beliefs and practices.
Understanding the professional ethical issues involved in religion and spirituality.	Ability to recognize when a client's spiritual or religious views are healthy coping responses and when they are harmful.

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Areas of Spiritual Competency for Mental Health Providers (cont)

Knowledge	Skills
Understanding the variety of spiritual and religious experiences and traditions, and their unique perspectives on transpersonal issues.	Ability to collaborate with and refer to religious and spiritual professionals. Ability to obtain information on religious and spiritual experiences and beliefs that impact clinical outcomes.
Source: David Lukoff, PhD. drlukoff@comcast.net	

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Spiritual Assessments

☐ Spiritual Assessment Interview
☐ FICA
☐ HOPE

Source: Spiritual Competency Resource Center.
www.spiritualcompetency.com

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Spiritual Assessment Interview

A. Religious Background and Beliefs.
B. Spiritual Meaning and Value.
C. Prayer Experiences.

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Spiritual Assessment Interview

A. Religious Background and Beliefs

1) What religion did your family practice when you were growing up?
2) How religious were your parents?
3) Do you practice a religion currently?
4) Do you believe in God or higher power?
5) What have been important experiences and thoughts about God/Higher Power?
6) How would you describe God/Higher Power? Personal or impersonal? Loving or stern?

Spiritual Assessment Interview (cont)

B. Spiritual Meaning and Value

1) Do you follow any spiritual path or practice (e.g. meditation, yoga, chanting)?
2) What significant Spiritual Experiences have you had (e.g., mystical experience, near-death experience, 12 step spirituality, drug-induced, dreams)?

Spiritual Assessment Interview (cont)

C. Prayer Experiences.

1) Do you Pray? When? In what way (s)?
2) How has prayer worked in your life?
3) Have your prayer been answered?

(Recommended exercise: Use the spiritual
Assessment Interview with yourself.)

Source: Spiritual Competency Resource Center
www.spiritualcompetency.com

FICA Spiritual Assessment

Another approach to Spiritual Assessment
uses the acronym FICA.

F: Faith and Beliefs

I: Importance and Influence

C: Community

A: Address

FICA Spiritual Assessment (cont)

F: FAITH AND BELIEFS

1) What are your spiritual or religious beliefs?
2) Do you Consider yourself spiritual or religious?
3) What things do you believe that give meaning to your life?

FICA Spiritual Assessment (cont)

I: IMPORTANCE AND INFLUENCE

1) Is it important in your life?
2) How does it affect how you view your problems?
3) How has your religion/spirituality influenced your behavior and mood during this illness?
4) What role might your religion/spirituality play in resolving your problems?

FICA Spiritual Assessment (cont)

C: COMMUNITY

1) Are you part of a spiritual or religious community?
2) Is this supportive to you and how?
3) Is there a person or group of people you really love or who are really important to you?

A: ADDRESS

1) How would you like me to address these issues in your treatment?

Source: Improving Care for the End of Life: A Sourcebook for Health Care Managers and Clinician.

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HOPE Assessment

Yet another approach to spiritual assessment is entitled HOPE

H: Source of Hope, strength, comfort, meaning, peace, love and connection

O: The role of Organized religion for the patient.

P: Personal spirituality and practices

E: Effects of medical care and end-of-life decisions.

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HOPE Assessment Example of Questions

H: <u>**Source of Hope, strength, comfort, meaning, peace, love and connection**</u>

1) I was wondering, what is there in your life that gives you internal Support?
2) What are your sources of hope, strength, comfort and peace?
3) What do you hold on to during difficult times?
4) What sustains you and keeps you going?

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HOPE Assessment Example of Questions (cont)

O: <u>**Organized Religion**</u>

1) Do you consider yourself part of an organized religion?
2) How important is this to you?
3) What aspects of your religion are helpful and not so helpful to you?
4) Are you part of a religious or spiritual community? Does it helps you? How?

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HOPE Assessment Example of Questions. (cont)

P: Personal Spirituality/Practices

1) Do you have personal spiritual beliefs that are independent of organized religion? What are they?
2) Do you believe in God? What kind of relationship do you have with God?
3) What aspects of your spirituality or spiritual practices do you find most helpful to you personally? (e.g., prayer, meditation, reading scripture, attending religious services)

HOPE Assessment Example of Questions. (cont)

E: Effects on Medical Care and end-of-life issues.

1) Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (or affect your relationship with God).
2) As a doctor, is there anything that I can do to help you access the resources that usually help you?
3) Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?
4) Would it be helpful for you to speak to a clinical chaplain/community spiritual leader?
5) Are there any specific practices or restrictions I should know about in providing your medical care?

Source: Gowri Anandarajah, M.D. and Ellen Hight, M.D.Spirituality and Medical Practice: Using the HOPE Questions as Practical Tool for Spiritual Assessment. (2001)

Potential Boundary Issues

☐ The mental health provider's position, in dealing with spirituality, can become an intimate interaction. The provider often becomes that source of comfort for a person facing loss. The pitfalls of this intimacy are the potential for mutual distress and emotional burden.

☐ These issues make it necessary to proceed with sensitivity and caution.

Recommendations for Service Providers

☐ Self Awareness and Attitudes
☐ Training: Acquiring Knowledge and skills.
☐ Consultation
☐ Work in collaboration with Faith-based spiritual organizations in your community.
☐ Referral and linkage.

Ethical Issues

☐ **RESPECT FOR ETHICAL AND LEGAL BOUNADRIES**

We advocate for the inclusion of spirituality as a potential resource in mental health services. None of our work should be construed as advocating that mental health providers should "push religion" on the people they serve. There are barriers (including political, legal and cultural) between the public mental health system and spirituality/religion that need to be addressed carefully and respectfully. We are committed to helping service providers understand these barriers so they can make informed choices about policy and practice. In particular, we believe that mental health providers should never promote a particular religion or proselytize. They should, however, be receptive and responsive to the expressed interests of their clients and potential clients, including their requests for support with the spiritual aspects of their wellness and recovery.

Mental Health and Spirituality Initiative Values statement. Nov. 2009.

Ethical Issues (Cont.)

☐ **Engagement of Faith Based Organizations**

Faith communities and spirituality can be a source of coping and social support for those struggling with the impact of mental health issues: poverty homelessness, loss of meaning and purpose, stigma, isolation, etc. Some faith communities have become "welcoming congregations" to people with mental health issues and others have adopted mental health advocacy as part of their social justice agendas. Mental health agencies are better able to reach underserved, unserved and inappropriately served populations when they invite collaboration with local faith based organizations.

Mental Health and Spirituality Initiative Values Statement November 2009

Ethical Issues (Cont.)

☐ **The Paramount Importance of Client Choice**

☐ We are passionate about choice- including individuals and families choice not to engage on spirituality and/or religion. Mental health services are enriched by an open, welcoming and no-judgmental stance toward spiritual, religious, and cultural beliefs, practices, rituals, values theologies and philosophies – including secularism – that may be different from ones own. We welcome the opportunity to be enriched by the wisdom that others have gleaned from their own spiritual path and/or life experience

Mental Health and Spirituality Initiative Values Statement Nov. 2009

Questions and Answers

☐ If a consumer wants to read the Bible while in session, what would be the correct approach?

☐ When a consumer requests to open the therapy session with a word of prayer, would allow the consumer to pray? Would it be appropriate for the Clinician to offer a prayer?

☐ When issues of religion/spirituality arises while in session, when would be appropriate to refer Consumer to a faith based organization?

☐ Would it be appropriate to allow consumer to not to engage in a spirituality assessment if he/she chooses not to engage?

☐ Thank you.

ATTACHMENT #18

List of Informational Materials for Distribution

Sheet No.	1	Date	5/3/10
Performed By	Julie Fairburn	Supplies	Spanish Booklets

Description	Language	Quantity	Location
Conozca Los Peligros Del éxtasis Y De Otras Drogas De Discoteca	Spanish	1	County Circle
La Marihuana: Información Para Los Adolescentes	Spanish	91	County Circle
La Marihuana: Lo Que Usted Debe Saber Sobre	Spanish	2	County Circle
Buena Salud, Buena Vida: Su Guía De Recursos De Salud	Spanish	4	County Circle
Cuando La Esquizofrenia Toca A Alguien Que Ama	Spanish	7	County Circle
Fobia Social: Una Enfermedad Real	Spanish	8	County Circle
Historias personales sobre la depresion	Spanish	1	County Circle
Juventud Latina- Hable Con SUs Hijos Sobre Las Drogas y sus Peligros	Spanish	1	County Circle
La Marihuana: Lo Que Los Padres Deben Saber	Spanish	61	County Circle
Los Hombres Y La Depresión	Spanish	9	County Circle
Manual De Derechos Para PacientesDe Salud Mental	Spanish	14	County Circle
Manual de Violencia Domestica Guia de Sobrevivencia	Spanish	1	County Circle
Principios para la Prevencion de HIV en las Poblaciones de Usuarios de drogas	Spanish	1	County Circle
Principios De Tratamiento Para La Drogadiccion	Spanish	1	County Circle
Que Significa Ser Padres? Guia para ayudarles a tener exito...	Spanish	1	County Circle
Trastorno De Ansiedad Generalizada: Una Enfermedad Real	Spanish	17	County Circle
Trastorno De Comportamiento Obsesivo Compulsivo: Una Enfermedad Real	Spanish	10	County Circle
Un Amigo Marca Una Gran Diferencia	Spanish	23	County Circle
Guia De La Familia (COPE)	Spanish	1	County Circle
Encontrando Respuestas Huntos Los Hispanos y La Salud Mental	Spanish	1	County Circle
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			County Circle
			County Circle
			County Circle
			County Circle
			County Circle
			County Circle
			County Circle
			County Circle
			County Circle

List of Informational Materials for Distribution

Sheet No.	2	Date	7/12/10
Performed By	Julie Fairburn	Supplies	Brochures & Pamphlets

Description	Language	Quantity	Location
AB-1424	English	38	County Circle
AB-1424	Spanish	1000	County Circle
Abuse How You Can Protect Elder and Dependent Adults	English	2	County Circle
After an Attempt	English	1	County Circle
After an Attempt	Spanish	2	County Circle
ANKA Full Service Partnership	English	32	County Circle
Trastorno Bipolar	Spanish	24	County Circle
Bipolar Disorder	English	8	County Circle
Community Drug Alert Bulletin (Anabolic Steroids)	English	50	County Circle
Community Drug Alert Bulletin (Club Drugs)	English	197	County Circle
Community Drug Alert Bulletin (Inhalants)	English	99	County Circle
Community Drug Alert Bulletin (Methamphetamine)	English	98	County Circle
Community Drug Alert Bulletin (Prescription Drugs)	English	106	County Circle
Community Drug Alert Bulletin (Stress & Substances Abuse)	English	79	County Circle
Confidentiality Guidelines Brochures	English	1000	County Circle
Directivas de Confidencialidad Brochures	Spanish	1000	County Circle
Conservator ship And You Brochures	English	5	County Circle
Consumer's Guide to Depression and Maniac Depression	English	4	County Circle
Divorce and Children Brochure	English	4	County Circle
Erase the Stigma of Mental Illness Brochure	English	188	County Circle
Borremos la Estigma de las Enfermedades Mentales Brochure	Spanish	125	County Circle
Fair Housing: Legal Rights for People w/ Mental Health Disabilities Brochure	English	41	County Circle
Programa que Aboga Por La Familia Brochure	Spanish	1000	County Circle
Family Advocate Program Brochure	English	1000	County Circle
HHOPE Program Brochure	English	1	County Circle
Handbook For Private LPS Conservators	English	1	County Circle
Medicare Rx Brochure	Spanish	23	County Circle
Peer Support and Resource Service Center Brochure	English	21	County Circle
Centro de Recursos y Servicios, y Apoyo de Colegas Brochure	Spanish	17	County Circle

List of Informational Materials for Distribution

Sheet No.	3	Date	7/12/10
Performed By	Julie Fairburn	Supplies	Brochures & Pamphlets

Social Security- Working While DisaDiesoAiGoide To Plans ...	English	Quantity	County Circle
NAMI Family-to-Family Education Program	English	1	County Circle
NAMI Program Educativo Familia-a-Famila Brochure	Spanish	211	County Circle
NAMI National Alliance on Mental Illness MT. San Jacinto Affiliate Brochure	English	33	County Circle
NAMI Temecula Valley Brochure	English	100	County Circle
NAMI Mental Illness: An Illness Like Any Other Brochure NAMI	English	87	County Circle
NAMI Peer-to-Peer Education Course NAMI	English	36	County Circle
NAMI The PACT Advocacy Guide	English	17	County Circle
NAMI Western Riverside We Can Help When Navigating Mental Health	English	167	County Circle
NAMI Understanding Bipolar Disorder and Recovery	English	112	County Circle
NAMI Western Riverside	English	73	County Circle
NAMI Family-to-Family Education Program	English	12	County Circle
NAMI Understanding Major Depression and Recovery	English	260	County Circle
NAMI You Are Not Alone	English	12	County Circle
NAMI Understanding Schizophrenia and Recovery	English	161	County Circle
Network of Care for Behavioral Health	English	2	County Circle
Network of Care Para la Salud de la Conducta	Spanish	1	County Circle
Riverside County Substance Abuse Program	English	5	County Circle
Riverside County Mental Health Board	English	34	County Circle
Social Security- Benefits For Children With Disabilities	English	15	County Circle
Social Security- How Workers Compensations And Other...	English	1	County Circle
Social Security- Your Right To Question The Decision To Stop...	English	1	County Circle
Social Security- Entering The Community After Incarceration...	English	1	County Circle
Social Security- Identity Theft And Your Social Security #	English	1	County Circle
Social Security- When A Representative Payee Manages Your $	English	1	County Circle
Social Security- How Work Affects Your Benefits	English	1	County Circle
Social Security- A "Snapshot"	English	1	County Circle
Social Security- Food Stamps and Other Nutrition Programs	English	1	County Circle
Social Security- How You Earn Credits	English	1	County Circle
Social Security- Your Ticket To Work	English	1	County Circle
Social Security- How We Decide If You Are Still Disable	English	1	County Circle

List of Informational Materials for Distribution

Sheet No.	4	Date	7/14/10
Performed By	Julie Fairburn	Supplies	Brochures & Pamphlets

Description	Language	Quantity	Location
Social Security- Working While Disabled- How We Can Help	English	44	County Circle
Schizophrenia National Institute of Mental Health	English	29	County Circle
Suicide Prevention- Warning Signs and Risk Factors	English	7	County Circle
Suicide Prevention Information- Risk Factors and How to Help Someone...	English	26	County Circle
Trastorno Bipolar Brochure	Spanish	1	County Circle
The Brain's Response to Inhalants	English	89	County Circle
The Brain's Response to Marijuana	English	37	County Circle
The Brain's Response to Steroids	English	34	County Circle
The Brain's Response to Methamphetamine	English	43	County Circle
The Brain's Response to Hallucinogens	English	42	County Circle
The Partnership for a Drug-Free America MetLife Foundation	English	25	County Circle
What Is WRAP? Brochure	English	79	County Circle
Who Will Care When I'm Not There? Plan of California	English	6	County Circle
Wraparound Program Brochure	English	7	County Circle
You Have The Right Brochure	English	78	County Circle
Usted Tiene El Derecho	Spanish	61	County Circle
Your Right To Make Decisions About Medical Treatment	English	74	County Circle
Su Derecho De Hacer Decisiones Acerca De Su Tratamiento Medico	Spanish	5	County Circle
IEHP Benefits of Joining IEHP/Beneficios de Unirse a IEHP (oneside E other S)	English/Spanish	9	County Circle
IEHP Disability Programs/ Programas Para Personas Con Discapacidades E&S	English/Spanish	4	County Circle
			County Circle
			County Circle
			County Circle
			County Circle

List of Informational Materials for Distribution

Sheet No.	5	Date	5/3/10
Performed By	Julie Fairburn	Supplies	English Booklets

Description	Language	Quantity	Location
100 Signs For Emergencies	English	57	County Circle
100 Signs For Parents	English	88	County Circle
100 Signs For Travelers	English	25	County Circle
A Family Guide to Mental Health: What You Need To Know	English	68	County Circle
A Primer For Parents / Una Cartilla Para Padres	English/Spanish	23	County Circle
About Cocaine	English	1	County Circle
About Crack Cocaine	English	2	County Circle
About Drinking and Driving	English	1	County Circle
About Inhalants	English	2	County Circle
About Methadone	English	2	County Circle
About Recovery	English	1	County Circle
About Steroids	English	5	County Circle
About Women And Alcohol	English	2	County Circle
Administration of Mental Health Services By Medicaid Agencies	English	1	County Circle
Anxiety Disorders	English	51	County Circle
Anxiety Disorder: When Worry Gets Out Of Control	English	24	County Circle
Attention Deficit Hyperactivity Disorder	English	16	County Circle
Autism Spectrum Disorders: Pervasive Developmental Disorders	English	9	County Circle
Behavioral Health Guide: Riverside County Regional Medical Center	English	4	County Circle
Bipolar Disorder (Man And Woman On Cover)	English	1	County Circle
Bipolar Disorder (Man On Cover)	English	1	County Circle
Clinical Practice Guidelines For ADHD	English	0	County Circle
Communicating In A Crisis: Risk Communication Guidelines For Public Officials	English	1	County Circle
County of Riverside Dept. Of Mental Health LGBTQ Resource Guide	English	0	County Circle
General Anxiety Disorder: A Real Illness	English	4	County Circle
Handbook Of Rights For Mental Health Patients	English	2	County Circle
Living With Bipolar Disorder	English	1	County Circle
Marijuana: Facts For Teens	English	61	County Circle
Marijuana: Facts Parents Need To Know	English	17	County Circle
Medications For Mental Illness	English	15	County Circle

List of Informational Materials for Distribution

Sheet No.	6	Date	5/3/10
Performed By	Julie Fairburn	Supplies	English Booklets

Description	Language	Quantity	Location
Panic Disorder: A Real Illness	English	24	County Circle
Panic Disorder: When Fear Overwhelms	English	39	County Circle
Social Phobia (Social Anxiety Disorder): Always Embarrassed	English	27	County Circle
Social Security: Disability Benefits	English	40	County Circle
Social Security: Understanding The Benefits	English	42	County Circle
Starting Your Treatment With Zyprexa	English	18	County Circle
Women And Depression: Discovery Hope	English	3	County Circle
Emotional Abuse: Words Can Hurt	English	1	County Circle
Feeling Good- Body & Soul	English	1	County Circle
Gangs- A Community Response	English	1	County Circle
IEHP Doctor Directory/Directorio de Doctores (in English and Spanish)	English/Spanish	1	County Circle
IEHP Healthy Child Handbook	English	7	County Circle
Looking after someone you care about- The COPE Family Guide	English	1	County Circle
Principles of HIV Prevention in Drug-Using Populations	English	1	County Circle
Principles of Drug Addiction Treatment	English	1	County Circle
Speaking About Schizophrenia	English	1	County Circle

List of Informational Materials for Distribution

Sheet No.	7	Date	7/14/10
Performed By	Julie Fairburn	Supplies	NATIONAL INS OF MH

Description	Language	Quantity	Location
Attention Deficit/ Hyperactivity Disorder	English	20	County Circle
Trastorno de Deficit de Atencion e Hiperectividad (facil de leer)	Spanish	25	County Circle
Attention Deficit Hyperactivity Disorder (ADHD)	English	2	County Circle
Bipolar Disorder	English	25	County Circle
Bipolar Disorder	English	5	County Circle
Trastorno Bipolar (facil de leer)	Spanish	25	County Circle
Depression	English	10	County Circle
Depresion	Spanish	1	County Circle
Women and Depression: Discovering Hope	English	8	County Circle
Real Men. Real Depression/ Estos hombres son reales. La depresion tambien.	English/Spanish	1	County Circle
Depresion: Facil De Leer	Spanish	25	County Circle
Depression: Easy To Read	English	1	County Circle
When Worry Gets Out of Control: Generalized Anxiety Disorder	English	1	County Circle
When Unwanted Thoughts Take Over: Obsessive-Compulsive Disorder	English	1	County Circle
Cuando Pensamientos Indeseados Toman Control: Trastorno O-C	Spanish	25	County Circle
When Fear Overwhelms: Panic Disorder	English	1	County Circle
Cuando el Miedo Consume: Trastorno de Panico (Facil de Leer)	Spanish	25	County Circle
Post-Traumatic Stress Disorder (tri-fold)	English	10	County Circle
Post-Traumatic Stress Disorder (PTSD)	English	1	County Circle
Trastorno de Estres Postraumatico (Facil de Leer)	Spanish	15	County Circle
Schizophrenia	English	5	County Circle
Schizophrenia	English	25	County Circle
Always Embarrassed: Social Phobia (Social Anxiety Disorder)	English	1	County Circle
Ayudando a Niños y Adolecentes a Superar la Violencia y los Desastres...	Spanish	25	County Circle
Helping Children and adolescents Cope w/ Violence and Disasters: What...	English	15	County Circle
Anxiety Disorder	English	1	County Circle
Neuroimaging and Mental Illness: A Window Into the Brain...	English	10	County Circle
Treatment of Children w/ Mental Illness: Frequently asked ? about the treatment	English	15	County Circle
Trastornos de Ansiedad	Spanish	25	County Circle

List of Informational Materials for Distribution

Sheet No.	8	Date	7/14/10
Performed By	Julie Fairburn	Supplies	NATIONAL INS OF MH

Description	Language	Quantity	Location
Helping Children and adolescents Cope w/ Violence and Disasters; What...	English	8	County Circle
Brain's Inner Working: Activities for Grades 9-12	English	1	County Circle
Helping Children and adolescents Cope w/ Violence and Disasters: What...	English	8	County Circle
Trastorno Bipolar en Niños y Adolecentes (facil de leer)	Spanish	25	County Circle
Ayudando a Niños y Adolecentes a Superar la Violencia y los Desastres...	Spanish	25	County Circle
Mental Health Medications	English	2	County Circle
Bipolar Disorder in Children and Teens: A Parent's Guide	English	15	County Circle
NIMH General Poster	English	25	County Circle
Ayudando a Niños y Adolecentes a Superar la Violencia y los Desastres...	Spanish	25	County Circle
A Participant's Guide to Mental Health Clinical Research	English	25	County Circle
Bipolar Disorder in Children and Teens	English	25	County Circle
Fighting Depression (DVD)	English	2	County Circle

List of Informational Materials for Distribution

Sheet No.	9	Date	7/14/10
Performed By	Julie Fairburn	Supplies	ONE Brochures

Description	Language	Quantity	Location
California Citrus State Historic Park	English	1	County Circle
Can Friends Be a Good Medicine?	English	1	County Circle
Careers @ Telecare Diversified Mental Health Services	English	1	County Circle
Community Actioon Partnership of riverside County- Peer Mediation	English	1	County Circle
Como Superar La Depresion	Spanish	1	County Circle
Coping Tips for Siblings & Adult Children of Persons w/ Mental Illness	English	1	County Circle
Do you care for someone who's at risk of suicide?	English	1	County Circle
Entendiendo la Esquizofrenia: Una Guia..	Spanish	1	County Circle
Fostering Care Across Communities	English	1	County Circle
GTM Prescription Discount Card	English	1	County Circle
IEHP- Cuidado Medico Para Adultos y Niños	Spanish	1	County Circle
Inland Regional center Serving People w/ Developmental Disabilities	English	1	County Circle
Los Beneficios de Participar con IEHP	Spanish	1	County Circle
Marriage	English	1	County Circle
Parenting	English	1	County Circle
Prevencion del Suicidio- Signos de alerta y factores de riesgo	Spanish	1	County Circle
Psychological First Aid: A Guide for Emergency& Disaster Response Workers	English	1	County Circle
Queen of Hearts Therapeutic Riding Center, Inc. Supporting Hands	English	1	County Circle
Resource& Referral Children's Services Unit	English	1	County Circle
Riverside County Department of Veterans Services	English	1	County Circle
Sleep Disorders	English	1	County Circle
Teenage Depression NAMI	English	1	County Circle
Telecare Corporations Telecare Los Angeles Older Adults	English	1	County Circle
The NAMI Guide for Recovery from Mental Illness	English	1	County Circle
What to Expect on a 14 Day hold (Patients Rights Advocacy Program)	English	1	County Circle
Wellness Program County of Riverside Human Resources	English	1	County Circle
Depression and the Latino Community/ Depresion y la Comunidad Latina	Spanish/English	1	County Circle

List of Informational Materials for Distribution

Sheet No.	10	Date	7/14/10	
Performed By	Julie Fairburn	Supplies	ONE Brochures	

Description	Language	Quantity	Location
Guia para el Diagnostico Doble y la Recuperacion...	Spanish	1	County Circle
Hablemos Del Suicidio NAMI	Spanish	1	County Circle
Trastornos De Ansiedad	Spanish	1	County Circle
Una Explicacion De La Esquizofrenia	Spanish	1	County Circle

List of Informational Materials for Distribution

Sheet No.	11	Date	7/19/10
Performed By	Julie Fairburn	Supplies	Posters

Description	Language	Quantity	Location
What is a Mental Illness?	English	12	County Circle
Que es una enfermedad mental?	Spanish	14	County Circle

ATTACHMENT #19

Slide 1

Riverside County Department of Mental Health

Cultural Competency Focus Groups

PROVIDING HELP / EMPOWERING RECOVERY
RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

Slide 2

Background

Focus Groups-
One element of an overall organizational and service provider assessment

Community and RCDMH staff focus groups- Information gathered to guide the development of the RCDMH Cultural Competency Plan.

Community Members
20 Focus Groups
334 participants

RCDMH Staff
32 Focus Groups
358 participants

PEI focus groups with specific populations

Slide 3

Background

Large amount of information obtained

Task to distill the key ideas and summarize and organize the information

Present it in such a way that it is useful for informing and guiding the process

Slide 4

Background

Key ideas were grouped according to Health Resources and Service Administration (HRSA) Domains

Governance — Staff Development — Planning and Monitoring — Service/Interventions — Communication — Organizational Values — Organizational Infrastructure

Indicators for Cultural Competence in Health Care Delivery Organizations

Slide 5

Strengths-

Organizational Values - Governance - Organizational Infrastructure - Planning and Monitoring

- Department values cultural competency and is committed to staff diversity
- Bilingual/bi-cultural staff
- Consumers and family members are a part of our workforce
- Policies and practices to support cultural competency
- Existing cultural competence committees and expressions of cultural appreciation
- Some budget to support cultural competence
- Programs (Family Advocates, Cultural Competence program, Outreach and Engagement team)
- Material Resources (Spanish translated materials)

Slide 6

Strengths-

Organizational Values - Governance - Organizational Infrastructure - Planning and Monitoring

- Inclusion of family and consumers
- Mental Health Board
- Connections to community organizations and interagency collaborations
- Data is used to assess community need
- Consumers and family members have been part of the focus group process

Challenges

Organizational Values - Governance - Organizational Infrastructure - Planning and Monitoring

General knowledge and awareness of the department's mission and vision for cultural competency and recovery and wellness

Communicating the policy and providing direction and support for implementation

Limited resources-How to meet the mandates of the vision

Keeping everyone engaged in the process (both staff and community)

Revenue focus - Medi-Cal billing

Documentation demands and requirements

Challenges

Organizational Values - Governance - Organizational Infrastructure - Planning and Monitoring

Increasing family involvement

Integration of Mental Health Boards and consumers

Improving collaboration-especially interagency collaboration

Working in the community

Outreach to specific groups

Feedback mechanisms for communicating planning and results

Policy on how to define next steps following collection of data

Planning and knowledge of how evaluation is conducted

Recommendations

Organizational Values - Governance - Organizational Infrastructure - Planning and Monitoring

Cultural Competency should be viewed as an opportunity

Increase recognition and value of culture-(find ways to keep that value in front of staff activities, value the expertise of staff from different cultures)

Define a vision that supports the community as partners with inclusiveness and culturally relevant services

Leadership- (meetings with community leaders; internal connection of line staff with management)

Acceptance of Peer Specialist

Improving community involvement

Recommendations

Organizational Values - Governance -Organizational Infrastructure - Planning and Monitoring

Mental Health Board development (improving board structure, direction and connection to the community)

Educating leaders about the legal boundaries of the mental health system

Open Dialogue (consumers, staff, contract agencies, community at large)

"Institutionalizing" voice of consumers and family members

Evaluation/Research (asking the right questions, communicating the results)

Monitor penetration and access

Inclusion in planning

Specific focus groups and data for un-served communities

Key Themes

Organizational Values - Governance -Organizational Infrastructure - Planning and Monitoring

Importance of partnership

Building community capacity in partnership

Collaboration

Community involvement in the process

Need for a community liaison

Continued communication –Open forum and continued recommendations

Awareness and participation in the planning process

Utilizing the community and volunteers

Availability of Resources

Recommendations

Organizational Values - Governance -Organizational Infrastructure - Planning and Monitoring

Leaders willingness to compromise

Investing in community leaders

Training leaders in the community

Organization and community task force to deal with mental health issues

More research

Making connections-more networking and more communication with the department of Mental Health

Community/town hall meetings

Resources for families that do not have insurance

Strengths - Communication

Bilingual staff and Language Line

Bilingual materials

Family advocates and Peer specialist facilitate communication

Contacts in the community provide input

Challenges - Communication

Psychiatric services-doctors indicated language is big cultural issue

Using interpreter services

    Language line difficult to use,

    Enough time for interpretation

    Losing context and understanding in translation

    Familiarity with bilingual staff available and use of Language line

Interpreter training

Meeting the needs of Deaf Community and those with other languages

Unique needs in Substance Abuse services

Recruiting and retaining bilingual staff

Challenges - Communication

Access to bilingual materials (Asian languages, adequate materials in Spanish, availability of Substance Abuse materials)

Communication with the Community

Internal department communication

Communication with management/supervisors

Recovery focus in the language we use

Unique needs in Substance Abuse services

Recommendations - Communication

More bilingual staff

More appropriate bilingual materials

Spanish Survival class/Spanish training

Improving interpreter services and interpreter training

Improving internal communication- training for staff

Improving communication with the community at large—Use media

Improving Interagency communication

Key Themes Communication

Community experiences issues with communication

Language needs

Informing the community in general

Educating the community on mental health

Resource and Referral

Outreach

Community liaison

Comunication among social servcies agencies

Collaboration with other agencies

Recommendations - Communication

Educate people who need services but also the general public about the in/outs of mental illness

Provide information/updates on the department of mental health

Networking meeting quarterly to know what is available

Information to community on how to get help for self or others, navigating the system

Method for agencies to keep each other informed of programs available

Start with parent, teachers health care providers

Use technology to communicate (Internet, newspapers, radio, my space)

Need Spanish information that is easy to read (signs and materials)

More staff able to speak the language (needs for deaf community, monolingual spanish)

Strengths - Staff Development

Trainings-Departmental trng and conferences used for training

Cultural competency celebrations also provide opportunity for training

Staff (training amongst staff, multidisciplinary teams, volunteer consumers, staff champions in the department)

Advisory groups required for contracts

Challenges - Staff Development

Morale issues

Loss of resources

Direction from supervision

Staff Diversity

Inclusion for all staff at training

Assessing cultural competency

No follow-up on training provided

Challenge to integrate what is learned into daily practice

Frequency of Cultural Competency training

Interpreter training

Recommendations - Staff Development

Training in general (Cultural Competency trng for everyone, regional trng)

Training relevancy/content

    Training for specific groups (e.g. LGBT)

    Defining culture

    Training application

Education and training for first responders

Education on working with the community

Resources

Training on culture, spirituality and recovery

Training on Recovery focus

Key Themes - Staff Development

Training for community organizations to build capacity

Training on signs and symptoms of mental illness and need for referral

Training to understand the boundaries of the services and resources available from county and the methods to navigate the system

Invest in community leaders

Recommendations - Staff Development

Make sure people know who has mental illness.

Educating the clergy where the families go

Develop a "First Response Plan" for community organizations

Train group leaders to navigate and manage situation.

To bring more information to the community; to enlist more people to participate. (volunteers)

Strengths - Services and Interventions

Programs

    Multidisciplinary teams,

    Co-occurring groups,

    Some Spanish groups,

    Officer of the day to assist walk-ins

Family Involvement

Community Events

Welcoming practices

4

Challenges-Services and Interventions

Limited services

  Medi-cal limitations

  Resources for funding and long term stabilization

  Not enough doctors

  Core services not available

  No socialization services

Lack of time to engage consumers

Case overload with paperwork

Lack of material for groups-need curriculum

Knowledge of mental health and community resources

Appropriateness of services

Recommendations-Services/Interventions

More evidenced-based services

Community–Based services

Events and workshops: e.g. Anti-Stigma Youth Awareness and consumer/peer run events

Community Resources

Interagency Collaboration

Culturally competent services: develop strategies to change the communities thinking about Mental Health, Mental Illness and to assist with creating culturally relevant services

We need a more defined plan on how to do cultural competence

Shared knowledge of what is working

Key Themes Services and Interventions

Difficulties with services

  Long wait times at clinic

  Long wait times for an appointment, particularly to see doctor

  Need for more group hours

  Better set-up for crisis services

  Transportation

  Accessing services is an ordeal

  Difficulty accessing Spanish speaking staff

  Staff indifference/negativity

Due to severity of criteria at Mental Health Clinics, many left unserved or under served, particulary youth

Lack of resources and lack of insurance to get services.

Recommendations Services/Interventions

Need for more group hours

Need Spanish groups and men's groups

More services for families with Spanish speaking members in the community

Better set-up for crisis

Services for specific groups (youth, parents, substance abuse,)

Collaborative programs between community organizations

Prevention

Specific Populations LGBTQ

Service availability

Support for families

Specific needs of LGBTQ (stigma, suicide risk, screening for depression anxiety and suicide)

Specific Populations Spanish Speaking

Programs for specific groups

Increasing access- (locations Thermal & Mecca)

Support and information to parents and caregivers

Language and cultural needs

Improve outreach and knowledge of available resources

Stigma reduction

5

Specific Populations African American Community

Community partnerships

Prevention programs at community level

Cultural competent staff (Education /training provided by CBOs/FBOs to DMH staff on self-knowledge/awareness and how one views others)

Improve outreach and knowledge of available resources

Specific Populations Native Americans

Culturally tailored services

Reduce stigma

Increase access and reduce disparities

Parent education

Specific Populations Deaf Community

Culturally tailored services

Reduce stigma

Increase access and reduce disparities

Parent education

Communication training for staff

Stigma

Many focus group respondents made comments and shared experiences regarding stigma

Confidentiality is an issue

People need to feel trust to tell their stories without embarrassment and shame

The family should trust to speak with safety and trust " confianza"

Fear of being labeled

Ways to reduce stigma:

Decrease stigma by spreading good experiences and result form interacting with MH providers/professionals

Language changes: Mental Health is usually interpreted negative We need to have names and titles more attractive and less stigmatizing

Cultural Competence Organization and Community Assessment Riverside Cultural Competence Plan Requirements (CCPR) Logic Model Development

Introduction

The logic model is a tool to illustrate the overall plan for developing capacity to reach underserved populations in Riverside County over the next few years. This plan is based on the idea of "organizational cultural competence", which aims to increase compatibility between Riverside County Mental Health and the community by making strategic changes at both organizational infrastructure and direct service levels (Hernandez & Nesman, 2006). The logic model will provide the "big picture" for change and will include information that is similar to that included in the Cultural Competence Plan Requirements (CCPR) by the state. It will be developed based on the ideas expressed by the community and staff that have been summarized in the Needs Assessment Focus Group Report and will be refined through work with a core group appointed by the Cultural Competence/Disparities Committee.

The attached document outlines information that might be included in the logic model using information from the Cultural Competency Needs Assessment Focus Group Report. Each item in the outline came from an idea expressed in the focus groups, with the type of focus group indicated in parenthesis (e.g. community, staff, prevention/early intervention). Information has also been color coded according to the type of focus group as follows:

- Black print= Staff focus groups
- Blue print= Community focus groups
- Red print= PEI focus groups

Components of the Logic Model Outline

The outline is organized into the main components of the logic model, which include:

- Mission/Vision
- Values/Guiding Principles
- Context
- Strategies
- Outcomes/Effects on Disparities
- Implementation Goals

Each component of the outline has bulleted items listed under it that came from the focus groups. Some items are broad ideas about what is working or what needs change, while other items give direction or specific recommendations for actions that might be taken. Ideas and actions are not only directed at the organization, but also include ways in which community agencies, community leaders, and others can contribute to decreasing disparities for

Health. As the Needs Assessment Focus Group Report is reviewed, it will be important to consider the following:

1) What are the main ideas or themes about challenges and strengths that I keep hearing?
2) Is there anything missing that wasn't included in the Focus Group Report?
3) What would be my top priorities for action?
4) What would the mental health service system look like when the cultural competence plan has been implemented?

As the Logic Model Outline is reviewed, it would be important to identify three kinds of information:

1) Broad ideas or categories of recommendations
2) Actions to be taken, and by whom
3) Goals for cultural competence development

- Older adults are underserved, unaware of services (pei)

Strengths
Population(s)
- Invite us to meetings and we will come (community)
- Parents want to know what to do: "teach us what to do and we will do it in our homes" (community)
- People go to churches and community based agencies for information, programs, help (community)

Organization
- Cultural competence is valued/ appreciated/acknowledged as a need; there is buy-in; it is part of the vision (staff)
- Commitment to staff diversity (staff)
- Support provided to community events (staff)
- Welcoming and engagement initiative: outreach & engagement team, training (staff)

Practice
- Staff is dedicated and committed to cultural competence (staff)

Community
- Regional MH Board gives some input to Dept. and MH Board (staff)
- Connections between MH and some community organizations & other agencies (staff)
- Community is hungry for information and help (community)
- NAMI provides information, family programs (community)

Challenges
Population(s)
- Some not comfortable with having services in the home (staff)
- Hidden populations are hard to reach (Vietnamese) (staff)
- Lack of transportation (relates to location of services) (staff)
- Many people don't have insurance (community)
- Don't know the services that are available or how to get them (community)
- Lack of information about treatments (community)
- Need information in different languages (community)
- Fear about confidentiality if talk about mental illness (community)
- Stigma about mental illness in community and within families (community)
- Poverty, lack of resources, lack of insurance (community)
- Difficult to find and understand information about programs if English isn't your first language (community)
- People who seek help at a psychiatric hospital may be rejected by others in the community and seen as "crazy" (community)

Organization
- Mission/vision and policy related to cultural competence is not well defined, communicated, operationalized, or resourced (staff)
- Leadership needs to direct and support cultural competence (staff)
- Policies/procedures are barriers to working in the community (staff)
- Need outreach tailored to specific groups (staff)
- Focus is on revenue & budget (staff)

- No longer holding interagency meetings (staff)
- Community leaders, clergy, CBOs ("first responders") need training on mental illnesses and how to respond (community)
- Participants in community meetings don't feel that their information will remain confidential if they speak up about mental health needs (community)

STRATEGIES
Current Actions/Structures

- **Governance & Infrastructure** (CC Committee, Ethnic Service Manager, budget allocations, contract requirements) **(HRSA: Governance, Organizational Infrastructure)**
  - Cultural Competency committee is active &has representation from each dept (staff)
  - Outreach efforts through "outreach teams" (staff)
  - Agency contracts include cultural competence and linguistic services (staff)
  - Family members/consumers on committees (staff)
  - Data is used to assess community needs (staff)
- **Training for CC development (HRSA: Communication, Staff Development)**
  - Consumers participate in Sheriff's Dept. training (staff)
  - Trainings available, some mandatory: Brief Multicultural Training, Poverty, Medications, Welcoming (staff)
  - Training Committee examines and tracks effectiveness of trainings (staff)
  - Training for supervisors on working with Peer Counselors /Peer Specialists (staff)
  - Training at conferences & celebrations (staff)
- **Multicultural workforce development (HRSA: Communication, Staff Development)**
  - Many bilingual staff, some involved in outreach (staff)
  - Peer case managers and Peer support staff learn from each other (staff)
  - Multidisciplinary teams (staff)
  - Advisory group for peer specialists (staff)
- **Language capacity** (interpreter services, translation of materials) **(HRSA: Communication, Staff Development)**
  - Language designated positions (staff)
  - Language Line (staff)
  - Bilingual staff; have a list and most are pre-certified (staff)
  - Bilingual materials developed through Translation Committee (staff)
  - Family Advocates and Peer Specialists communicate with consumers and families in a way that increases comfort, empowers (staff)
  - Beginning to communicate "I am here for you" through staff activities in the community, outreach & engagement, interagency meetings (staff)
- **Adaptation of service array** (alternatives, options, contracts, referrals/linkages) **(HRSA: Services/Interventions)**
  - Family to Family and Family Advocate programs increase access (staff)
  - Office of the Day accepts any walk in for Info & Referral (staff)
  - Dual diagnosis classes (staff)
  - ITF doctors involve families (staff)
  - Anti-Stigma Youth Awareness and other consumer/peer events (staff)
  - "Welcoming practices" (staff)

- MH Board development- structure, goals, rules, membership, mandates, planning, reporting (staff)
- Increase consumer involvement in policy-making and decision-making (staff)
    - Institutionalize/ integrate the voice of consumers and family members through peer and family advocates; supported by upper management (staff)
    - Have clients involved in advisory groups (community)
- Budget to support cultural competence (staff)
    - Change focus on revenue (staff)
    - The department is focusing on productivity, training takes away from productivity, we are not receiving the trainings we need to do a quality job (staff)
    - Do not have time to become involved in events and activities (staff)
    - Budget for implementation of cultural competence strategies (staff)
    - Explore additional revenue sources (staff)
    - Examine how Wraparound can bill for going into the community (staff)
- Increase collaboration (staff)
    - No unified interaction among the various clinics and lack of shared information. County departments are compartmentalizing and do not have knowledge of services with other departments in the community. (staff)
    - Interagency meetings were taking place before, but are not happing anymore (staff)
    - E-mail information to other agencies to keep informed- they can distribute information if it is provided (community)
    - Go to community programs and introduce MH programs (community)
    - Provide information and work together with AA groups, Alanon, other agencies, churches, Narcotics anonymous, First Esperanza Youth, etc. (community)
    - Network, exchange information with agencies, get phone numbers to reach people directly (community)
    - Meet with churches, schools, doctors, other providers in the community (community)
    - Understand community roles in partnership (community)
    - Long term investment in African American community partnership through continuous dialogue with liaisons in the community (pei)
- Revise RFP/contracting to support community based services (staff)
    - Increase funding of community based organizations and non-profit providers (staff)
- Policies and procedures to support implementation of cultural competence (staff)
    - Include cultural considerations in Quality Improvement and Billing guidelines (staff)
    - Revise Purchasing policy (staff)
    - Simplify paperwork (staff)
    - Include cultural competence representative in clinical staff meetings (staff)
    - Allow time for doctors to attend community meetings (staff)
- Improve internal organizational communication about cultural competence (staff)
    - Improve communication between management & line staff- weekly meetings & memos (staff)

- Provide staff with resources (bilingual materials, centralized location for information, Internet resources on cultural competence, new program information, share info about community based organizations that are resources) (staff)
- Get input from diverse staff- peer specialists, bilingual staff, older adult program (staff)
- Training for first responders (community leaders, people working in the community) (staff)
  - Training for community leaders and organizations to build capacity (community)
  - Develop a "first response plan" for community organizations (community)
  - Invest in community leaders; train how to navigate & manage situation (community)
  - Educate leaders to understand the legal boundaries of the MH system (community)
  - Outreach/education for psychologists, psychiatrists, medical doctors in the community (community)
  - Educate the clergy where families go (community)
- Train community members on signs, symptoms and referral (community)
  - Train police department, school district, community leaders, non-profits (community)
  - Workshops for leaders, teach how to identify problems, recognize need for referral, make the referral (community)
- Provide parenting education through Indian Child & Family Services (ICFS) (pei)
- Mental health awareness, education and training for agencies serving African American & Hispanic communities (e.g. police, schools, probation, ministers) (pei)
- Training for CBO/FBO professionals to advocate for the African American community (pei)

- **Language capacity (interpreter services, translation of materials) (HRSA: Communication, Staff Development)**
  - Enhance interpretation process (staff)
    - Interpreter training, testing, brochures, supervision, and quality monitoring (staff)
    - Train on use of language line and interpreters (staff)
    - Ensure outside interpreters are trained (staff)
    - Develop testing that is adequate to determine quality of interpretation capacity (staff)
  - Develop appropriate materials for all languages needed and all types of communication: assessment, education, outreach, & media (staff)
    - Outreach and educational materials that are culturally and linguistically sensitive (staff)
    - Complete assessment package in Spanish available to Spanish speaking clinicians to give to clients (staff)
    - Develop media and written materials to give to clients (staff)
    - Continue field testing of translated materials with the impacted community; forms in more languages (staff)
    - Need information in different languages (community)
    - Signs in different languages (e.g. Spanish) (community)
    - Information that is easy to read (community)
    - More classes in Spanish on mental health (pei)

- Newsletters (community)
- Use new technology- My Space (community)
- Use website, internet (community)
- Use alternatives to get information to Native Americans about services & resources- newsletter, events, e-mail, listservs, radio, newspaper (pei)
- Involve families in treatment
  - Psychiatric services involve families (staff)
  - Draw more families into learning about mental health during treatment (staff)
  - Incorporate whole family in services with Native Americans (including fathers) (pei)
- More evidence based programs; share knowledge about what is working (staff)
- Include peer specialists in interventions (staff)
  - Advertise and empower peer care (community)
- Increase community based services (staff)
  - Classes for parents provided in the community (e.g. schools) (staff)
  - Presence at events and workshops (staff)
  - Clinicians go into the homes (staff)
  - Information and referral to community resources (staff)
  - Collaborate/coordinate with community based organizations (staff)
  - Enhance 211 services to include African American mental health resources & information, manned by community based organization (CBO) & faith based organization (FBO) professionals (pei)
  - More community based activities that involve all ethnic groups/races (pei)
  - Increase community resources/referrals to them (pei)
- Address barriers: transportation, poverty, insurance, location of services, lack of knowledge about mental health, need for privacy (staff)
  - Locate clinics closer to our communities (community)
  - Increase therapy/access to treatment in Spanish speaking communities (e.g. Mecca, Thermal) (pei)
  - Make services more accessible, less intimidating (pei)
  - More resources for families that don't have insurance (community)
  - Inform the community about mental health & services (community)
  - Free information (community)
  - Bring information to the community: Presentations in the community, Meetings weekly in the community (community)
  - NAMI Family to Family programs and information to the community (community)
  - Inform in different ways and different languages (e.g. Spanish) (community)
- Distribute resource and referral information community-wide (community)
  - Bulletins with list of agencies and phone numbers, list of resources, programs & services available, definitions & information about different treatments (community)
  - Continuously update information about programs (community)
  - Get the word out to people on the street, city wide- bulletin boards, restaurants, flyers (community)
  - Resource center (community)
  - E-Mails to clinics & other agencies to keep up to date (community)

- More bilingual programs for families, more information in Spanish (pei)
- Classes and activities that bring families together (English classes, parenting classes)- can provide MH info there also (community)
- Parent conferences to identify mental health issues, teach what to do (community)
- Wrap program- kids learn to write their own action plans (community)
- Gangs, drugs, violence prevention (community)
- Suicide prevention training, resources (community)
- Programs for teenagers- peer support, groups, discussions (community)
- Programs in the school setting (community)
- Education about prevention, what to do when someone is mentally ill, signs of mental illness and prevention tips (community)
- Community based youth & family optimal wellness programs directed by and delivered by African American community based providers with liaisons to the community (pei)
- Community based education/awareness initiatives (pei)
- Education and training programs through CBOs/FBOs (pei)
- Stigma reduction by educating community, community agencies (police), work places, parents/ families, youth about mental illness (staff)
    - Community members share good experiences and good results from interactions with MH providers (community)
    - Have people who have had the experience share how they overcame mental illness (community)
    - Use different terminology instead of "mental health", which is interpreted as negative and "crazy" (community)
    - Spanish speaking- use "mental health" instead of "mental illness", focus on health (pei)
    - Use terms like "Wellness Center" instead of "Mental Health Clinic" (community)
    - Youth speak in terms of "hope" (community)
    - Avoid medical terms (community)
    - Use simple words like wellness & "bienestar familiar" (family well-being) (community)
    - Educate the community- about mental illness, mental health, & drug abuse (community)
    - Spanish speaking- Classes for the community for erasing negative ideas (stigma) about MH (pei)
    - Educate about who needs services (community)
    - Educate families that have a mentally ill member (community)
    - Information for youth (community)
    - Education to address stigma for children at risk for mental health problems (pei)
    - Brochures on different topics (community)
    - Educate police department (community)
    - Information provided by doctors or others who are trusted by Spanish speaking community, to reduce stigma (pei)
    - Seminars and workshops to groups (like focus group), in Spanish and English to reach different generations (community)

TO BE COMPLETED WITH WORKGROUP

OUTCOMES/EFFECTS ON DISPARITIES

Short-Term Measures

Long-Term Measures

IMPLEMENTATION GOALS

Monitoring/Process Goals (staff)

- **Provide Opportunities for Community Feedback (staff)**
    - Get feedback on focus groups from clients and unserved populations e.g. black community.
    - Hold specific focus groups for underserved communities.
- **Update the community on Cultural Competence Plan development (staff)**
    - Hold public hearings for plan implementation.
    - Updates in Spanish & English for public forums.
    - Distribution of plan updates to clinics and public libraries.
- **Identify & Measure Disparities in Access and Utilization:**
    - Review penetration rates and set a goal to increase rates by assessing barriers to services by ethnic populations.
    - Conduct access to services studies to identify the barriers to services and develop strategies to reduce the barriers.
- **Include staff and community in Planning (staff)**
    - Create a Community Committee to identify the needs and develop strategies.
    - Distribute evaluations that have been analyzed and ask for input from the staff and community.
- **Collect relevant data in Evaluation and Research studies (staff)**
    - Conduct evidence based studies with clinicians, internal studies to monitor staff competencies.
    - Update the data collected on forms; ask the correct questions of clients about culture and ethnicity.
    - Communicate the mission by posting it; review mission and assess level of accomplishment, how are contributing to the mission
    - Research, Q/I, evaluate to measure success of programs.

Benchmarks for New Actions (1, 2, 3 YEAR PRIORITIES)

ATTACHMENT #20

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH
COMMUNITY CAPACITY BUILDING INITIATIVE
7/8/10

GOALS

1. Educate the community to reduce the stigma of mental illness
   a. Build awareness of mental health issues
   b. Build understanding of the needs of those with mental health problems

2. Reduce barriers that keep people from acknowledging their problems and seeking help.

3. Build welcoming communities and resources that support and engage those with any level of mental health problems.
   a. Build specific supports in communities targeted to high risk individuals
   b. Build supports, activities and engagement strategies for the mentally ill in their communities outside of county funded mental health services
   c. Promote, support and train communities in growing their own culturally appropriate and linguistically accessible mental health prevention programs and resources
   d. Promote and support identification and utilization of cultural and linguistic community resources for treatment and early intervention in mental health problems

STRATEGIES

In order to begin building community capacity to support those with mental health problems and those at risk of problems the Department will pursue the following strategies.

1. Develop anti stigma activities such as community education and media efforts around mental health issues including depression, trauma, serious psychiatric illness, and suicide. Target identified groups and communities as well as general education.

2. Utilize "seed money" and technical assistance to support community non profit agency efforts to build sustainable programs in order to ensure supports and resources for those at highest risk and those with beginning symptoms.

3. Coordinate efforts and funding with DPSS, CHA and Office on Aging (and other public agencies) to work with trauma survivors, integrate health/mental health services and target services and supports to other high risk groups.

4. Develop groups and facilitate activities in the community that support those with mental illness which can be sustained through its members plus provide the information to families, consumers and agencies.

5. Assist ethnic communities to identify activities that meet their unique cultural needs and identify ways for the dept to support/promote the meeting of those needs.

6. Fund and facilitate development of specific PEI activities per community planning efforts.

7. Facilitate the development of community housing for mentally ill consumers through community efforts and education.

ACTIVITIES

The Department of Mental Health is pursuing numerous specific activities to build community capacity and reduce stigma.

I. Provide General Community Education
    Media
    Websites
    Presentations
    Dare to Be Aware Conference

II. Provide Community Education to Targeted Groups
     Law Enforcement Training
     Schools/Colleges
         Breaking the Silence
         Parents and Teachers as Allies
         Active Minds
         Suicide Prevention
     Faith Based
         Call to Care
         Spirituality Initiative

III. Special Population Outreach and Education
      Promotores de Salud
      LGBT Outreach
      Deaf Outreach
      Outreach and Planning with ethnic communities
      TAY Peer to Peer

IV. Build Consumer and Family Support in Communities
     NAMI groups and classes
     Department developed support groups
     Community resource listings
     ArtsCore

V. Support Community Agency Development and Expanded Programs
    Training in EBP practices
    Leadership development
    "Seed" money to create sustainable community agencies

VI. Build New Community Programs
     PEI Programs

VII. Housing Development and Education
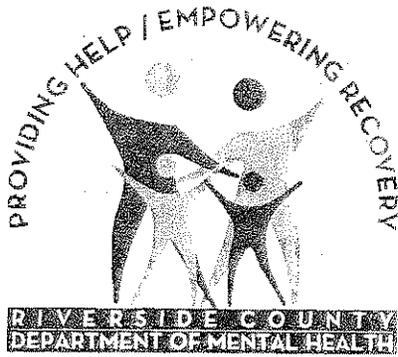
RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH

Jerry A. Wengerd, Director

TO: Mental Health Board

FROM: Donna M. Dahl, Assistant Director for Programs

DATE: January 5, 2010

SUBJECT: Stigma & Community Capacity Building Initiative

As DMH continues development of a recovery oriented system and implements other phases of MHSA it has become clear that a variety of new efforts must be seen as a part of the overall transformation of the Department's services.

Need for Anti-Stigma Activities

Stigma keeps people from acknowledging and seeking help when needed and reduces community and family acceptance of mental health problems.

The President's New Freedom Commission recognized the serious impact of stigma and identified its reduction as a priority in transforming mental health care in the nation.

The UC Davis Center for Reducing Health Disparities (2008) focus group findings suggest that *"new, concerted, and ongoing efforts to engage communities in the development and dissemination of new programs, to promote social inclusion, and to building sustainable relationships with underserved communities are critically needed"*. Research has been clear about the effects of stigma and discrimination on a person's ability and/or willingness to access services and their isolation from their community.

Through all of the Riverside County MHSA community planning processes stakeholders identified a high need for:

a. Activities to reduce stigma and discrimination related to identifying mental health needs and accessing mental health services
b. Culturally competent, community based outreach and engagement to all age groups
c. Activities designed to increase awareness regarding mental health.

It was also determined that *"specific outreach, engagement, and information regarding resources as well as specific stigma reducing strategies would be necessary in order to engage participation in any PEI activity"*. For all these reasons, the local PEI plan includes a focus on reduction of stigma.

<u>Need for Community Support and Integration as a Part of Recovery</u>

It is also clear that a part of recovery from mental illness has to do with community engagement. In "Recovery Oriented Leadership" by Community Activators and MHA Village it states, *"We live within the life of our community, however we define that. The process of recovery often includes either rebuilding or developing connections with other people and places in the community. The essential result of stigma – isolation and feelings of not-belonging – can only be overcome when a person finds relationships and places to belong outside of mental health and other social service systems. More than simply places to hang out, the person needs people within those places who value his/her presence and actively welcome them. We all need purpose in our lives, and it is within the context of community that we locate the opportunity to give and receive acknowledgement for our contribution"*.

Mark Ragin further states, *"Recovery tries to help people attain meaningful roles in life. These roles will require them to be reintegrated into the community, to be welcomed and to be valued, and to find their niches. Recovery cannot be achieved while people are segregated from their communities...Community development and anti-stigma work are important new programmatic and staff responsibilities"*.

The department has a responsibility to support and build on the strengths of existing community resources and work with communities to build bridges to community engagement and support for our consumers. We want to help communities support all their members. We recognize that the Department needs to work with communities to be accepting and welcoming places for those with mental health problems. In addition, current budget limitations require us to utilize community resources and assist communities to develop supports for those individuals who do not meet criteria for county services.

<u>Need for Prevention and Early Intervention</u>

Community involvement and support is a protective factor in the prevention of serious mental illness. The Department's PEI efforts will focus heavily on development of community supports and intervention for individuals at risk of serious mental health problems. The Department will provide resources in the community to build community capacity to better support those who are most vulnerable so they do not need our treatment services.

Stigma and Community Capacity Building Initiative Proposal

There is a critical interaction between anti stigma efforts to educate individuals and communities, the ability of communities to support and welcome all its members, and efforts to intervene early with those at risk or experiencing problems. Thus, the Department proposes to utilize PEI resources/activities and Statewide project resources to develop a **Stigma and Community Capacity Building Initiative**. The goals of this initiative are as follows:

1. Educate the community to reduce the stigma of mental illness
2. Reduce barriers that keep people from acknowledging their problems and seeking help.
3. Build welcoming communities and resources that support and engage those with any level of mental health problems.
   a. Build awareness of mental health issues
   b. Build understanding of the needs of those with mental health problems
   c. Build specific supports in communities targeted to high risk individuals

d. Build supports and engagement strategies for the mentally ill in their communities outside of county funded mental health services.

To accomplish this we propose a Community Capacity Building Committee that will develop and monitor an overall community development plan, guide development of strategies, oversee the integration and coordination of strategies by the implementing groups and provide the overall vision for the initiative.

The Committee will consist of department staff involved in PEI, outreach, stigma and consumer support work plus Mental Health Board, consumers and community representatives.

Building Community Capacity

Community
Support

Community
Acceptance

Individuals
With
Mental Health
Problems

Treatment
For MI

Community
Awareness

Community
Outreach

Community
Interventions
for High Risk
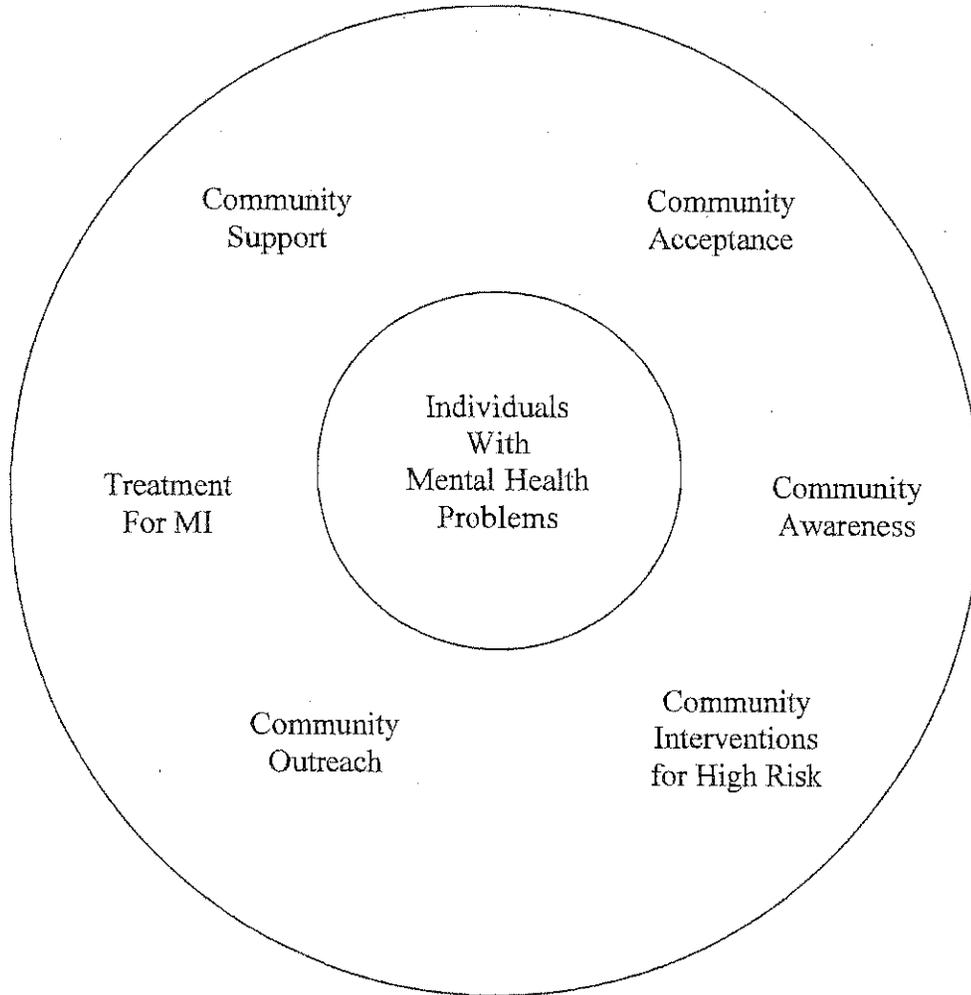
ATTACHMENT #21

Name	DeptID	Earn Code
Abejon,Esperanza	4100203617	BC2
Acuna-Balderas,Margie V	4100415501	BC2
Adam,Marisa	4100204512	BC1
Aguilar,Manuel C	4100514680	BL1
Akerlundh,Isabel C	4100203615	BC3
Algarin,Maria D	4100415518	BC2
Alvarez,Rosalie	4100514677	BL2
Aragon,Myriam Y	4100221534	BC3
Aranda,Julia	4100217829	BC2
Archuleta,Elaine M	4100202604	BC2
Arellano,Maria	4100205629	BC2
Arellano,Violeta	4100202808	BC2
Arias,Taide	4100207811	BC1
Avena,Amelia Y	4100203612	BC2
Avena,Enedina	4100203528	BC3
Bard-Henoch,Cheryl S	4100203615	BC1
Beard,Pepsia Jo	4100204821	BC1
Blunt,Mary L	4100204820	BL1
Bravo,Ralph	4100514671	BL2
Briceno,Lilia	4100202685	BC2
Buenas,Maribel	4100203691	BC2
Cabrera,Hildamari	4100203615	BC2
Cabrera,Mario A	4100204820	BC3
Cadena,Leilani G	4100205689	BC2
Calderon,Monica	4100514667	BL2
Campbell,Norine C	4100202808	BC2
Campbell,Samuel A	4100202522	BC1
Cancelada,Maria E	4100203612	BC3
Carlos,Norberto	4100204517	BC2
Castaneda,Libet	4100205689	BC2
Cazares,Lilie	4100205629	BC1
Chairez,Patricia	4100210822	BC1
Chapa,Martha C	4100203691	BC2
Chavez,Deisy	4100205632	BC2
Cho,Tina	4100421542	BL1
Contia,Elizabeth S	4100206661	BL2
Contreras,Miriam	4100205810	BC2
Corea,Jose R	4100413658	BC3
Cornejo,Sandra S	4100210822	BC2
Cox,Maria D	4100514668	BL2
Cruz Vasquez,Luis A	4100514666	BC2
Cuevas,Mark	4100202604	BC1
Deleon,Bertha	4100210818	BC1

Delgadillo,Adriana D	4100204624	BL1
Diaz,Zenaida L	4100203612	BC2
Dickens,Claudia	4100205629	BC2
Dominguez,Fabiola B	4100514730	BL1
Douglas,Rachel	4100207697	BC2
Duenes,Andres N	4100416644	BL2
Duran-Eason,Lupe	4100202604	BC1
Durazo,Consuelo	4100205698	BC2
Echegoyen,Marta	4100203809	BC2
Echegoyen-Soto,Leslie S	4100210824	BC2
Elliott,Nisha Limbrick	4100207697	BC1
Escandelli,Nereyda S	4100203615	BL1
Espino,Nancy	4100312827	BC1
Espinoza,Claudia	4100415518	BC2
Espinoza,Francisco J	4100203615	BL2
Espinoza,Zulma I	4100207697	BC3
Estrada,Naomi	4100514663	BL1
Fajardo,Angelica G	4100211645	BC2
Fajardo,Maria L	4100204512	BC1
Faulkes,Gina	4100205689	BC2
Felix,Guadalupe M	4100202685	BC2
Fernandez,Charlene D	4100101530	BC1
Fernandez,Karina	4100204821	BC2
Ficere,Irma Isela	4100211645	BC2
Flores,Anna M	4100205629	BL2
Flores,Desiree M	4100514671	BC2
Flores,Grace	4100204820	BC2
Flores-Castro,Rose	4100514667	BL1
Florez,Elisa	4100203612	BC2
Fullinwider,Yolanda	4100207642	BC3
Galanis,Michael G	4100202605	BL1
Galeano,Jose Joaquin	4100202504	BC2
Gallegos,Hilda	4100203611	BC2
Galvan,Eva	4100203616	BC3
Galvez,Monica E	4100203691	BC1
Gamez,Laura A	4100101600	BL2
Garcia,Denise	4100205643	BL2
Garcia,Denise Sara	4100413657	BC1
Gomez,Araceli	4100514680	BL1
Gomez,Jessica O	4100203513	BC2
Gonzalez Aguilar,Elizabeth	4100415518	BC1
Gonzalez,Albert	4100416524	BL1
Gonzalez,Celia	4100202685	BC2
Gonzalez,Griselda	4100210818	BC1

Gonzalez,Maria T	4100207521	BC1
Gonzalez,Mary A	4100210818	BC1
Gonzalez,Mireya	4100202604	BC2
Gonzalez,Mireya L	4100514662	BC2
Gonzalez,Veronica	4100202685	BC1
Gonzalez,William	4100101600	BC2
Graf,Lety M	4100203612	BC2
Guerra,Angelica Maria	4100202609	BC1
Guerrero,Veronica	4100514666	BL1
Gutierrez,Artemisa	4100202604	BC2
Gutierrez,Maricela F	4100207502	BC3
Gutierrez,Noe G	4100514662	BL1
Gutierrez,Shelley F	4100514677	BC1
Hammond,Veronica	4100211645	BC1
Hermanson,John	4100202609	BC2
Hernandez,Alicia	4100312827	BL2
Hernandez,Arturo R	4100203612	BC2
Hernandez,Daisy	4100203617	BC2
Hernandez,Isaias R	4100205629	BC2
Hernandez,Lorraine	4100514663	BL1
Hernandez,Manuel J	4100202604	BL1
Hernandez,Mayra Alejandra	4100202610	BC2
Hernandez-Gomez,Rosa E	4100203691	BC3
Huerta,Alfredo M	4100221534	BL2
Huerta,Francisco	4100204620	BC2
Huggins,Melissa B	4100205698	BL1
Iniguez,Maria	4100514662	BC2
Inzunza,Elena D	4100205710	BC2
Isales Jr,Carmelo	4100204820	BC2
Israel,Fortuna	4100204620	BC3
Jarquin Jr,Luis	4100207642	BC2
Jimenez,Maria T	4100202817	BC2
Jimenez,Ulda	4100202604	BC2
Kidder,Maria L	4100415501	BC2
Krause,Maria D	4100202610	BC1
Lai,Chun C.	4100202604	BC1
Lamadrid,Luis C	4100514677	BC2
Larson,Thomas C	4100210822	BC1
Le,Nina N	4100211645	BC1
Lee,Elisa P	4100207641	BC2
Leon,Elizabeth M	4100204620	BC2
Llanas,Candy L	4100514665	BL2
Loera,Mary Jo	4100514663	BL1
Lopez,Elisa V	4100205698	BC2

Lopez,Mario M	4100419508	BC1
Lopez,Norberto	4100514665	BC1
Lopez,Raul	4100514666	BL2
Lopez,Robert T	4100210818	BC2
Lopez,Samuel D	4100514663	BL1
Lumba,Ivan	4100514669	BL1
Luna,Steve	4100203615	BC1
MacAdam,Alexander	4100205810	BC2
Mackay,Norma	4100204619	BC1
Madigan,Chrystal Marie	4100204820	BC1
Madrigal,Guadalupe	4100514666	BL2
Maduena,Maria C	4100202604	BL2
Magana,Laura	4100514666	BL2
Marquez,Leopoldo	4100203615	BC2
Martinez,Jose U	4100514677	BC1
Martinez,Norma L	4100210516	BL1
Martinez,Richard	4100514667	BL2
Martinez,Rosa E	4100210516	BC1
Massoud,Soulafa S	4100203809	BC1
Mays,Jessica	4100203615	BC2
McCoy,Esther	4100205689	BL2
Meda,Rosa I	4100312825	BL2
Medina,Noemi C	4100205630	BC2
Medrano,Marco A	4100101601	BC1
Menchaca,Veronica A	4100413654	BL1
Mendez,Cindy G	4100205632	BC3
Mendoza,Herlinda E	4100202604	BL2
Meneses,Francisco X	4100514671	BL2
Merino,Bertha C	4100203615	BC2
Miker,Rodney	4100514674	BC1
Miranda,Fabiola	4100210819	BC2
Miranda,Karina	4100203615	BC2
Monreal,Maribel	4100514677	BC1
Montano,Teresa	4100514663	BC2
Monteon,Julian J	4100514666	BC1
Montgomery,Vanda	4100205689	BC1
Montoya,Jessica O	4100207659	BC1
Moody,Yvonne R	4100101600	BL2
Moore,Maricela	4100204820	BC1
Morales,Mina	4100514671	BL2
Morales,Salvador A	4100206636	BC2
Moreno,Carlos G	4100203691	BC3
Munoz,Maria D	4100202808	BC1
Murcia,Ana C	4100205632	BL2

Murcio,Cynthia C	4100413677	BC1
Murillo,Maria C	4100205630	BC2
Negron,Luz M	4100221534	BC3
Neyra,Nereida A	4100312682	BL1
Nguyen,Quoc	4100206634	BC1
Ortega Jara,Emilia	4100205810	BC2
Ortega,Maria V	4100202604	BC2
Palacios Gonzalez,Arturo	4100205629	BC2
Palacios,Brenda L	4100207697	BC3
Palacios,Rudolph	4100514667	BL2
Palafox,Margaret P	4100514663	BC2
Palomarez,Maria S	4100204624	BC1
Paramo,Janice C	4100204624	BC1
Parry,Suzanne	4100514673	BC1
Pedraza,Alice R	4100204820	BL2
Penilla,Dianet	4100203691	BC2
Perez,Eduardo M	4100312682	BL2
Perryman,Candy	4100205632	BC1
Ponce,Moises	4100221534	BC2
Portillo,Josefina H	4100202604	BC1
Ramirez Castro,Adriana B	4100205629	BC2
Ramirez,Alicia	4100203616	BC2
Ramirez,Joseph C	4100514667	BL2
Ramirez,Maria T	4100202504	BC1
Ramirez,Melina	4100514674	BL2
Ramirez,Victor N	4100210822	BC1
Ramirez-Neally,Eliza Jeanette	4100207521	BC2
Ramos,Helen	4100204620	BC2
Ramos,Minerva C	4100210819	BC2
Ramos,Veronica	4100204624	BL1
Regla,Yadira Maria	4100202604	BC2
Restrepo,Javier	4100206636	BC1
Reyes,Alex A	4100211645	BL1
Reyes,Hilda R	4100204620	BC2
Reza,Jerry C	4100204820	BL1
Rios,Alicia D	4100202604	BC2
Rissling,Anna M	4100204512	BL1
Rivas,Miranda M	4100204512	BC2
Rivera,Evelyn Patricia	4100413644	BC1
Roberts,Anne B	4100202604	BL1
Rodriguez,Anna L	4100221534	BC1
Rodriguez,Irma S	4100514665	BL2
Rodriguez,Laura E	4100211645	BL2
Rodriguez,Rita	4100202685	BC2

Rojas,Juan	4100514674	BL2
Romero,Esperanza	4100204620	BC3
Rucobo,Madeline	4100202604	BL1
Ruiz,Mariejose B	4100203612	BC2
Ruiz,Norma C.	4100202522	BL2
Ruiz,Pedro O	4100210516	BC2
Ruvalcaba,Sandra L.	4100203612	BC2
Saiz,Christina L	4100205698	BC2
Sanchez,Adrian D	4100312647	BC1
Sanchez,Erika	4100217829	BC3
Sanchez,Fausto	4100210823	BC1
Sanchez,Laura S	4100210822	BC1
Sanchez,Maria	4100202604	BC2
Sanchez,Natacha J	4100207697	BC1
Sanchez,Socorro	4100514663	BC2
Sandoval,Elvia	4100203809	BC2
Sandoval,Melissa A	4100413652	BC1
Santilli,Isabel	4100207697	BC2
Sapien,Gloria G	4100203809	BL2
Serrato,Jesus Alfredo	4100210819	BC1
Solano,Yolanda R	4100203691	BC2
Solorio,Consuelo M	4100514662	BL2
Soto,Marivel	4100210824	BC1
Soto,Olga P	4100210824	BC2
Stone,Judith L	4100210814	BC3
Tavira,Douglas H	4100206636	BC1
Thuve,Mark K	4100514672	BL1
Torres,Laura M	4100514663	BL1
Torres,Vanessa	4100205710	BC2
Trevino,Irma	4100202604	BC1
Trevino,Veronica	4100206636	BC1
Urbina,Ismael	4100205629	BC2
Valdivia,Maria G	4100514672	BC2
Vargas Manney,Yolanda	4100202817	BC2
Vasquez,Linette A	4100514730	BC2
Venable,Eugenia A	4100202685	BC2
Verdugo,Mark S	4100211645	BL1
Vertti,Antonio G	4100204512	BC3
Villa,Michael J	4100514680	BL1
Villagomez,Dinery C	4100207697	BC3
Villalpando,Sylvia T	4100204620	BC3
Waight,Roxanne Rebecca R	4100204512	BL2
Warfel,Evelyn	4100210823	BC2
Webb,Andrea R	4100514668	BC1

Wicki,Thaddeus A.	4100203615	BC3
Wilson,Benjamin J	4100205629	BC1
Wukadinovich,Karin	4100202522	BC1
Yeung,Sarah A	4100205632	BC2
Yglesias,Lucille A	4100514666	BC1
Young,Lily H	4100202604	BL1
Zamora,Maria E	4100205632	BC3
Zapata,Luis A	4100203611	BL1
Zaragoza,Arturo	4100202604	BL2
Zarco-Sale,Olivia	4100514674	BL2

ATTACHMENT #22

Fig.1

Percentage by Age

14.1%

28.5%

57.3%

☐ Under 17
▓ 18 to 59
☐ 60+
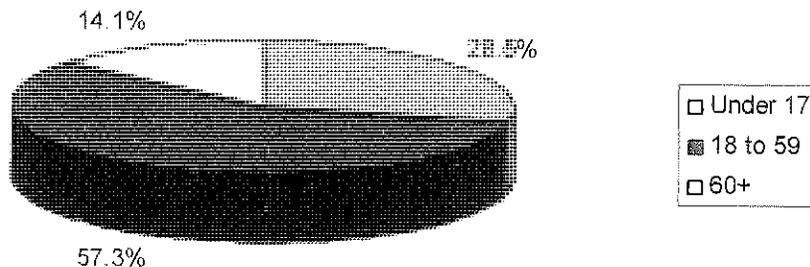
Riverside County's estimated population in 2008 was 2,119,618.*

More than half (57.3%) of this population were between the ages 18 to 59.

The 60+ age group accounted for less than 15% of the population, while youth age 17 and under accounted for more than 25% of the population.

There is not a significant difference in the amount of females versus males within the county. Females comprise a slightly higher percentage of the population than males (Fig.2).

Fig.2

Percent by Gender

75.0%

49.8%   50.2%

50.0%

25.0%

0.0%

Males   Females
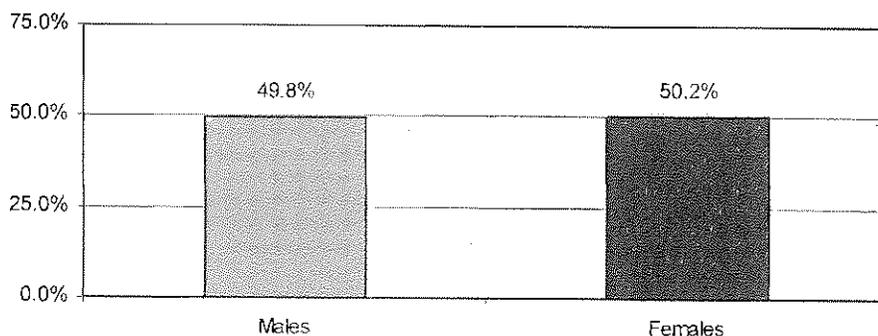
Fig.3

Percent by Race/Ethnicity

50.0%   46.1%
                40.9%
40.0%

30.0%

20.0%

10.0%   4.6%   0.5%   6.3%   1.7%

0.0%

White   Hispanic   Asian/PI   American   Black   Multirace
                               Indian
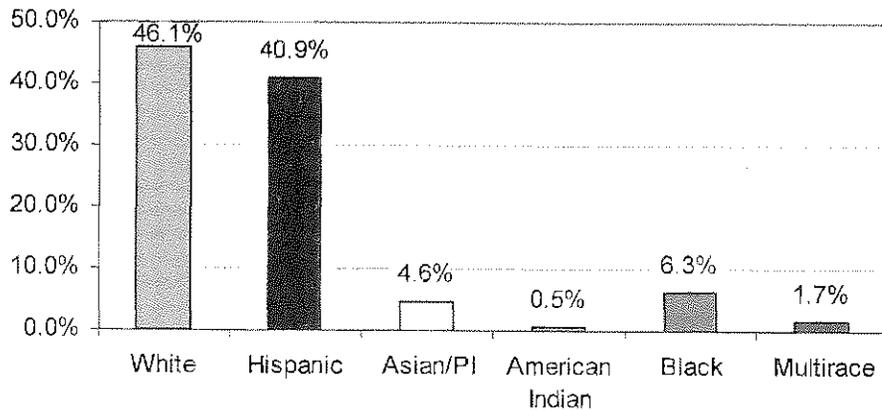
White and Hispanic are the majority race/ethnic groups in Riverside County (87%). Of the remaining 13%, the larger population is Black, followed by Asian/Pacific Islander, Multirace and American Indian (Fig3).

*Data Source: State of California, Department of Finance, *Race/Ethnicity Population with Age and Sex Detail, 2000-2050.*

ATTACHMENT #23

Riverside County Department of Mental Health (RCDMH)	Cultural Competency/ Reducing Disparities Committee. (Combined Cultural Competency and Reducing Disparities Committees)
Purpose: Key Elements: - Inclusive & Transparent - Partnership & Collaboration between department & Community. - Outcome: Culturally Competent Strategic Action Plan - Use input gathered from the organization and the community for strategy development.	To develop a participatory process for the development of Cultural Competency Plan for Reducing mental health disparities. It focuses on system level: Policies, interagency collaboration. **By consensus the group agreed to the following Purpose:** **To develop, recommend and maintain a formal practice, through a participatory process in partnership and collaboration with the community; for the purpose of implementing and optimizing the State mandated Cultural Competency Plan that ensures fairness and equality across systems in order to reduce mental health disparities in Riverside County.**
Membership: Elements: - Community leaders - Expertise from different ethnic communities. - County staff active in their communities. - Community experts who are trusted by the community with an ability to "drill down" into the community.	The Cultural Competency and Reducing Disparities Committee shall be composed of up to 36 members. - Members should possess expertise and leadership in the community, - demonstrate strong communication links with diverse communities and stakeholders, - possess ability to work effectively with others with different backgrounds and perspectives, - demonstrate a commitment to the successful development, and implementation of the committee's goals and objectives
Responsibilities: Elements: - Advisors to the organization - Reviewers of County response to needs of the community. - Monitors of strategic cultural action plan. - Trainers of the organization and the community. - Participation in ongoing Cultural Competence strategic planning process.	The Cultural Competency and Reducing Disparities Committee will: - Advise RCDMH regarding strategic direction, priorities and ongoing activities necessary for the reducing mental health disparities. - Annually review and evaluate the Committee work plan and accomplishments. - Participate in ongoing Cultural Competency strategic planning process. - Provide leadership and advocacy in insuring that RCDMH is accountable to the consistent quality implementation of cultural competency and the reducing

- Leadership and Advocacy to RCDMH. - Review the organization to see that it remains accountable to the implementation of cultural competency and reducing disparities. - Process for staying focused on the goals and purpose of the Disparities (CORE) Group. - Offer a community perspective to the organization on the services provided and recommendations and strategies for modifying services to connect more closely with the community.	disparities in the mental health system.
	
	Work Group Recommendations:
	1) **To ensure that every diverse community group has a voice/input regarding their mental health needs**
	
	2) **Building Partnerships: to ensure the building of partnerships with the community by developing trust and confidence, and to establish a fluid communication in order to maintain solid relationships of trust, Confidence, Relationships, Improve communication**
	3) **To develop a strategic plan which encompasses department staff and community leaders in order to ensure continued department participation with the community.**
	4) **Develop a system to monitor and/or enhancing the partnerships.**
	5) **To recommend ongoing training on cultural competency with staff and community.**
	   • **Cultural Celebration open to the community**
	   • **In service trainings.**
	6) **Recommending specific skills building trainings for the unique needs of our diverse communities. i.e. Working with LGBT**

Meeting Schedule 2009-2010	**The Cultural Competency and Reducing Disparities Committee will meet on a monthly basis. Group agreed to meet the second Wednesday of each month from 9:00-11:00**

Officers
 	
Current Cultural Competency Committee chair: Brandon Lee
Co-chair: Moises Ponce
	The committee decided to have two Co-chair: one internal(department staff) and one external(community representative)
	
	   - Coordinate with Cultural Competency Program Manager
	   - Facilitate the committee meetings
	   - Develop a meeting agenda
	   - Convene special meetings

Special Committees or taskforces Elements: - Purpose for subcommittees - Role of subcommittees. - Interaction of subcommittees with the larger committee. - Current Subcommittes are:	As needed, subcommittees will be formed to address specific issues or committee needs. Subcommittees will report to the large group every month.

Translation, Spirituality, Deaf and Hard of Hearing, LGBTQ,	
Reaching Consensus	Consensus is a decision making process that works creatively to include all persons making the decision. It is the most powerful decision proves as all members agree to the final decision. Every ones gets the opportunity to voice their opinion.
Compensation	Members of the community will serve on a voluntary basis. Reasonable expenses for meeting participation will be compensated per RCMHD stipends policy.

Update and approved by committee on 10-14, 2009

ATTACHMENT #24

Department of Mental Health Director

Mental Health Service Management Team

Cultural Competency Program

Cultural Competency/Reducing Disparities Committee

- Spirituality Taskforce
  - Call to Care Training Program
- Translation and Interpretation
- Training & Celebrations Taskforce
- Outreach & Engagement Activities: Building Community Capacity
- Ethnic & Cultural Specific Taskforces
  - LGBT
  - Native Americans
  - Asian Americans
  - African American
  - Latinos/ Hispanic Promotores Program

ATTACHMENT #25

Board of Supervisors

Bill Luna
County Executive Officer

Mental Health
Board

Jerry Wengerd
Mental Health Director

Alison Emery, Director of Consumer Affairs
Myriam Aragón (Acting), Family Advocate (Adults)
Vacant, Family Liaison (Children)
Mary Stetkevich, Patients' Rights Advocate

Dr. Jerry Dennis
Medical Director

Maria Mabey
Assistant Director
Administration

Donna Dahl
Assistant Director
Programs

Administrative Services
Joe Zamora
Admin Services Manager III

Information Technology
Rosie Whitehead
Information Technology Officer

Cultural Competency
Myriam Aragón
MHS Program Manager

MHSA
Bill Brenneman
MHS Program Manager

CHILDREN'S SERVICES
Erlys Daily
MHS Administrator

DESERT REGION
David Lundquist
MHS Administrator

MID-COUNTY REGION
Luis Zapata
MHS Administrator

SUBSTANCE & ALCOHOL
Karen Kane
SA Svcs Program Administrator

WESTERN REGION ADULT
Maria Marquez
MHS Administrator

WESTERN REGION CHILDREN'S
Steve Steinberg
MHS Administrator

CRISIS/INPATIENT
Joe Sebastian
MHS Program Manager

DETENTION SERVICES
Mike Malone
MHS Program Manager

MHSA INNOVATION & PEI PROJECTS
Deborah Johnson
MHS Program Manager

OLDER ADULT
Barbara Mitchell
MHS Program Manager

PUBLIC GUARDIAN
William van der Poorten
MHS Program Manager

QUALITY MANAGEMENT
Ryan Quist
MHS Program Manager

ATTACHMENT #26

Cultural Competency/Reducing Disparities Committee
Membership for 2010

Members	Position	Bi-Lingual Language Spoken	Ethnicity	Cultural Group
Algarin, Maria	Fam. Advocate, Sr. MH Peer Specialist	Spanish	Latina	Family Member/Family Advocate Staff
Aragon, Myriam	Manager, Cultural Competency	Spanish	Latina	
Arciniega, Pedro	Community Member	Spanish	Latino	Consumer
Delgado, Ninfa	Vice President, Riverside Community Health Foundation, Riverside	Spanish	Latina	Homeless Population - External
Diaz, Janseen	BHS	English		Substance Abuse/ Staff
Dovalina, Melissa	BHS II	Spanish	Latina	Substance Abuse/Staff
Durazo, Consuelo	Peer Specialist, Wraparound	Spanish	Latina	Parent Partner
Emery, Alison	Director, Consumer Affairs, DMH	English		Consumer Affairs
Espinoza, Clauda	Fam. Advocate, Sr. MH Peer Specialist	Spanish	Latina	Family Member/Family Advocate Staff
Fajardo, Alex	Promotores	Spanish	Hispanic/latino	CBO
Fullinwider, Yolanda	TRAC	English		Women Issues/Staff
Harris, William W.	Supervisor, Friday Night Live, DMH	English		
Hernandez, Jr. Jairo	Community Member	Spanish	Latino	Consumer
Hilton, Veronica	Program Director	English	African-American	CHA/Staff
Huerta, Alfredo	Clinical Therapist, Indio	Spanish	Latino	Desert Region Mental Health Clinic/Staff
Isales, Carmelo	Jefferson Wellness Center	Spanish	Latino	Staff
Lee, Brandon	Staff Analyst, MH Admin.	Chinese	Asian-American	Staff
Moriarty, Gloria	Ctr on Deafness Inland Empire	English		Deaf & Hard of Hearing - External
Parker, Adonis	RISE Interpreting	English		Deaf & Hard of Hearing - External
Ponce, Moises	CT I, Perris MH	Spanish	Latino	Mid-County Region/Staff
Ramirez, Juan	Community Member	Spanish	Latino	Community Member
Richmond, Anthony	Peer Specialist, Jefferson Wellness Center	English	African-American	
Rosales, Javier	Latino Network	Spanish	Latino	
Thomas, Daphne	BHS, Older Adult Services-SMART Prg.	English		Staff
Troncozo, Leticia	Medical Interpreter/Translator	Spanish	Latina	Staff
Tulloch, Louis	Jefferson Transitional Program (JTP)	English		Staff
Vass, Pamela	Secretary, DMH Childrens Services	English	African-American	Staff
Vauhn-Blakely, Jennifer	The Group	English	African-American	
Wilbur, Amanda	DPSS, IT	English		Staff

FY 2010

Consultants for the Cultural Competency/Disparities Committee

Members	Position	Bi-Lingual Language Spoken	Ethnicity	Cultural Group
Ramsey, Benita	LGBT Consultant	None	African-American	LGBT
Dr. Renda Dionne	Native American Consultant	None	Native American	
Mike Madrigal	Healer	None	Native American	Spiritual Healer
Riverside Asian American Community Association	Asian American Consultants	Thai, Lao, Vietnamese, Chinese		
Ben Jauregui	Deaf & Hard of Hearing Consultant	American Sign Language, Spanish	Latino	

Cultural Competency Program Volunteers

Lada Bounleut	Volunteer for Cultural Competency Program	Chinese	Asian American	
Myriam Gomez	Volunteer for Cultural Competency Program	Spanish	Latina	
Susanna Luu	Volunteer for Cultural Competency Program	Chinese	Asian American	
Raquel Aguilar	Volunteer for Cultural Competency Progam	Spanish	Latina	
Lydiah Kirutia Wanjau	Volunteer for Cultural Competency Program	Swahili, Kikuyu, Luo	African American	

Revised: 05/25/2010 *ar*

ATTACHMENT #27

Riverside County
Department of Mental Health
Cultural Competence Plan
Goals and Objectives
Update
2007-2008

Goal 1: Providing barrier-free access to all residents of Riverside County.

1.1. **Objective: Provide consumers with services and written materials in their language of choice**

Activities	Status Update/Reporting Units
1.1.1. Establish contracts with Interpretation agencies to provide interpretation and translation services.	1.1.1. **Completed. On going.** Contracts are established. Effective September 26, 2006, county awarded contracts to Continental Interpretation Services and Language Services.
1.1.2. Increase the number of hire bilingual staff.	1.1.2. **Completed. On-going.** Report from human resources. Per reported dated 12/07 a total 257 Spanish speaking, 2 Vietnamese, 2 Tagalog, and 2 American Sign Language.
1.1.3. Develop policies and procedures to support and encourage use of language services.	1.1.3. **Completed.** Policy # 162 effective September 18, 2000. Language Accessibility Procedure, Page 2.
1.1.4. Development of tracking system to monitor use of interpreter's services and translation services.	1.1.4. **Completed. On-going.** Translation committee report on number of requests for translation and list of documents translated. List of translated documents posted on the intranet. The numbers of hours of Interpretation services provided by bilingual staff are not captured yet. Invoices on outside vendors' services need to be summarized on a quarterly basis. Protocols to accomplish this task need to be developed.

Activities	Status Update / Reporting units
1.1.5. Ensured that all information materials distribute to the clients are translated into threshold language.	1.1.5. **Completed. On-going.** Check list of translation materials compared with list of English materials/ forms. Translation committee reports. The goal of the translation committee is to ensure that all the information materials and forms distributed to clients are translated into threshold language Spanish.

1.2. Objective: Determine why the Hispanic and Spanish speaking population in particular are under represented in our service population through a Latino Access study.

Activities	Status Update / Reporting units
1.2.1. Conduct a Latino Access Study.	1.2.1. **Completed.** Access study was completed on March, 2004.
1.2.2. Analysis of study and draw recommendations for improvement of access.	1.2.2. **Completed.** The study concluded that 72% of the clients reported they would like an interpreter offered in spite of the fact that they speak some English.
1.2.3. Develop an action plans to implement recommendations.	1.2.3. **Completed.** Interpreter's services are currently offered to Latinos who speak Limited English.

1.3. Study the groups that are underserved and determine universal factors that create barriers to consumers.

Activities	Status Update/ Reporting Units
1.3.1. Undertake a study that will determine groups that are in fact underserved and what issues are those create barriers to their accessing care such as childcare, transportation, etc. - Analysis of penetration and retention rates. - Percent of unmet needs - Surveys - Focus groups	1.3.1. **Completed.** Research and evaluation Unit to provide quarterly reports on penetration and retention rates, and percentage of unmet needs by regions and by clinics. Cultural Competency Program to work with Program managers and Supervisors to conduct studies to determine issues impacting penetration and retention rates.

1.3.2.	Implement an action plan to overcome those barriers.		MHSA CSS plan provides the list of activities designed to address the disparities.
		1.3.2.	**Completed/ongoing** Outreach and engagement project plan presented in the CSS plan. The department is currently in the implementation process. Two staff members are currently hired to do ethnic specific outreach and engagement in both desert and mid county regions. Development of outreach plan for Ethnic specific communities, hearing impaired, and LGBT community began.

Goal 2: Recruitment and retention of ethnically diverse staff representative of the Department's service areas as the budget allows.

2.1. Objective: Recruitment of ethnically diverse staff representative of the Department's service area.

Activities		Status Update/ Reporting Units	
2.1.1.	Declared the desert region a Health Professional Shortage Area.	2.1.1.	**Completed.** National Health Services Corps application for all four Desert clinics sites are pending renewal as of 11-1-07. One staff (PhD) has been successfully recruited via loan repayment.
2.1.2.	Visiting Universities MSW Programs.	2.1.2.	**Completed.** Activity completed as part of the MHSA Workforce Development Education and training component.
2.1.3.	Submitting grant proposal to seek alternate sources of funding for positions.	2.1.3.	**Completed.** MHSA CSS approved by State Department of Mental Health.
2.1.4.	Advertising in ethnically appropriate publications, conferences and trainings.	2.1.4.	**Incomplete.** The department currently advertises positions available in the website.
2.1.5.	Designating bilingual positions with additional compensation according to the level of bilingual abilities.	2.1.5.	**Completed.** Based on need analysis the department has designated bilingual positions. See bilingual compensation Policy # 305.

2.2. Objective: Retention of ethnically diverse staff representative of the Department's service areas.

Activities	Status Update/ Reporting Units
2.2.1. Implementation of 20/20 program per department's Policy 342.	2.2.1. **Completed.** 20/20 program has been implemented. Currently 4 staff is participating in this program. Policy #342 was revised on May 20 2002.
2.2.2. Bilingual pay differential for employees that use their bilingual abilities in the performance of their job duties.	2.2.2. **Completed.** Bilingual Compensation Policy # 305. List of bilingual pay staff by language, and job classification.

Goal 3: Cultural Competence training for all mental health staff including management, supervisory, clinical and support staff.

3.1. Objective: Provide staff with a least one training per year that focuses on cultural competence specific topics such as the Culture of Poverty, the Latino culture, etc.

Activities	Status Update/ Reporting Units
3.1.1. Conduct one or more trainings per year that cover issues specific to Cultural Competency.	3.1.1. **Completed. On-going.** Training unit conducted a total of 21 trainings. Each trainer is required to include cultural considerations in their training.

3.2. Objective: Include cultural competency components in all training events, when they are appropriate.

Activities	Status Update/ Reporting Units
3.2.1. All trainers need to be informed that they need to include cultural competency components in their training materials as it pertains to the subject they are covering.	3.2.1. **Completed.** Training Unit sent a letter to presenters requesting inclusion of cultural considerations in their presentation as a requirement to do a presentation. Training evaluation form was modified to include a question regarding meeting diversity/multicultural/ language issues during the training presentation. (Evaluation form question #14). Cultural Competency Committee

	recommended the creation of a Training Subcommittee to review the training outlines prior to training presentation.

Goal 4: Development of partnership with community organizations and other agencies to facilitate and improve access to services for consumers.

4.1. Objective: Strengthen and grow partnership with community organizations and other agencies to facilitate and improve access.

Activities	Status Update/ Reporting Units
4.1.1. Develop a desert region program called "A Call to Care". The faith based community is trained on the assessment of mental illness and the referral process of mental health services.	4.1.1. **Completed.** Desert Region program manager developed a contract with Catholic Charities to roll out the program. Training program was completed.
4.1.2. In the Western region a breakfast was help with local clergy where they were provided with information and resources on mental illness to assist them in serving their members who are in need of mental health services.	4.1.2. **Completed.** Western region Program Manager completed this project. Training was completed.
4.1.3. Partnership programs have been developed with local community and public organizations such as the University/Eastside Community collaborative which focused in a primary Hispanic neighborhood.	4.1.3. **Incomplete.** Collaboration was initiated two years ago, but has not continued after staff changes and re-assignments. The Cultural Competence Committee will provide recommendations on how to continue.
4.1.4. Annual Youth Anti-Stigma Conference.	4.1.4. **Completed.** Training Unit completed this task. Since 2002 the Conference is scheduled yearly. The 2007 conference took place on October with participation of approximately 1500 teens. The conference planning committee is a collaborative effort among Riverside School Districts, Mental Health Department, Social Service Department and other community representatives.

5

5. Future Objectives in Support of Identified Goals

Activities	Status Update / Reporting Units
5.1. Creating a process to drive the development and location of services and programs sites by July 2006. This will include recommendations of factors to be considered when locating a program site such as public transportation, etc.	**Completed.** Program Managers determination of location of MHSA programs per needs assessment, population to be served, etc. Public transportation availability is one of the key factors in consideration when selecting a program site.
5.2 Contracted interpreters are being given a brochure that outlines our expectations of them and includes a brief overview of mental health. This will be completed by July 2006	**Completed.** A brochure was developed. Brochure outlines the expectations of the interpreters that are providing services.
5.3 Designing a Cultural Competence Web page that will educate, inform and promote both the public and employees on the department's philosophy, goals and activities by January 2006	**Completed.** Cultural Competence Webpage was developed by the Cultural Competence Committee. The Webpage includes the Cultural Competence Plan, and information on Cultural Competence Committee activities.
5.6 Creating clinical documentation requirements that staff will be trained on and that will be included in the QI Audit to further ensure they are adhered to and become standard procedures by July 2006. These requirements will ensure progress notes and treatment plans reflect culture, age and gender. Not only we want them to be documented but we also want to make sure they are utilized.	**Incomplete.** Intake package and treatment plan cultural considerations session. Documentation on progress notes needs to be established.
5.7 Reviewing the Contract and contract provider selection process cultural competency criteria to include more concrete guidelines for providers by July 2006. The current documentation needs to be brought up to date to reflect our cultural competency standards of today.	5.7 **Completed.** Boiler plate was review and improved in 2007. Section XXI: Cultural Competency, Page 26.
5.8 Developing strategies that will assist in recruiting and retaining ethnic minorities by July 2006.	5.8 **Ongoing.** Currently Developing the Workforce Development Education and Training Component of the MHSA.
6 Review, create and revise current tools to measure staff and contract provider's knowledge and ability to provide cultural competent services by July 2006.	6. **Incomplete.** Cultural Competency Organizational Assessment and Staff Cultural Competency Evaluation are scheduled to take place in 2008.

ATTACHMENT #28

Cultural Competence Committee
In-House CCC Assessment
September 2007

Purpose:

To survey members of the Cultural Competence Committee (CCC) concerning the strengths and weaknesses of the CCC relative to meeting needs of culturally diverse populations in the County of Riverside.

Goals:

Based on the responses to the survey, the CCC would be able to establish specific goals for the CCC.

Name: _____

Program you representing at the Cultural Competence Committee:

_____

1. Which trainings have you attended that specifically addressed areas of cultural competence?

2. What specific training or consultation have you provided to department units/programs in the areas of cultural competence?

3. What projects or program components do you develop, monitor, or implement that address the needs of various cultural and ethnic groups?

4. Are client education materials available in languages and reading levels appropriate for the population you are serving? Are those culturally appropriate?

5. Does your staff/ work unit or program that you represent at the CCC include members of diverse cultural and social groups representing the population coming to the clinic? Are there any gaps? Please specify.

6. What things would you like to help/change that will strengthen the committee functions.

7. Do you have knowledge and ability to discuss the following documents? Please mark the documents.

- ☐ CA State DMH Cultural Competence Plan Requirements www.dmh.ca.gov/http://www.dmh.ca.gov/DMHDocs/docs/notices 02/02-03

- ☐ Guidance Memorandum- Title VI Prohibition against National Origin Discrimination-Persons with limited English Proficiency www.hhs.gov/progorg/ocr/lepfinal.htm

- ☐ Surgeon General Report- Mental Health: Culture, Race, and Ethnicity- www.surgeongeneral.gov

- ☐ Cultural Competence Standards in Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups- Website: www.samhsa.gov

- ☐ National Standards for Cultural and Linguistic Appropriate Services in Health Care Final Report (CLAS) http://www.omhrc.gov/clas.

- ☐ President's Freedom Commission on Mental Health-Achieving the Promise: Transforming Mental Health Care in America. http://www.mantalhealthcommission.gov.

- ☐ Towards a Culturally Competent System of Care Vol. 1. A Monograph on Effective Services for Minority Children who are Severely Emotional Disturbed. March 1989. By Terry L. Cross, Barbara J. Bazron, Karl W. Dennis, Mareasa R. Isaacs. Georgetown National Center for Cultural Competence

- ☐ Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities. California Mental Health Directors Association. February 2005

- ☐ County of Riverside Department of Mental Health Cultural Competence Plan 2004

- ☐ Mental Health Service Act Considerations for Embedding Cultural Competency

ATTACHMENT #29

Riverside County
Department of Mental Health
Cultural Competence committee
Committee meeting 10:00-12:00 Administration Room A/B
Training Topics (45) minutes presentation)
2008

Date	Topic (1)	Coordinator (2)	Department Events (3)
January 10	GLBT	Overview of Taskforce and LGBT outreach and Engagement Report	Article for the news letter
February 14	Black History Month	Presentation of a video; " A Girl Like Me"	Each clinic did a presentation about Black History Month
March 13	HIV/AIDS	HIV/AIDS Presentation Myths and Facts	
April 10	Women issues	Presentation: " Women's Issues in Our Own Backyard"	
May 8	Asian American/ Pacific Islander Month	Presentation: " HOPE" honored and celebrated Asian American/Pacific Islanders.	Asian American /Pacific Islanders Month Celebration
June 12	Hearing Impaired / Deaf community	Presentation title: "Deaf and Hard of Hearing culture".	Send article to all staff title: *"Interacting with People Who Are Deaf or Hard-of-Hearing* Communication Tips.
July 10	European Americans	Cancelled	
August 14	Linguistic Services overview of Interpretation and translation issues	Reviewed of Providing Linguistic Services challenges	Distribution of Interpretation Services Available Poster.
September 11	Hispanic/Latino Month	Presentation of the video: " Counseling Latinos in a time of Growth and Change" Patricia Arredondo	Hispanic/Latino Month Celebration Event.

October 9	GLBT	Presentation about Transgender Community. Panelist's presentation	Three Regional LGBTQ Celebration Months. October 22, 28, 30
November 13	Native Americans Month	Native American Outreach Challenges and Opportunities	
December 11	Multiculturalism a Celebration of Diversity	Celebrating Diversity	

(1) Topic: Per committee decision
(2) Coordinator: Cultural Competence Committee member who will take the lead to coordinate the presentation with assistance of the Cultural Competence Program, identifying presenters, and assist with the logistics for the presentation.
(3) Department wide events coordinated by the Cultural Competency Committee

Riverside County
Department of Mental Health
Cultural Competence/Reducing Dispatities committee
Committee meeting 9:00AM-11:00AM Administration Room A/B
In-Service Training Topics (30) minutes presentation)
2010

Date	Topic (1)
January 13	MHSA Innovations Overview
February 10	MHSA Update Presentation
March 10	Native American Presentation
April 14	Budget Presentation For the Department of Mental Health
May 12	
June 9	
July 14	
August 11	
September 8	
October 13	
November 10	
December 8	

(1) Topic: Per committee decision
(2) Coordinator: Cultural Competence Committee member who will take the lead to coordinate the presentation with assistance of the Cultural Competence Program, identifying presenters, and assist with the logistics for the presentation.
(3) Department wide events coordinated by the Cultural Competency Committee

Riverside County
Department of Mental Health
Cultural Competence/Reducing Dispatities committee
Committee meeting 9:00AM-11:00AM Administration Room A/B
In-Service Training Topics (30) minutes presentation)
2009

Date	Topic (1)
January 10	None
February 19	Black History Month
March 12	Focus Group: Indicators of Cultural Competency in Healthcare Delivery Organizations
April 9	Outreach and Engagement – A Review of the Concept and the Activities Taking Place in RCDMH
May 14	PowerPoint Presentation - Asian American/Pacific Islander
June 12	DVD Presentation: Innovative Approaches to Counseling Asian-American People
July 9	Discussion of CORE Group
August 13	Presentation: Introduction of Evidence Based Practices
September 11	None
October 14	Innovations Overview
November 13	None
December 9	None

(1) Topic: Per committee decision
(2) Coordinator: Cultural Competence Committee member who will take the lead to coordinate the presentation with assistance of the Cultural Competence Program, identifying presenters, and assist with the logistics for the presentation.
(3) Department wide events coordinated by the Cultural Competency Committee

ATTACHMENT #30

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RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH

Cultural Competency Committee's Recommendations for
Embedding Cultural Competence through the
Prevention and Early Intervention (PEI) Plan
October 2008

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Purpose:
The purpose of this document is to propose possible operational strategies for embedding cultural competency in the Prevention and Early Intervention (PEI) Plan component of the Mental Health Services Act (MHSA). Collectively, the Cultural Competency Committee came-up with the recommendations in order to effectively develop PEI Programs that meet the need of racial, ethnic, and culturally diverse populations in our community. In addition, it addresses the need to establish organizational, systemic changes, as well as build community participation.

The Cultural Competence PEI Program examined the following elements:

- Improve service access, including early intervention.
- Effective integration of the client's family (including extended family members) into planning process.
- Use of relevant community supports.
- External resources in client involvement and participation.
- Build financial incentives and opportunities for community members to become part of the process.

Recommendations:
1. Culturally Competent, system-wide self assessment.

   Action:
   1a. Identify a culturally competent, self-assessment instrument.
   1b. Conduct a self-assessment annually.
   1c. Develop an action plan for improvement.
   1d. Implement action plan.
   1e. Create on-going reports.

2. Develop PEI programs in response to community needs by increasing community participation, building partnerships and reach a consensus on priority needs.

   Action:
   2a. Conduct community baseline needs assessment (i.e.: ethnic/cultural/linguistic access studies).
   2b. Conduct focus groups specific to cultural/ethnic/linguistic groups.
   2c. Establish collaborations and building capacity in working with cultural/ethnic/linguistic community, such as leadership training, community based organizations, etc.

3. Have members from racial/ethnic/linguistic communities participate on advisory boards/committees.

   Action:
   3a. Diversify current Mental Health Boards/Committees/Taskforce representation by:
   1. Targeted outreach.
   2. Providing leadership training and public speaking.
   3. Provide transportation and incentives for volunteers to participate.
   4. Provide interpretive services.

4. Establish a procedure to ensure that all policies and program development decisions are reviewed for cultural considerations.

   Action:
   4a. Have Cultural Competency members be part of the planning development committee (i.e.: PEI Steering Committee, plan review & RFP development, etc.)
   4b. Have a member of the Cultural Competency Committee on each committee and taskforce.

5. Allocation of some of the PEI funding for building relationships with underserved and unserved cultural/ethnic/linguistic diverse communities.

6. Develop outcome measures and quality indicators that are culturally competent based.

   Action:
   6a. Involve ethnic/cultural/linguistic communities in the development of outcomes measures, and quality indicators.

7. Establish a coalition focused on reducing disparities to culturally/racially/ethnically underserved and unserved populations.

   Action:
   7a. Outreach and provide the infrastructure to bring representatives from the community, such as CBOs, grassroots organizations, non-traditional associations.

8. Increase the participation of monolingual/bilingual consumer and family members.

   Action:
   Target recruitment of different languages.
   8a. Conduct focus groups to identify present needs to increase participation.
   8b. Ensure interpretative services are always available at meetings, events, etc.
   8c. Collaborate with current groups to include more multi-cultural/multi-linguistic voices.

Riverside County Department of Mental Health

Reducing Disparities Task Force Initial Report

Recommendation for Reducing Disparities in Mental Health Services for Ethnic and Cultural Groups

November 3, 2008

Background

The Mental Health Service Act (MHSA) (formerly known as Proposition 63) was approved by California voters to provide a 1% tax on personal income over $1 million in order to expand and transform the county mental health service system. It became effective January 01, 2005.

The MHSA has five components. Each one of these components requires surveying people and organizations that are involved in mental health services including county mental health staff, community based organizations, consumers and their families, and other county and government organizations.

Per the State guidelines, "An objective of PEI is to increase capacity for mental health prevention and early intervention programs led by appropriately trained and supervised individuals in organizations and systems where people in the community currently go for purposes other than mental health treatment services." The intent of PEI programs is to engage individuals before the development of serious mental illness or serious emotional disturbance or to alleviate the need for additional or extended mental health treatment.

What is Prevention?

- ✓ Prevention in mental health involves building protective factors and skills, increasing support and reducing risk factors or stressors.
- ✓ Prevention efforts occur prior to a diagnosis for mental illness.
- ✓ Generally there are no time limits on prevention programs.

What is Early Intervention?

- ✓ Addresses a condition early in its manifestation
- ✓ Is of relatively low intensity
- ✓ Is of relatively short duration (usually less than one year)
- ✓ Has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services
- ✓ May include individual screening for confirmation of potential mental health needs

Definitions

The Reducing Disparities Task force adopted the definitions of Disparities, underserved, unserved and inappropriately served presented by the 1999 Surgeon General Report on Mental Health, and the 2001 Supplemental that examines culture, race and ethnicity in mental health, highlighting the inequality that exist for minority groups needing mental health services; and the New Freedom Commission on Mental Health report Achieving the Promise: Transforming Mental Health Care in America.

The Surgeon General Report Supplement to Mental Health extensively documents the "striking disparities" that exist for racial and ethnic minorities in mental health. They found that "racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they received care, it is more likely to be poor in quality".[1]

The New Freedom Commission on Mental Health came to the conclusion that minorities are unserved, underserved or inappropriately served in the current mental health care.[2]

Riverside County Reducing Disparities Taskforce

The goal of the Reducing Disparities Task Force (RDTF) was to provide feedback to ensure that county mental health efforts to reduce mental health disparities are integrated into the PEI plan. Reducing disparities in mental health access, service utilization and outcomes for cultural, ethnic, and linguistic populations is one of the priorities for the Prevention and Early Intervention Planning. The Mental Health Services Act throughout its various components specifically aims to increase cultural competence and improve services to address unmet needs for unserved, underserved, and inappropriately served communities.

The Reducing Disparities Task Force provided a unique opportunity for community leaders and experts to come together to explore the current disparity issues in the county mental health system, and to benefit from each others' expertise and wisdom in strategically addressing these mental health disparities.

Group Process

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[1] United States Public Health Service Office of the Surgeon General (2001). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service.

[2] New Freedom Commission on Mental Health (2003). Achieving the promise: Transforming Mental Health care in America. Rockville, MD: Department of Health and Human Services.

- Forming of a diverse task force with representation of community leaders, community based organizations, faith based organizations, partner public agencies, mental health staff, consumers and family members.
- Based on information presented by the RCDMH Research unit and with group discussion the taskforce recommended working on recommendations on how to reduce mental health disparities among the ethnic and cultural groups where the disparity gap is higher.
- Taskforce members adopted "unserved, underserved, and inappropriately served cultural populations" as its priority population, with the understanding that it forms an umbrella for including all other identified priorities.
- Task force members divided into subgroups to address each of the identified unserved, underserved, and inappropriately served ethnic and cultural populations.
- Each of the subgroups worked on coming up with recommendations on how to reduce disparities. Although the time was limited due to PEI planning process deadlines, each of the subgroups had an opportunity to meet, conduct focus groups, and conduct interviews with some key leaders in the community that voiced their concerns and recommendations.
- Taskforce membership reflects the diversity of the community of the community of Riverside County and included such community leaders, community based and faith based organizations, public agencies, consumers and family members, and members of the unserved, underserved, and inappropriately served ethnic and cultural populations.

Challenges and Opportunities

- Building community participation, engagement, and trust.
- Identification of community based and faith based organizations that are serving the unserved, underserved, and inappropriately served ethnic and cultural populations.
- Given the short time frame, this process was fruitful, but not exhaustive. Task members were able to involve the community due to their ongoing relationships they had established with the community. Although the community identified the need for more involvement.
- Created an ongoing process to look at disparities in mental health and provide recommendations on ethnic, cultural and linguistically appropriate strategies.

Proposed Recommendations for Reducing Mental Health Disparities

General Recommendations

I. Create the Reducing Mental Health Disparities Committee: This committee will be responsible for overseeing the Reduction of mental health Disparities in the County of Riverside Department of Mental Health.

    a. Members of the committee will be recognized as key partners and have active involvement and representation on all MHSA policy recommendations, program

reviews, and activities that address the needs of unserved, underserved, and inappropriately served racial, ethnic, cultural communities.

b. Members will be from racial, ethnic and cultural unserved, underserved, and inappropriately served groups representative of the community. An emphasis will be made to address regional and geographical differences among the ethnic and cultural groups, including the urban and rural communities.

c. Reach consensus on common priorities and present recommendations regarding implementation of strategies for reducing disparities.

d. Committee will have an active role in decision making.

e. Create a vehicle to provide recommendations for reducing disparities to the mental health department.

II. **Increase awareness of cultural and ethnic disparities in mental health by providing information reports and data analysis on efforts taking to reduce disparities.**

- Collecting ethnic and cultural data from external Sources
- Access to data that allow for measurement/analysis of disparities
- Using data to reduce mental health disparities by tailoring population specific interventions.
- Data results will be use to make funding priorities and program decisions

III. **Promote mental health and combat stigma**

- Allocate funding for community based and faith based organizations involvement.
- Develop mental health promotion of prevention and early intervention programs in the community, and with the community.
- Partner with community based organizations, faith based organizations, public agencies, and other non-mental health organizations to promote mental health.
- Utilize ethnic, cultural, and linguistic radio, television and newspaper media that serves Riverside County.

IV. **Educate, empower, and support consumers and family members**

- Provide education and training to Community Based organizations, faith based organizations, partner public agencies, advocacy agencies, and community at large on mental health prevention and early intervention.
- Funding and promoting sharing of resources with existing agencies in the community.
- Build community collaborative and partnerships.
- Change the name from mental health PEI to reflect wellness and empowerment.
- Continue inclusion of consumer and family members.

Ethnic and Cultural Specific Recommendations
Top Three Priorities [3]

V.   Native Americans

Recommendations include A Native American Wellness Alliance (NAWA) housed across Native American organizations that serve the entire Riverside Native American Indian population. Tribal consortiums and tribal agencies within Riverside County that could be part of this alliance include Riverside San Bernardino County Indian Health Inc. (RSBCIHI), Indian Child and Family Services (ICFS), Torres Martinez Tribal TANF, Sherman Indian School and University of California Riverside- Native American Student Program.   RSBCIHI and ICFS are tribal consortiums serving the entire Native American population. RSBCIHI has a behavioral health, substance abuse and health promotion department.   ICFS serves Native American children and families. They have a prevention program and foster and adoption program. Noli is a tribal middle and high school (approx. 145 students) and Sherman is a boarding high school (approx. 500 students). They have students from a variety of tribes. Torres Martinez TANF has offices in Thermal, Anza, Hemet and Los Angeles. The provide job training and supportive services for welfare families. UCR has a summer program for youth to attend college exposure/enrichment classes.

The top three areas the Native American Wellness Alliance would provide services include:

- Culturally tailored, evidence based parenting. Indian Child and Family Services has culturally tailored and evaluated an evidence based program within the Riverside County American Indian community. The SPIRIT Incredible Years Program is a 15 week in home parenting program for children ages 0-11 years old. ICFS is not fully funded to deliver this program to families needing prevention services. With the NAWA, ICFS could provide this program to TANF families and RSBCIHI clients. Both tribal organizations have requested these services. In addition, ICFS could motivate referred families to engage in clinic and TANF services that are recommended and would be beneficial. For example, RSBCIHI has stated they would like to use ICFS' in home SPIRIT parenting program. ICFS conducts an Indian Family Wellness Assessment (IFWA) as part of these services. A menu of options is generated for each family based on their unique needs.   RSBCIHI is interested in ICFS assessing families for interest in stress management services which the clinic could then provide. Additionally, the IFWA

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could be expanded to be a comprehensive motivational interviewing family assessment tool linked to referral sources for Native American families throughout the county.

- School drop out prevention program. This program would be two fold focusing on college exposure and culturally tailored substance abuse/gang reduction prevention education. Both Noli and Sherman have substance abuse prevention programs but limited finding. There is a need for funding cultural programs that educate and promote a substance free/gang free lifestyle. Noli has stated they could benefit from money for staffing, transporting kids, program supplies and materials, taking youth to conferences and food for youth events. In addition UCR has a summer program for Native American youth to live on campus for a week. Youth are exposed to college enrichment activities and a substance free lifestyle. The Native American Student Program Director stated funding to expand the length of time these students are on campus, up to a month, would beneficial.

- Traditional Healing blended with Mainstream education regarding stress reduction, substance abuse and mental health disorders. Establishing a network of traditional healing resources through the Tribal organizations is an important component of a prevention program for Native Americans. There is a lack of culturally appropriate service in the county for Native American clients. Funding NAWA could help to reduce this disparity. ICFS could hire cultural providers to conduct ceremonies, run sweat lodges and be involved in cultural activities. At weekly cultural meetings education could be provided about prevention of mental health disorders and stress reduction. RSBCIHI could provide services for stress reduction. The Behavioral Health Department at RSBCIHI has recently set up bio feedback machines to aid in reducing stress and is targeting this as an area they want to expand. NOLI and Sherman could provide these types of services to their students, using ICFS and RSBCIHI as a resource in addition to their own resources. Native American college students at UCR could be involved in providing prevention messages and mentorship for youth involved in these programs.

Native Americans have disproportionately high rates of child neglect, substance abuse and mental health programs. They also have high rates of school drop-out. Intervening early in parenting services, substance abuse prevention and school drop -out are top priorities for these youth. All the Tribal programs listed above are currently under-funded and the Tribal organizations/consortiums are overburdened and don't work together in ways to maximize service to the Native American Community. Establishing a Native American Wellness Alliance from within the community focusing on parenting, school drop out, which includes substance abuse and gang violence prevention and traditional healing, would be an innovative prevention program strengthening the Native American community in Riverside County. Costs for each priority are estimated to range from $100,000-$300,000 annually depending on the extent of services. (Note: This is a rough estimate).

Three focus groups and five interviews were conducted with the Behavioral Health Director of RSBCIHI, school counselor of NOLI Indian School and Executive Director of ICFS. The Board Chairman of RSBCIHI and ICFS and Torres Martinez TANF staff at the Anza site attended focus groups.

VI.   African American

African Americans live, work and play in a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health and leads to mistrust of Mental Health Systems. Annelle Primm, M.D states, deep-seated racism in the United States sets in motion a "vicious cycle" whose psychological and biological consequences have a crushing impact on health status. Depression and all its sequels are an inevitable and particularly devastating part of this cycle." In community focus groups, African American Community members echoed her sentiment in vivid language expressing their mistrust and suspicion of Department of Mental health and system given the history of mistreatment and inadequate care by government entities. Dr. Primm further shares in a speech to the Congressional Black Caucus, "When we have a mental illness like depression, we are very likely not aware that we are ill, we tend to stay away from psychiatrists and mental health professionals because of the stigma, we may stay away from physicians... because we are uninsured, but even if we happen to get in the door of some health provider, we are less likely to be diagnosed at all, we receive inferior or inadequate treatment, or, worse, our symptoms are misunderstood, and we are diagnosed with schizophrenia." Disparities exist in both access to and quality of mental health care for African Americans Examples of these disparities include: the underutilization of psychiatric services by persons from African Americans, problems in treatment engagement and retention of persons, the over diagnosis of schizophrenia among African Americans, the inappropriate use of antipsychotic medications among African Americans (and the use of these medications at higher dosages among African Americans), According to the 2001 Surgeon General's report on mental health, "the prevalence of mental disorders was believed to be higher among African Americans than among Whites, and African Americans were more likely than Whites to use the emergency room for mental health problems. African Americans with depression were less likely to receive treatment than Whites (16 percent compared to 24 percent). Only 26 percent of African Americans with diagnosed generalized anxiety disorder received treatment for their disorder, compared with 39 percent of Whites with a similar diagnosis... For certain disorders (e.g., schizophrenia and mood disorders), errors in diagnosis are made more often for African Americans than for whites. " Increasing evidence suggests that, in clinical settings, African Americans are less likely than whites to receive evidence-based care in accordance with professional treatment guidelines.

- Development of Community Based Youth & Family Optimal Wellness programs directed by and delivered by African American community based providers in a community setting. The Youth & Family Optimal Wellness after school program will promote resilience in African American children and youth The program will be delivered in a culturally appropriate method and connect children/youth to positive role models and mentors. Based on the Self Enhancement Inc. (Oregon community based program), the Youth & Family Optimal Wellness resilience development program focuses on the strengths of the African-American community and deals directly with the deleterious effects of racism. African-American children, vulnerable victims of racism, are at significantly increased risk of Incarceration, School failure, Victimization by violent crime, Teen pregnancy, Reliance on social programs, Poverty.

  The Youth & Family Optimal Wellness PEI Project consists of a 12-week daily, intensive community-based program, followed by on-going weekly interventions, and tracking until adulthood. It is designed in two phases. The first phase is an intensive 12-week multimodal after-school program. The   second phase involves weekly follow up, community and family

engagement and leadership promotion. Students, ages 5 through 11, will work with   health care educators, tutors and African-American professionals Monday through Friday. Through age appropriate African-American History education,   bibliotherapy and story telling activities, exercise and health education, conflict resolution skills training and academic tutoring, the participants will   gain academic competence, a sense of African-American identity, and the confidence that they can address life's challenges successfully within the   African-American   community   and develop allies outside the community.

* Long term investment in African American community partnership with DMH & MSHA through development of a culturally competent African American Outreach component, including but not limited to a funded African American Outreach Coordinator, through the development and implementation of a culturally competent community based education and awareness initiative.

* Faith based outreach and education component such as PEWS Project

PEWS (Programs for Emotional Wellness and Spirituality) was established in 2005, PEWS educates African American.clergy, lay staff and church communities to better recognize mental illness and how to link parishioners to mental health services when needed. PEWS also works to address the   negative attitudes surrounding mental illness in the African American community. Although the Black Church taught religious doctrine and scriptures, it   also taught Blacks how to contend with difficulties and adjust to life in a society that did not value or honor them or their heritage. The Black Church was   a haven from societal injustices and a place where African Americans acquired skills, knowledge, and values through the church's educational programs.   The belief and faith that one can rise above personal struggles, adversity, racism, and poverty is a familiar refrain that echoes throughout the African   American church today. These beliefs have been inculcated through a variety of educational programming in the church. Two studies in 1994 and 1995 correlated religious involvement in the African American community with health status and reduced depression. PEWS (Programs for Emotional   Wellness and Spirituality) have produced two short award-winning educational videos, Anything But Crazy: African Americans, Emotional Wellness and   Spirituality, and Getting to the Other Side: African Americans and Co-Occurring Disorders. The program's most recent initiative is assisting historically   black churches to develop mental health ministries to promote emotional wellness and help identify and assist those in need of mental health services. PEWS   has   been   the recipient of Mental Health America's Betty Humphrey Cultural Competency Award, and has been featured on National Public Radio   as well as in Positive Community Magazine, The (Newark) Star Ledger, Mental Health Monthly, and the recently published book Black Pain, among other   publications.

VII.   Latino/ Hispanic

* Develop and fund a Promotores de Salud (Health Promoters) program. The community member and leader involved in the PDS program engage in extensive outreach and prevention and early intervention community activities and community institutions' programs (Health Fairs, Community Fiestas, Academic, Legal, Social and Faith-Based programs). PDS services would help in the elimination of stigma by breaking the silence about mental health issues among the underserved/unserved Latino/Hispanic population throughout the Riverside County.

- Develop and fund "Accessibility to MH Services Program." - Latino/Hispanic communities are among the most underserved/unserved populations in the Riverside County. Accessibility to MH services is critical but often not a reality to this community due to lack of transportation services, literature translated into their language or due to immigration concerns. This program could create a system where these concrete needs are appropriately met so that MH services are within reach for those in need (e.g. One-Stop MH Mobile Out-reach Unit, purchase transportation vans, provide gas-vouchers, etc.).

- Increase funding to support and integrate Mental Health activities with local cultural community activities. Latinos/Hispanics are known to be family-oriented and highly involved in the local cultural, family-oriented activities or Fiestas, There needs to be additional funds allocated to support these events and to provide stipends for consumers and family members actively involved in the development and implementation of these events.

VIII. Asian American

- Develop resources in different languages that are simple and understandable.

- Greater outreach to the Asian community at community centers, faith/spiritual groups, cultural festival and fairs, adult schools, etc.

- Integrate Mental Health into useful and relevant topics such as stress management, stress relief, well-being, wellness, etc. and not such much on MH services. Help to build "better" family relationships.

IX. Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ)

- Implementation of a Targeted prevention and early intervention program directed to Lesbian, gay, bisexual, transgender and questioning (LGBTQ) children, youth and their families in a community based setting. The Rainbow Youth Leadership and Resiliency PEI Project addresses the isolation and invisibility of sexual minority youth. Many LGBTQI youth experience a hostile and unhealthy climate in schools and communities that is marked by violence, bullying, neglect and invisibility. Many are severely isolated and are at disproportionate risk for a range of problems including: suicide, violence, dropping out of school, substance abuse, HIV/AIDS and other STDs, incarceration, teen pregnancy, reliance on social programs, lack of medical insurance, unemployment or underemployment, poverty, and rejection from family and friends. (Special focus on High School Gay Straight Student Alliances, Rainbow Pride Youth Alliance, Bienestar Human Services Youth programs, Brothers United youth adult outreach, and Gay Associated Youth). (See attachment for more details)

- Implementation of a culturally competent Peer Based Community Mental Health Outreach Worker program designed to provided a targeted outreach and engagement

campaign in the LGBTQI community in natural community settings (Pride Organizations, Open and Affirming Congregations, Health Fairs, HIV/AIDS programs, Depression screening, support groups, and targeted treatment slots). A special focus will place on LGBT seniors (Rainbow Senior Center, Transgender Community (Trans-Soul) and Young Men of Color (Brothers United). Numerous studies have shown that LGBT individuals are exposed to higher levels of daily stress because of stigmatization, isolation from family and society, and discrimination. High levels of stress, in addition to contributing to physical illness, also may precipitate the development of certain types of mental illnesses. There is evidence of higher rates of depression, anxiety, and suicide in LGBT individuals. With the lack of social support, it is not surprising that LGBT individuals have higher rates of mental health care utilization than heterosexuals.

- Develop specific support to LGBT people through LGBT Organizations. Provide direct funding to support a community collaboration between the County Department of Mental Health, the Jeffrey Owen Center, Desert Pride Center, Rainbow Senior Center, Gay Associated Youth, Rainbow Pride Youth Alliance, P-Flag, Transgender-Soul, and the open and affirming faith community (UFCSJC, FCC, UU) to support a targeted Anti-Stigma Campaign directed at addressing the dual stigma of mental illness within the LGBTI community.

X. Deaf and Hard of Hearing

- Education: Educate the Deaf (including any related consumers and family members) about MH, respect about deaf community, elimination of stigma about deaf and MH, signs of mental illness. Education about abuse, emotional, various parts of abuse. Education about risk factors that might lead to anger. Educate community about how particular behavior patterns lead to MH problems (anger, DV, substance abuse).

- Forums to educate Deaf community about MH programs. Greater outreach into the Deaf community (and related family members) to gain participation, i.e., establishing a Task Force.

- Accommodation: Deaf and HH communication accommodation to provide effective communication. (Use the appropriate wording to be more inclusive of all communities.) Example, video phones, Telecommunications Device for the Deaf (TDD), Teletype machines (TTYs), effective communication (making sure to provide not just interpreting services but also Real Time Captioning (RTC), etc.

XI. Homeless

There are 4508 homeless adults and children on a given day in Riverside County, of which 30% have been diagnosed with mental illness, 47% have a substance abuse problem, and 25% have been a victim

of assault while living on the street. Mental health issues among the homeless become even more complex due to a myriad of barriers. Not only are there language, cultural, housing, and transportation issues, but there is a factor of competing needs. Homeless individuals and families are faced with immediate needs of where they will sleep, what will they eat, where will they shower and mental health needs are more often than not, seen as less of an immediate priority. In addition it is challenging to provide any type of follow up care/treatment due to the transient nature of this population.

The Homeless Work Group of the Reducing Disparities Taskforce met and discussed the needs, methods, and services that are needed to make any progress in providing mental health care to the homeless. What became clear was that there is no mechanism in place for the prevention of mental health issues. There are services in place for severe cases but we have failed to assist individuals and families in prevention and support areas. The Work Group discussed different ways to engage homeless communities to develop effective strategies to reduce the mental health disparities among this population.

Conversations were also held with homeless service providers in which they stated that the stigma related to receiving treatment in a mental health facility is still a barrier to overcome. They also confirmed that transportation is an issue to access services and that many are turned away for services because their case is not severe enough. They also added that wait time to be seen, lack of insurance and the transferring of cases from county to county create additional barriers.

The top three recommendations were:

- Increase homeless outreach teams that include using peer support approaches with an emphasis on prevention and intervention strategies.

- Take the time to build relationships with community homeless serving organizations and identify central providers – where a variety of health and human services can be provided in a "one stop" center and all individuals would be assessed and case managed. This would in turn lessen the barriers of transportation, stigma, and follow up treatment, wait time, medication compliance, and where preventive approaches could be included.

- Identify different specialized homeless populations and develop specific strategies to work with these populations. **Example:** Veterans, parolees, substance abuse, immigrants, etc.

ATTACHMENT #31

ATTACHMENT #31

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY/REDUCING DISPARITIESCOMMITTEE MEETING

May 12, 2010

PRESENT: Moises Ponce, Myriam Aragon, Dr. Renda Dionne, Ben Jauregui, Anthony Richmond, Alfredo Huerta, Alison Emery, Yolanda Fullinwider, Jennifer Vaughn-Blakeley, Lydiak Wanjau, Melissa Dovalina, Janssen Diaz, Gloria Moriarty. **Guests:** Deborah Johnson, MH Services Manager, Ben Wilson, CTS

AGENDA ITEM	DISCUSSION	ACTION
I. WELCOMING & INTRODUCTIONS	Meeting was called order at 9:10AM Myriam Aragon opened the meeting by welcoming and thanking everyone for attending. Moises Ponce, Co-Chair, asked that everyone introduce themselves.	
II.REVIEW OF MINUTES	Minutes for the meeting in April 14, 2010 were reviewed and approved with one member abstaining.	Approved minutes to be e-mailed to members.
III. CULTURAL COMPETENCE PLAN REQUIREMENTS	Myriam gave a power point presentation and gave updates on the Plan Requirements. She explained the process and timelines	No Action needed
IV. CULTURAL COMPETENCY ORGANIZATION & COMMUNITY ASSESSMENT UPDATE	State of the Cultural Competence Requirements in each of the Criterions were discussed: Criterion 1 – Areas of Improvement: Rise awareness of Cultural Competency: expenses, number of hours of bi-lingual services, Policy needs to be updated, Community partnership. Contract agencies need to adhere to the same guidelines of cultural competence. Criterion 2 – Update assessment of services needed. Areas of Improvement: develop better report systems. Information on disparities. Cultural ethnic specific information: 71% of population is not receiving services. Keep a contact log on every person we get in contact with. There are many that are being helped, but also have many that are being turned away. We need to keep phone numbers and services provided or denied and were the were referred to. Criterion 3 – Implementing MHSA Programs targeting unserved and underserved population. Areas of Improvement: Reports from services rendered, cultural appropriate, consumer satisfaction; monitoring outcomes/starategies used and meeting goal on reducing disparities. Criterion 4 – Inclusion – client/family and community representatives in different commitees Criterion 5 – Improvements: Interpretation training, introduction to cultural competency in new employee training, number of hours and to make these trainings CEU's available.	No Action needed

	Criterion 6 – Retaining Multicultural Workforce: Improvements: to measure workforce composition. Contract units to report and include contract information. Language capacity – 31% current staff is bi-lingual. 24/7 phone lines and TDD equipment. Criterion 7 – Improvement: 50% of staff is bilingual, information in writing concerning bi-lingual services to provide documentation. Criterion 8 – Services: Question asked: How are we improving on the deaf services? Struggle with phone services, like TDD. Included in new technology – lap top. Suggestions on improvements are on going trainings; develop training system on sensitivity, request representation. –	
V. CULTURAL COMPETENCY REDUCING DISPARITIES IN-SERVICE TRAINING	Ben Jauregui, Disability Program Manager at IEHP presented on the "10 Commandments of Communicating with People with Disabilities"	No action needs to be taken.
VI. CULTURAL COMPETENCY IN "MAY IS MENTAL HEALTH MONTH" CELEBRATION	May is Mental Health Month – Flyer for this Event was distributed to the committee members. Moises reported on the status of planning of the event scheduled for Tuesday, May 18th, from 3PM – 6PM. He stated that there will be a medical group to take blood pressure and blood sugar tests, a bicycle repair group and LGBT is scheduled to do a short theater presentation. There will be a table set up outside to distribute materials as well as give aways.	No Action needs to be taken.
VII. ANNOUNCEMENTS	1. African-American Self Help Group, Thurs. May 13th, at 4060-A County Circle, Modular Conference Rm. 2. Pow Wow at Morongo Cultural Board, Sat. May 15 3. May is Mental Health Month Event, May 18th 3PM-6PM, Bordwell Park. 4. Inland Empire Disabilities Collaborative Mtg. & Training May 18, 2010 from 9:30AM-11:30AM. 5. Deborah Johnson requested representation from CCC/Reducing Disparities for the Reducing Stigma Project. Alison Emery volunteered to represent the Committee.	Myriam and Moises will participate and bring back information.
VIII. ADJOURNMENT	Meeting was adjourned at 11:05AM **The next meeting is June 9, 2010, in MH Conference Rm. A/B at 9AM-11AM. If you have any special accommodations, please let us know by June 3, 2010.**	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY/REDUCING DISPARITIES COMMITTEE MEETING

April 14, 2010

PRESENT: Moises Ponce, Dr. Renda Dionne, Ben Jauregui, Susanna Luu, Anthony Richmond, Veronica Hilton, Claudia Espinoza, Leticia Troncoso, , Carmelo Isales, Alfredo Huerta, Yolanda Fullinwider, Consuelo Durazo, Anna Rodriguez.   **On Conference Call:** Benita Ramsey
New Members: Melissa Dovalina, Janssen Diaz, Gloria Moriarty

AGENDA ITEM	DISCUSSION	ACTION
I. WELCOMING & INTRODUCTIONS	Meeting was called order at 9:10AM Moises Ponce, co-chairman opened the meeting by welcoming and thanking everyone for attending the meeting and asked that everyone introduce themselves.	
II REVIEW OF MINUTES	Minutes for the meeting in March 10, 2010 were reviewed and approved with on member abstaining.	Approved minutes to be e-mailed to members.
III. CULTURAL COMPETENCE PLAN REQUIREMENTS	Moises asked that one person from each of the groups give a summary of their criterion they have been working on. Members presented their comments regarding cultural competency plan criterions from the State and discussed: a. Representation of more community partners in the committee b. Interpretation services for other community members during the committee meetings. c. Work with other agencies that are involved in reducing disparities, or other same issues that Mental Health Department is working in the community. d. Continue in developing relationships in the communities. e. Deaf & hard of Hearing Community, look in to communication systems that are available at the clinics. f. Service providers training could include community participation as well as other county departments.	
IV. LOGIC MODEL PRESENTATION UPDATE	Due to time limit, the logic model was not discussed.	Tabled for discussion at next meeting.
V. CULTURAL COMPETENCY PROGAM FLOW CHART	Presentation Update – Cultural Competency Program Flow Chart Presentation: Budget Update Donna Dahl, Assistant Director-Programs presented on the Mental Health Budget overview.	No action needed to be taken.

VI. CULTURAL COMPETENCY IN "MAY IS MENTAL HEALTH MONTH" CELEBRATION	**May is Mental Health Month** – Flyer for this Event was distributed to the committee members. Moises reported on the status of planning of the event scheduled for Tuesday, May 18th, from 3PM – 6PM. He reported that he had attended the May is Mental Health Month committee, and had been approved to have other activities and the Recreation Room was reserved for our use. Following are some of the activities that will be taking place in the recreation room. 1. Allow for outside agencies, example: Medical group to take people's blood pressure and blood sugar test. 2. Non-Profit Organization to provide minor bicycle repair. 3. Short Theater presentation by LGBT group. There will be a table set up outside to distribute materials as well as give always.	Anna to send registration form. Information on the Registration form would be forwarded to everyone and distribute to organizations.
VII. ANNOUNCEMENTS	1. May is Mental Health Month Event, May 18th 3PM-6PM, Bordwell Park. 2. Inland Empire Disabilities Collaborative Mtg. & Training May 18, 2010 from 9:30AM-11:30AM.	Myriam and Moises will participate and bring back information.
VIII. ADJOURNMENT	Meeting was adjourned at 11:05AM **The next meeting is May 12, 2010, in MH Conference Rm. A/B at 9AM-11AM** **If you have any special accommodations, please let us know by April 6, 2010.**	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY/REDUCING DISPARITIESCOMMITTEE MEETING
March 10, 2010

PRESENT: Moises Ponce, Ninfa Delgado, Dr. Renda Dionne, Mike Madrigal, Ben Jauregui, Susanna Luu, Anthony Richmond, Brandon Lee, Veronica Hilton, Manuel Aguilar, Claudia Espinoza, Anna Rodriguez. **GUESTS:** Tracy Halmagean, Phil Carmona and Luke Madrigal.

AGENDA ITEM	DISCUSSION	ACTION
I. WELCOMING & INTRODUCTIONS	Meeting was called order at 9:10AM Ninfa Delgado, co-chairman opened the meeting by welcoming and thanking everyone for attending the meeting and asked that everyone present introduce themselves.	
II. REVIEW OF MINUTES	Minutes for the meeting in February 10, 2010 were reviewed and approved, with the correction on spelling of one of the committee member's last name.	
III. CULTURAL COMPETENCE PLAN REQUIREMENTS	Moises spoke on the Cultural Competence Plan Requirements criterion that the group was to review and discuss at today's meeting. Since not all of the members were present, it was voted on and agreed by the committee to wait until next month's meeting to discuss the criterion. A suggestion for anyone that was not able to attend the meeting, to e-mail his or her recommendations to their team member.	Review of Criterion as Follows: Criterion 1: William Harris and Veronica Hilton Criterion 2: Consuelo Durazo and Michael Madrigal Criterion 3: Ben Jauregui and Elvis Zornoza Criterion 4: Anthony Richmond and Alfredo Huerta Criterion 5: Brandon Lee and Dr. Renda Dionne Criterion 6: Alison Emery and Susanna Luu Criterion 7: Benita Ramsey and Javier Rosales Criterion 8: Myriam Aragon and Ninfa Delgado
IV. LOGIC MODEL PRESENTATION UPDATE	Moises stated that the logic model presentation tentative dates are still April 28th and 29th. Moises mentioned that committee would work with the CORE group in the logic model process. The information on the Technical Assistant Meeting in San Bernardino, on March 18th was given. Members to contact Committee's secretary, Anna Rodriguez if they wish to attend.	Myriam will follow up

V. CULTURAL COMPETENCY PROGAM FLOW CHART	Presentation Update – Next on the Cultural Competency Flow Chart to present: Native Americans Dr. Renda Dionne presented on the Mental Health Issues and Stigma with children as well as parents in the tribes.	
VI. CULTURAL COMPETENCY CELEBRATION	**May is Mental Health Month** – Moises reported on the status of planning of the event that is scheduled for Tuesday, May 18th, from 3PM – 6PM. He also asked the group in their participation and asked if anyone had any ideas as to what they should have in the event. The following are some suggestions given by Committee members: 1. Have a speaker who can speak on the all cultures combined. 2. Allow for outside agencies, example: Medical group to take people's B/P, blood sugar test. 3. Have something different other than hot dogs and/or hamburgers, i.e. cultural and healthy foods served at the event. 4. Have healthy recipes available at the tables for people to take. 5. Bring vendors who are willing to participate and bring their information to give out to the community. 6. Have Animal Center to give community's pets shots. 7. The language on the Flyer to be distributed should be in a cultural competence recovery language. 8. Distribute Flyer at the Eastside Easter Hunt that will be held at Bobby Bonds Park. 9. Commitment from committee member to bring some one to do bike repairs.	Moises to take group's suggestions and ideas to the May Is Mental Health Month Committee.
VII. ANNOUNCEMENTS	1. Annual Eastside Community Fair Egg Hunt, Saturday, March 27th from 10 to 2PM. There will be 24 vendors, entertainment, health screening and more. 2. Religious Understanding Day at Mount San Jacinto College, Saturday 20th, located at 1499 N. State St., in San Jacinto. 3. Inland Empire Coalition Against Hate at Cal. Baptist University on March 11th, 6PM-8PM. 4. CODIE – Deaf & Hard of Hearing Training for about 1 hr to ½ hr. Date needs to be decided for MH to participate. 5. Fair Housing Rights & Responsibilities: An Overview of Federal and State Fair Housing Laws will be held on March 18th. 6. Conference for Couples on April 24th at 3845 Indiana Ave., Riverside	
VIII. ADJOURNMENT	Meeting was adjourned at 11:05AM **The next meeting is April 14, 2010, in MH Conference Rm. A/B at 9AM-11AM** **If you have any special accommodations, please let us know by April 6, 2010.**	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY/REDUCING DISPARITIES COMMITTEE MEETING
February 10, 2010

PRESENT:, Alfredo Huerta, Moises Ponce, Dr. Renda Dionne, Mike Madrigal, Alison Emery, Ben Jauregui, Susanna Luu, Benita Ramsey, Anthony Richmond, Javier Rosales, Brandon Lee, Veronica Hilton, Elvis Sornoza, Consuelo Durazo, Manuel Aguilar, William Harris, Bill Brennaman, Sharon Lee.

AGENDA ITEM	DISCUSSION	ACTION
I. WELCOMING & INTRODUCTIONS	Meeting was called order at 9:10AM Moises Ponce, co-chairman opened the meeting by welcoming and thanking everyone for attending the meeting. Moises asked that everyone present introduce themselves.	
II. REVIEW OF MINUTES	Minutes for the meeting in January 13, 2010 were reviewed and approved, with the correction on date for February meeting be made from Feb. 9 to Feb 10.	
III. MHSA UPDATE – BILL BRENNEMAN	Bill Brenneman, the MHSA Manager came to provide an update on MHSA funding Plan. Bill stated that they are required to do a Plan Update each year to request funding for the upcoming fiscal year and proceeded to speak on the mechanism used to request funds for all of the MHSA components. Plan will be posted on website.	None
IV. CULTURAL COMPETENCE PLAN REQUIREMENTS	The Cultural Competence Plan Requirements Were presented. – a. Group agreed to review Requirements and comment at next meeting Committee Planning Process Participation – Each group will read over the criterion assigned and bring with them any ideas on how these requirements will be achieved.	Review of Criterion as Follows: Criterion 1: William Harris and Veronica Hilton Criterion 2: Consuelo Durazo and Michael Madrigal Criterion 3: Ben Jauregui and Elvis Zornoza Criterion 4: Anthony Richmond and Alfredo Huerta Criterion 5: Brandon Lee and Dr. Renda Dionne Criterion 6: Alison Emery and Susanna Luu Criterion 7: Benita Ramsey and Javier Rosales Criterion 8: Myriam Aragon and Ninfa Delgado

V. LOGIC MODEL PRESENTATION UPDATE	Moises updated everyone on the logic model presentation. The tentative dates are April 28th or April 29th and it will be a 3-hour presentation.	Myriam will follow up
VI. CULTURAL COMPETENCY PROGAM FLOW CHART	A flow chart of the cultural competency program was distributed and discussed. Moises stated that there will be a presentation at every meeting by each of the programs listed on the flow chart.	Myriam will coordinate presentation for March or April.
VII. CULTURAL COMPETENCY TRAINING CELEBRATIONS	One idea was to have group participate in the May Is Mental Health Month event where speakers could be invited to speak on various topics. The committee should participate in the event by having a cultural table with information and the different groups represented, i.e. deaf & hard of hearing, Native American. The group discussed how to continue with Cultural Competency celebration. Group agreed to participate in the May is Mental Health event to bring awareness of the Cultural diversity. Moises and Myriam will speak to Jane McCoy who heads the Committee who prepares for this special yearly event.	Moises & Myriam will coordinate participation of May Is Mental Health Event with Jane McCoy.
VIII. LGBTQ TASKFORCE PRESENTATION	Resource Guide distributed at meeting.	
IX. ANNOUNCEMENTS	1. The (CBMS) California Brief Multicultural Training is scheduled for March 2,3,10 & 18, 2010. All Committee members are welcome to attend training. 2. The LGBT Resource Guide was presented to the Committee and distributed. 3. The 2010 California Mental Health Policy Forum is scheduled Feb. 11-12 and two members of the committee will be attending: Javier Rosales and Benita Ramsey. 4. Flyer on "Call to Care" A Caregiver Resource Day, provided by Catholic Charities will be held Wednesday, February 24, 2010 at the University of Phoenix. 5. Michael Madrigal announced a Community Forum on Hate and Violence scheduled for March 6, 2010. A flyer to this event was distributed to committee. 6. Alison Emery announced a workshop on "The Evolution of the Consumer Movement" presented by Jay Mahler, founding member of the CIMH Spirituality Initiative, that is scheduled Thursday, February 25, 2010.	
X. ADJOURNMENT	Meeting was adjourned at 11:00AM. **The next meeting is March 10, 2010, in MH Conference Rm. A/B at 9AM-11AM**	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY/REDUCING DISPARITIESCOMMITTEE MEETING

January 13, 2010

PRESENT: Myriam Aragon, Alfredo Huerta, Moises Ponce, Dr. Renda Dionne, Jennifer Vaughn-Blakely, Ninfa Delgado, Mike Madrigal, Alison Emery, Carmelo Isales,Ben Jauregui, Susanna Luu, Benita Ramsey, Anthony Richmond.

AGENDA ITEM	DISCUSSION	ACTION
I. WELCOMING & INTRODUCTIONS	Meeting was called order at 9:10AM Myriam opened the meeting by welcoming and thanking everyone for attending the meeting.	
II. REVIEW OF MINUTES	Minutes for the meeting in October 14, 2009 were reviewed and approved.	
III. SELECTION OF 2010 COMMITTEE OFFICERS/CO-CHAIRS	Committee members were asked to vote for a member of the committee, one for Internal and the second one for External. The final results were: Moises Ponce, Internal Representative. Co-Chair Ninfa Delgado, External Representative. Co-Chair	Approved
IV. REPORT OF MEMBERSHIP ISSUES	Membership: Subcommittees presented their recommendations and group accepted them: 1. Allowing time to build the committee. 2. Check with the committee to see if we need to move the meeting to a late afternoon 3PM-5PM or evening time to facilitate the community representatives' participation. 3. Have a 5 minute summary of the previous meeting at the beginning of each meeting. 4. Send the meeting's draft minutes a week prior to the next meeting. 5. Membership roster with attendance to be distributed at each meeting. 6. Do recruitment of members for the 10 categories of representation, when there is no representation (per document developed on August 27, 2009) 7. Arrangement of phone conference availability for the meetings. 8. Forming regional task force to facilitate participation of the Desert Region (to have further discussion regarding the logistics).	
V. UPDATE ON PEI IMPLEMENTATION	Volunteers were selected for team evaluations of RFP's: Anthony Richmond, Alfredo Huerta, Carmelo Isales, Ben Jaurequi, Ninfa Delgado & Moises Ponce.	Myriam to send Janine Moore, PEI Coordinator, Names of Volunteers
VI. UPDATE ON MULTICULTURAL ORGANIZATION & COMMUNITY ASSESSMENT	Summary of project was presented. Training on Model Logic was discussed. Group recommendation was to open the trainings to community based organizations, other than the Committee members. Ninfa Delgado volunteered her location for the trainings and will supply refreshments.	Myriam will coordinate presentation for March or April.

VII. UPDATE ON MULTICULTURAL COMPENTENCE PLAN	The Department has not received a letter regarding the Cultural Competency requirements. Waiting on State to say if Plan needs to be submitted. Potential date for submission of Plan to the State is June 14, 2010. This Committee will be very involved in implementing the Plan.	Myriam will continue updates on Plan requirements.
VIII. ANNOUNCEMENTS	1. The (CBMS) California Brief Multicultural Training is scheduled for March 2,3,10 & 18, 2010. All Committee members are welcome to attend training. 2. The LGBT Resource Guide was presented to the Committee.	Copy of LGBT Resource Guide to be distributed at next meeting Feb. 10th
IX. ADJOURNMENT	Meeting was adjourned at 11:00AM **The next meeting is February 9, 2010, in MHI Conference Rm. A/B at 9AM-11AM**	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY COMMITTEE MEETING

January 8, 2009

MEMBERS PRESENT:
Brandon Lee, Chair, Administration
Myriam Aragon, Manager, Cultural Competency
Keith Boone, Substance Abuse
Joaquin Galeano, MH Mid County
Claudia Espinoza, Family Advocate
Theresa Gálvez, Patients' Rights
Alfredo Huerta, Indio MH
Leticia Troncoso, UTF
Moises Ponce, MH-Perris
Consuelo Durazo, Parent Partner
Carla Madueña, Indio MH
Yolanda Fullinwider, TRAC
Joshua Guess, Friday Night Live

MEMBERS Present:
William Harris, Substance Abuse
Anna Rodriguez, Secretary Cultural Competency

NEW MEMBERS:
Carmelo Isales, MHSS A, Western Adults
Don Kirtland, Blaine Street Clinic

MEMBERS ABSENT:
William Gonzalez, Public Guardian
David Camplin, Vice Chair, CalWORKS
Luz Negron, Parent Support

MEMBERS ABSENT, CONT.:
Carlos Vargas, MH-Blaine Clinic
Azonda Moxley, Substance Abuse
Luis Becerra, MTFC
Kei Tiggs, Older Adults
Cindy Claflin, Parent Support
Ethel Nwandu, IMD/LTC
O'Connor, Cheryl, QI Outpatient

ITEM	DISCUSSION	ACTION
I. CALL TO ORDER/ INTRODUCTIONS	Brandon Lee, Chair of the Cultural Competency Committee called the meeting to order at 10:05 a.m. Self-introductions were made by members present.	
II. REVIEW AND APPROVE MINUTES	The Minutes for the meetings of November 13, 2008 were reviewed by the Committee and approved. Some members suggested that the acronyms and/or titles be written out in the minutes so that they would know what they stood from when added next to the person's name.	

ITEM	DISCUSSION	ACTION
III. REPORTS FROM SUBCOMMITTEE MEMBERS	1) LGBTQ Task Force – Members of the Cultural Competency Committee who volunteered to participate discussed some of the activities that had gone on, which included a focus group done in Indio. It was stated that Benita Ramsey had come up with some recommendations and had discussed priorities. Joaquin Galeano, Carla Madueña, Luis Becerra and William Harris represent the Cultural Competency Committee at the LGBTQ Task Force. The list of the Sub-Committees was requested by committee members. Myriam stated she is working on a list of various sub-committees. 2) Spirituality and Mental Health – The first invitation letter to all managers and staff announcing the first meeting scheduled for February 10th was sent out Three members of the Cultural Competency Committee will be represented at the Spirituality and Mental Health and they are Alfredo Huerta, Cindy Claflin and Moises Ponce. 3) Translation – The protocol of doing translations and the importance in keeping track of how many documents are translated was explained. Myriam stated that the limit for completing translations is one (1) month. A presentation of a report on number of translations was recommended. Translation department wide policies were also discussed as well as linguistic services, patient forms and other issues. 4) Deaf & Hard of Hearing – Two members of the Cultural Competency Committee will be assisting to identify strategies for in forming an outreach and engagement committee for the Hard of Hearing. 5) Homeless – A Homeless Event was done on December 21, 2008. The goal of this event was to help the homeless in the Riverside area by giving canned goods and other items that they could use through out the three (3) regions. Thank you to all the Cultural Competency Committee members who assisted in making this event possible.	Myriam will provide the list next meeting.
IV. NEW YEAR'S RESOLUTIONS	Committee Members made their New Year's resolution for 2009.	
V. ELECTION/RE-ELECTION OF CHAIR AND VICE CHAIR	Members took turns in nominating members for Chairman and Vice-Chairman of the Cultural Competency Committee for year 2009. After much deliberation and voting, Brandon Lee was voted on to remain as Chairman and Moises Ponce was elected as the new Vice Chairman.	

ITEM	DISCUSSION	ACTION
VI. ROLES & RESPONSIBILITES	The new version of the Roles & Responsibilities for the Cultural Competency will be forwarded to members via e-mail.	Anna Rodriguez will forward through E-mail.
VII. NEWS LETTER SCHEDULE & TOPICS	Schedule and topics for monthly news letter was discussed. The following dates are the final dates that the News Letter is due: February 10th, April 14th, June 9th, August 11th, October 13th, and December 8th. It was stated that members are to decide topics for each month and who will write the article (s). It was stated that space for the article in the News Letter is limited to a number of words. An article on Black History Month will be done for the February 10th article by Carmelo Isales and Yolanda Fullinwider will do an article regarding women in the military for the April 10th News Letter.	Carmelo Isales Yolanda Fullinwider to work on draft.
VIII. CALENDAR OF EVENTS	Calendar of Events was discussed and it was decided that five (5) members of the committee would work and plan for February's Black History Month and events will be done at all three (3) Regions.	Claudia to Coordinate
IX. TRAINING TOPICS FOR CCC	Myriam passed out a list of training topics. Members came up with some suggestions for training which included Homeless that involved Women & Children and spirituality. Myriam also suggested having training session with the Committee on different topics during the year. Members to e-mail Myriam with topic ideas that could be discussed at each month's committee meetings.	All Committee Members to send topic ideas.
X. CCC PLAN FOR 2009	Myriam passed the "Draft" of the Revised Cultural Competency Plan for 2008 and asked that members read and give her feedback on what they want to do in order to complete the document.	Myriam to e-mail draft to Committee Members
XI. ANNOUNCEMENTS	Alfredo stated about a Mariachi Festival being held. Community Calendar of Events will be sent out to members.	
XII. ADJOURNMENT	Meeting was adjourned at 12:05 pm.	
XIII. NEXT MEETING DATE	The meeting in February was cancelled due to Lincoln's Birthday Holiday on February 12th. The next meeting will be held on Thursday, March 12th at 10AM at MH Administration Conference Room A/B	

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RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY COMMITTEE MEETING

March 12, 2009

MEMBERS PRESENT:
Brandon Lee, Chair, Administration
Myriam Aragon, Manager, Cultural Competency
Keith Boone, Substance Abuse
Claudia Espinoza, Family Advocate
Alfredo Huerta, Indio MH
Leticia Troncoso, ITF
Moises Ponce, MH-Perris
Yolanda Fullinwider, TRAC
Luz Negron, Parent Support
Ramona Casares, MH Mid County (for Joaquin Galeano)
Alison Emery, Director of Consumer Affairs
Kei Tiggs, Older Adults

MEMBERS Present:
Luis Becerra, MTFC
Don Kirtland, Blaine Street Clinic
O'Connor, Cheryl, QI Outpatient
Deysi Chavez, MV CHIPS
Anna Rodriguez, Secretary Cultural Competency

GUESTS:
Joe Sabastian, Long Term Care
Silvia Silva, Administration

MEMBERS ABSENT:
William Gonzalez, Public Guardian
David Camplin, Vice Chair, CalWORKS
Joaquin Galeano, MH Mid County
Consuelo Durazo, Parent Partner

MEMBERS ABSENT, CONT.:
Carlos Vargas, MH-Blaine Clinic
Azonda Moxley, Substance Abuse
Cindy Claffin, Parent Support
Ethel Nwandu, IMD/LTC (excused)
Sandra Rabon, Parent Partner
Carmelo Isales, MHSS A, Western Adults
Joshua Guess, Friday Night Live
William Harris, Substance Abuse

ITEM	DISCUSSION	ACTION
I. CALL TO ORDER/ INTRODUCTIONS	Myriam Aragon called the meeting to order at 10:05 a.m. Self-introductions were made by members present.	
II. REVIEW AND APPROVE MINUTES	The Minutes for the meetings of January 8, 2009 were reviewed by the Committee and approved.	Anna will send minutes to CCC Members and Program Supervisors/Managers

ITEM	DISCUSSION	ACTION
III. REPORTS FROM SUBCOMMITTEE MEMBERS	Myriam started by distributing a "draft" that noted the different Sub-Committees that included a description of the function for each.	
	1) LGBTQ Task Force – Moises Ponce reported that the group is working on prioritizing the recommendations and developing an action plan for more and better services to the LGBT population. The task force is also working in helping the LGBT elderly population in the communities to deal with stigma of coming out on their latter days of life and the difficulty of accessing services.	
	2) Spirituality and Mental Health - A first planning meeting took place and a decision was made to create a task force with the Cultural Competency Committee members to identify the next steps on this initiative. Moises Ponce was appointed to chair this committee.	Moises will schedule a meeting
	3) Reducing Disparities Task Force – No meeting has taken place in the last two months. The next meeting is scheduled for April 22, 2009.	
	4) Deaf & Hard of Hearing – Nothing to report. Group has not met.	
IV. CULTRUAL COMPETENCY NEWSLETTER	Protocol was presented with guidelines and deadlines for the article newsletter. The topic for April was chosen regarding women issues.	Yolanda Fullinwider will submit article the first week of April.

ITEM	DISCUSSION	ACTION
V. CULTURAL CELEBRATIONS	A decision of having secretarial support to ensure ongoing activities was made. Suzanne, Silvia and Anna were assigned to this function. As a result, the Committee decided to establish this year's events.	Moises, Claudia, Luis, Cindy and Alfredo; to coordinate.

VI. MAY IS MENTAL HEALTH MONTH	May is Mental Health Month Event is scheduled for Tuesday, May 19, 2009 from 3PM to 7PM at the ITF Courtyard. The theme will be "Live Life Well" and a draft of the flyer will be produced and sent out when it has been finalized. The Cultural Competency Committee agreed to participate in this event by having an informational table.	Anna will complete an application for display table for CCC.
VII. IN-SERVICE TRAINING	A presentation on Indicators of Cultural Competence in Health Care Delivery Organizations was done.	
VIII. ANNOUNCEMENTS	Cultural Competency Committee will hold a "special" meeting on Monday, April 27, 2009 at the MH Admin. Bldg. Conference Rm. A/B from 8:30AM – 12:00PM. Community event flyers were distributed.	
IX. ADJOURNMENT	Meeting was adjourned at 12:00 pm.	
XI. NEXT MEETING DATE	The next meeting will be held on **Thursday, April 9th at 10AM-12:00PM in the MH Administration Conference Room A/B**	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY COMMITTEE MEETING

April 9, 2009

MEMBERS PRESENT:

Brandon Lee, Chair, Administration
Myriam Aragon, Manager, Cultural Competency
Keith Boone, Substance Abuse
Claudia Espinoza, Family Advocate
Alfredo Huerta, Indio MH
Leticia Troncoso, ITF
Moises Ponce, Co-Chair, MH-Perris
Ramona Casares, MH Mid County (for Joaquin Galeano)
Kei Tiggs, Older Adults
Cindy Claflin, Parent Support
Carla Madueña, MH Indio
Carmelo Isales, MHSS A, Western Adults
Joshua Guess, Friday Night Live
Anna Rodriguez, Secretary Cultural Competency
Suzanne Boyd, OA Family Advocate

MEMBERS Present:

NEW MEMBERS:
Yolanda Scurlock, BHS, MH Indio
Stacie Schehl, Patient Advocate

MEMBERS ABSENT:
William Gonzalez, Public Guardian
David Camplin, Vice Chair, CalWORKS
Joaquin Galeano, MH Mid County
Consuelo Durazo, Parent Partner
Deysi Chavez, MV CHIPS
Yolanda Fullinwider, TRAC

MEMBERS ABSENT, CONT.:

Carlos Vargas, MH-Blaine Clinic
Azonda Moxley, Substance Abnse
Ethel Nwandu, IMD/LTC (excused)
Sandra Rabon, Parent Partner
William Harris, Substance Abuse
Luz Negron, Parent Support
Alison Emery, Director of Consumer Affairs
Luis Becerra, MTFC
Don Kirtland, Blaine Street Clinic

ITEM	DISCUSSION	ACTION
I. CALL TO ORDER/ INTRODUCTIONS	Brandon Lee called the meeting to order at 10:10 a.m. Self-introductions were made by members present.	
II. REVIEW AND APPROVE MINUTES	The Minutes for the meetings of March 12, 2009 were reviewed by the Committee and approved.	Anna will send minutes to CCC Members and Program Supervisors/Managers

ITEM	DISCUSSION	ACTION
III. MEETING PROCESS AND PROTOCOLS	Moises Ponce, Co-Chairman discussed the Cultural Competency committee and its process. He stated the members should work together as a team to discuss and agree on various issues that are brought up at the monthly meetings. Approved minutes to be forwarded to managers and supervisors. Members will be contacted by e-mail to remind them of the upcoming meeting. One (1) week prior to meetings, a message to all committee members will be sent asking for agenda items.	Anna
IV. NEWSLETTER ARTICLE UPDATE	Article to be written up to 250 words. An extension for up to 6 weeks was given to finalize the article. Any one, who has a topic they want considered for the newsletter article, should submit it. The topic should be something that we want the community be made aware of.	

ITEM	DISCUSSION	ACTION
V. CULTURAL CELEBRATIONS	An information sheet of the different cultural celebrations was passed out to committee members for discussion. Committee was urged to participate in the celebrations. Celebrations will take place in all three (3) Regions: Western, Mid-County and Desert. These celebrations are for all Mental Health staff, who should be made aware of the events Members of the Committee volunteered to head the celebrations for the following coming months: **May** – Asian American Heritage Month: Western Region: Cindy Claflin **June** – Deaf Hard of Hearing: Western Region will be Keith Boone, Mid-County will be Moises and Claudia Espinoza and for the Desert Region it will be Alfredo Huerta, Yolanda Scurlock and Carla Madueña. Myriam is to find presenters for all of the three (3) regions. **July** – European Americans: Western Region – Keith Boone, Mid-county – Moises Ponce and Desert Region: Alfredo Huerta and Yolanda Fullinwider.	Moises, Claudia, Luis, Cindy and Alfredo; to coordinate.
VI. MAY IS MENTAL HEALTH MONTH	May is Mental Health Month Event is scheduled for Tuesday, May 19, 2009 from 3PM to 7PM at the ITF Courtyard. The theme will be "Live Life Well" and a draft of the flyer will be produced and sent out when it has been finalized. The Cultural Competency Committee agreed to participate in this event by having an informational table.	

VII. IN-SERVICE TRAINING	A Power-Point Presentation was given on "Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile."	
VIII. DISCUSSION	Outreach & Engagement Proposals for each of the Ethnic Groups was discussed.	
IX. ANNOUNCEMENTS	The May is Mental Health Month was discussed. Alfredo Huerta mentioned that there would be special events in MECCA during the month of April: 　April 25 – Riverside County Special Education Local Plan Area-A Workshop for Parents Desert Sands Unified School District. 　April 29 – Dia del Niño, MECCA Family Center	
XI. ADJOURNEMENT AND NEXT MEETING DATE	Meeting was adjourned at 12:05PM The next meeting will be held on **Thursday, May 14th** at **10AM-12:00PM in the MH Administration Conference Room A/B**	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY COMMITTEE MEETING

May 14, 2009

MEMBERS PRESENT:	MEMBERS Present, cont.:	MEMBERS ABSENT, CONT.:
Brandon Lee, Chair, Administration		Carlos Vargas, MH-Blaine Clinic
Myriam Aragon, Manager, Cultural Competency		Azonda Moxley, Substance Abuse
Claudia Espinoza, Family Advocate		Ethel Nwandu, IMD/LTC (excused)
Alfredo Huerta, Indio MH		Sandra Rabon, Parent Partner
Moises Ponce, Co-Chair, MH-Perris	NEW MEMBERS:	Luis Becerra, MTFC
Joaquin Galeano, MH Mid County	Elizabeth Aguiliar, Family Advocate, Indio	Ramona Casares, MH Mid County (for
Don Kirtland, Blaine Street Clinic		Joaquin Galeano)
William Harris, Substance Abuse	MEMBERS ABSENT:	
Alison Emery, Director of Consumer Affairs	William Gonzalez, Public Guardian	
Cindy Claflin, Parent Support	Consuelo Durazo, Parent Partner	
Yolanda Fullinwider, TRAC	Deysi Chavez, MV CHIPS	
Carla Madueña, MH Indio	Keith Boone, Substance Abuse	
Anna Rodriguez, Secretary Cultural Competency	Leticia Troncoso, ITF	
Raquel A. Aguiliar, Volunteer Cultural Competency	Yolanda Scurlock, BHS, MH Indio	
Luz Negron, Parent Support	Stacie Schehl, Patient Advocate	
	Carmelo Isales, MHSS A, Western Adults	
	Joshua Guess, Friday Night Live	

ITEM	DISCUSSION	ACTION
I. CALL TO ORDER/ INTRODUCTIONS	Brandon Lee called the meeting to order at 10:10 a.m. Self-introductions were made by members present.	
II. REVIEW AND APPROVE MINUTES	The Minutes for the meeting April 9, 2009 were reviewed by the Committee and approved.	Anna will send minutes to CCC Members and Program Supervisors/Managers

ITEM	DISCUSSION	ACTION
III. REPORTS FROM SUB-COMMITTEES	**Spirituality** – Had their first meeting to review training power point draft. Are working on the context and recovery language of the draft document. The Committee is working on developing a training on Spirituality and Mental Health for Mental Health providers. This training program will be presented to the Committee for final approval.	
	LGBTQ - This group is meeting once a month. The Committee is reviewing the PEI proposal draft on the specifics on the LGBTQ program recommendations.	
	Deaf & Hard of Hearing - The first fair for the Deaf & Hard of Hearing event on Saturday, May 9th and contacts with vendors and consultants were made. Sign Language booklets were distributed at the fair.	
	Translation – The Committee met and talked about the time that is given for translations to be completed which is 30 days. The group also discussed the accuracy and comprehension of translating and it should be people friendly.	
IV. UPDATE ON CULTRURAL CELEBRATIONS FOR MAY	Asian American/Pacific Islander History Month:	
	Western Region – Is scheduled for May 21, 2009 at MH Admin. Conference Room A/B. Speaker is from UCR, Joe Virata, Director of Asian Pacific Student Program. **Mid-County** – Is scheduled for May 27th. Father Art Balagat, who is the pioneer for the Asian Association and Pacific Islanders will be presenting. **Desert Region** – Is scheduled for May 20th. A speaker from UCI will be presenting.	
	The idea of preparing a flyer announcing all of the events for the year was discussed. A draft of the flyer will be presented at the next Cultural Competency Committee meeting.	Alfredo Huerta

ITEM	DISCUSSION	ACTION
V. DEBRIEF ON COMMUNITY & ORGANIZATIONAL ASSESSMENT PROJECT	Myriam reported on the additional Cultural Competency Meeting that was held on April 28th. Those present were Jerry Wengerd, Donna Dahl, CCC members, Bob Martinez and Rudy Lopez.	
	Bob and Rudy discussed the preliminary findings made from the 28 focus groups that were done. Discussion of forming a Core Group to implement recommendations was done.	

VI. MULDI-LANGUAGE SERIES USER GUIDE – DISCUSSION & IMPLEMENTATION	Group reviewed an 8 minute CD from the California Institute for Mental Health describing the various ways the multicultural brochures and CDs can be used. They are a series of multicultural brochures and interactive CDs that are available in 7 different languages of information on 12 mental health themes covering diagnosis, treatment and services for adults and children. At next meeting the discussion will continue to determine if the CCC members will take this information to the programs to determine how to implement.
VII. IN-SERVICE TRAINING	A Power-Point Presentation was given on Innovative Approaches to Counseling Asian-American People. Note: Due to technical difficulties this presentation was not completed and will be done next month
VIII. ANNOUNCEMENTS	The May is Mental Health Month was discussed. The Asian events preparations are being worked on and will be held on May 21 for Western Region, May 27th for Mid-County and May 20th for Desert Region.
IX. ADJOURNEMENT AND NEXT MEETING DATE	Meeting was adjourned at 12:05PM The next meeting will be held on **Thursday, June 11** at **10AM-12:00PM in the MH Administration Conference Room A/B**

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY COMMITTEE MEETING

June 11, 2009

MEMBERS PRESENT:	MEMBERS Present, cont.:	MEMBERS ABSENT, CONT.:
Brandon Lee, Chair, Administration Myriam Aragon, Manager, Cultural Competency Claudia Espinoza, Family Advocate Alfredo Huerta, Indio MH Moises Ponce, Co-Chair, MH-Perris Joaquin Galeano, MH Mid County Leticia Troncoso, ITF Cindy Claflin, Parent Support Elizabeth Aguiliar, Family Advocate, Indio Ethel Nwandu, IMD/LTC Kei Tiggs, Older Adults Consuelo Durazo, Parent Partner Carmelo Isales, MHSS A, Western Adults Suzanne Boyd, Family Advocate	**NEW MEMBERS:** Manuel Aguilar Paramo, Cultural Competency Program Volunteer **MEMBERS ABSENT:** Don Kirtland, Blaine Street Clinic William Gonzalez, Public Guardian Deysi Chavez, MV CHIPS Keith Boone, Substance Abuse Yolanda Scurlock, BHS, MH Indio Stacie Schehl, Patient Advocate Joshua Guess, Friday Night Live	Carlos Vargas, MH-Blaine Clinic Azonda Moxley, Substance Abuse Sandra Rabon, Parent Partner Luis Becerra, MTFC Ramona Casares, MH Mid County (for Joaquin Galeano) William Harris, Substance Abuse Alison Emery, Director of Consumer Affairs Yolanda Fullinwider, TRAC Raquel A. Aguiliar, Volunteer Cultural Competency Luz Negron, Parent Support Anna Rodriguez, Secretary Cultural Competency Carla Madueña, MH Indio

ITEM	DISCUSSION	ACTION
I. CALL TO ORDER/ INTRODUCTIONS	Brandon Lee called the meeting to order at 10:05 a.m. Self-introductions were made by members present.	
II. REVIEW AND APPROVE MINUTES	The Minutes for the meeting May 14, 2009 were reviewed by the Committee and approved. The spelling of the speaker for Mid-County's cultural event was corrected.	Suzanne will send minutes to CCC Members and Program Supervisors/Managers

ITEM	DISCUSSION	ACTION
III. REPORTS FROM PROGRAMS	CC Program announced that a state wide 4 day comprehensive self-assessment training curriculum for the cultural competency committee is forthcoming. Family Advocates stated that they are speaking more on cultural competency at the Mental Health Board meetings. Desert Region reported outreach on radio program and discussed with supervisors about the frequency of cultural competency events. The supervisors suggested quarterly events rather than monthly due to staff shortage. Myriam reiterated that events need to be kept simple and will examine the issue further. ITF Representative reported bilingual staff are being trained in medical terminology at ITF clinic	
IV. REPORTS FROM SUB-COMMITTEES	Spirituality – group attended a 2 day conference. Three goals were determined from the conference. 1. Training in spirituality terms and definitions with recovery focus. 2. Form a taskforce of consumers/community. 3. Begin roundtable dialogues with spiritual leaders about mental health. LGBTQ - This group is meeting once a month. The Committee is reviewing the PEI proposal draft on the specifics on the LGBTQ program recommendations. A telephone conference is scheduled for June 23rd focusing on the PEI July 6th public hearing. Committee's priorities are developing a resource manual and evidence based practice training.	
	Deaf & Hard of Hearing - Myriam announced that volunteers are needed for the subcommittee. Three individuals volunteered: Ethel, Consuelo and Manuel. Myriam announced that committee has a budget for training.	Meeting to be scheduled to develop action plan
	Translation – Manuel has come aboard as a volunteer. He discovered 2 pages of the Guide to Services were missing and is working on correcting it.	
IV. UPDATE ON CULTURAL CELEBRATIONS FOR JUNE	Group reviewed the Asian American/Pacific Islander History Month. Events were a success. Western Region – Is scheduled for June 22 at MH Admin. Conference Room A/B. Speaker is Lisa Price Regional Director for Central on Deafness Inland Empire Mid-County – Is scheduled June 30 at San Jacinto Clinic at 10:00 AM. The presenter will be Roberta Smith from the California Association for the Deaf San Jacinto Valley Chapter. Desert Region – Is June 17th at 12:00pm-1:00pm in Indio, and the speaker will be Francine Garza Flyer announcing all of the events for the year was done. A draft of the flyer was presented at the Cultural Competency Committee meeting. Suggestions and comments were reviewed.	Group agreed to have the picture taken out. Alfredo will finalize flyer.

ITEM	DISCUSSION	ACTION
V. UPDATE ON COMMUNITY & ORGANIZATIONAL ASSESSMENT PROJECT	It was discussed by some members that the final report was too negative. There was no focus on positive strengths of the department only the negative. It was stated that the department knows what it is doing right but needs to know what changes need to be done. Research was not addressed due to brevity of report.	
VI. MULDI-LANGUAGE SERIES USER GUIDE — DISCUSSION & IMPLEMENTATION	A series of multicultural brochures and interactive CDs is available in 7 different languages of information on 12 mental health themes covering diagnosis, treatment and services for adults and children. How to implement them among the department was discussed. Suggestions from the committee were that they could be shown in lobbies, taken to staff meetings and also placed in the Parent Partner resource library.	
	Members of the committee will be presenting the informational CDs in their staff meetings to get input on how to use this material.	Members to add this to their staff meeting agenda.
VII. DEAF AND HARD OF HEARING AWARENESS DIALOGUE	An informational handout on Disability Etiquette was distributed.	
VIII. IN-SERVICE TRAINING	A DVD Presentation was given on Innovative Approaches to Counseling Asian-American People.	
IX. ADJOURNEMENT AND NEXT MEETING DATE	Meeting was adjourned at 12:05PM The next meeting will be held on **Thursday, July 9** at **10AM-12:00PM in the MH Administration** Conference Room A/B	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY COMMITTEE MEETING

July 9, 2009

MEMBERS PRESENT:

Myriam Aragon, Manager, Cultural Competency
Alison Emery, Director of Consumer Affairs
Claudia Espinoza, Family Advocate
Alfredo Huerta, Indio MH
Moises Ponce, Co-Chair, MH-Perris
Yolanda Fullinwider, TRAC
Don Kirtland, Blaine Street Clinic
Leticia Troncoso, ITF
Cindy Chaflin, Parent Support
Kei Tiggs, Older Adults
Carmelo Isales, MHSS A, Western Adults
Consuelo Dnrazo, Parent Partner

MEMBERS Present, cont.:

NEW MEMBERS:
Manuel Aguilar Paramo, Cultural
Competency Program Volunteer

MEMBERS ABSENT:
Brandon Lee, Chair, Administration
William Gonzalez, Public Guardian
Deysi Chavez, MV CHIPS
Keith Boone, Substance Abuse
Yolanda Scurlock, BHS, MH Indio
Stacie Schehl, Patient Advocate
Joshua Guess, Friday Night Live
Elizabeth Aguiliar, Family Advocate, Indio

MEMBERS ABSENT, CONT.:

Carlos Vargas, MH-Blaine Clinic
Azonda Moxley, Substance Abuse
Sandra Rabon, Parent Partner
Luis Becerra, MTFC
Ramona Casares, MH Mid County (for Joaquin Galeano)
William Harris, Substance Abuse
Raquel A. Aguiliar, Volunteer Cultural Competency
Luz Negron, Parent Support
Auna Rodriguez, Secretary Cultural Competency
Carla Madueña, MH Indio
Ethel Nwandu, IMD/LTC
Joaquin Galeano, MH Mid County

ITEM	DISCUSSION	ACTION
I. CALL TO ORDER/ INTRODUCTIONS	Myriam Aragon called the meeting to order at 10:15 am. The meeting was held at the MH Administrative Building, Conference Room C.	
II. REVIEW AND APPROVE MINUTES	The Minutes for the meeting June 11, 2009 were reviewed by the Committee and approved. Mental Health & Spirituality Initiative- deadline to submit surveys is August 10th.	Suzanne will send minutes to CCC Members and Program Supervisors/Managers

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY COMMITTEE MEETING

July 16, 2009
(Additional Meeting)

MEMBERS PRESENT:

Brandon Lee, Chair, Administration
Myriam Aragon, Manager, Cultural Competency
Claudia Espinoza, Family Advocate
Alfredo Huerta, Indio MH
Moises Ponce, Co-Chair, MH-Perris
Cindy Claflin, Parent Support
Ethel Nwandu, IMD/LTC
Kei Tiggs, Older Adults

MEMBERS Present, cont.:

Consuelo Durazo, Parent Partner
Carmelo Isales, MHSS A, Western Adults
Don Kirtland, Blaine Street Clinic
Anna Rodriguez, Secretary Cultural Competency
Rudy Lopez, Consultant

NEW MEMBERS:
Pam Vass, Childrens Services
Anthony Richmond, Peer Specialist

MEMBERS ABSENT, CONT.:

Keith Boone, Substance Abuse
Leticia Troncoso, ITF
Luis Becerra, MTFC
William Harris, Substance Abuse
Alison Emery, Director of Consumer Affairs
Yolanda Fullinwider, TRAC
Luz Negron, Parent Support

ITEM	DISCUSSION	ACTION
I. CALL TO ORDER/ INTRODUCTIONS	Myriam called the meeting to order at 9:40 a.m. Self-introductions were made by members present. Two new members were introduced, Anthony Richmond, Peer Specialist and Pam Vass, Children's Services. Secretary to Erlys Daily.	
II. REVIEW AND APPROVE MINUTES	No minutes were reviewed at this meeting.	
III.DISCUSSION OF JULY 9, 2009 MEETING	Myriam asked members to discuss the meeting held on the 9th of July regarding the CORE Group Discussion of Options and Recommendation and asked that each member give their thoughts as to how the meeting had gone and if it was a productive one.	

ITEM	DISCUSSION	ACTION
IV. COMMENTS FROM MEMBERS	The following are some comments made by committee members 1. Meeting had been productive that everyone in the community would benefit from. 2. There should be community representation. 3. Meeting was a good one and sensed that everyone is working together. 4. One committee member stated that there is fragmentation and would like to see more of a solid group coming together. 5. Another member brought up the importance of the consumer participation.	
V. CCC/CORE GROUP INSTRASTRUCTURE AND REPORTING	It was decided by a majority of the votes that the CCC/CORE Group will continue to have the same reporting process that we have now (under Mental Health Director and Assistant Director).	
VI. ROLES & RESPONSIBILITIES OF CCC/CORE GROUP	The Roles and Responsibilities were once again discussed. Page 3 of this document was discussed as far as the consumer/outside representation.	
VII. WHAT WOULD YOU LIKE TO HAVE THE "EXPANDED" CCC DO?	Rudy Lopez asked the question to the members and the following recommendations were made: 1. Create change 2. Improve service to the community 3. Monitoring and accountability 4. Needs assessment of the community 5. Monitoring services/language services, Human Resources/Staff Reflecting Community 6. Addressing the discrimination issues 7. Changing the perception of the committee to a positive one 8. Create a situation where the committee has influence 9. To be a voice in the community 10. To be the voice of the community in administration/decision making – strong voices of change 11. To have the power to issue directives 12. Having our own review unit (RU) 13. To have effective communication between community and clinics 14. Bring more peers and family members to our group	

ITEM	DISCUSSION	ACTION
VII. CONTINUED....	15. Regional representation 16. Creation of governance on how we operate in the County of Riverside 17. Training of staff 18. Membership with power Anna to type up these recommendations and send to Committee Members. She will also send the CCC Roles and Responsibilities document.	Anna Rodriguez to send Members the Recommendations and Roles & Responsibilities
VIII. NEXT STEPS	Committee members are to review the recommendations and see if the items listed in these recommendations are already included in the CCC Roles and Responsibilities document.	
XI. NEXT MEETING	Rudy stated that this meeting had been a good one and very productive. He thanked everyone for a good job done. The meeting was adjourned at 11:15AM The next meeting will be held on **Thursday, August 13th at 10AM-12PM in the MH Administration Conference Room A/B.**	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY/REDUCING DISPARITIES COMMITTEE MEETING

September 9, 2009

PRESENT: Brandon Lee, DMH, Staff Analyst; **Myriam Aragon**, Manager, Cultural Competency; **Alfredo Huerta**, Indio MH; Moises Ponce, DMH-Perris Clinic; **William Harris**, Substance Abuse; **Cindy Claflin**, Parent Support; Yolanda Fullinwider, TRAC; Lisa Jackson, Sr. Peer Specialist; **Rudy Perez**, Arbor Education & training; Pamela Vass, DMH Children's Services; **Benita Ramsey**, LGBT Task Force; Adonis Parker, Rise Interpreting; Consuelo Durazo, Parent Partner; Ninfa Delgado, Riverside Community Health Foundation; **Javier Rosales**, Latino Network; **Dr. Renda Dionne**, Indian Child and Family Services; Carmelo Isales, MH-JWC, Western Adults; Leticia Troncoso, ITF; **Mike Madrigal**, Native American Inter-Faith Community; **Manuel Aguilar**, Cultural Competency; **Bob Martinez**, Consultant; **Rudy Lopez**, Consultant; **Anna Rodriguez**, Secretary, Cultural Competency.

ABSENT: Claudia Espinoza, Family Advocate Mid-County Region; **Alison Emery**, Director of Consumer Affairs; **Keith Boone**, Substance Abuse; **Jennifer Blakely**, The Group; Leonel Contreras, Maria Dyer; **Maggie Hawkins**, Robert Hernandez, Veronica Hilton, CHA; **Ben Jauregui**, Disability Program Mgr. IEHP; Jason Lee; Felix Minjarez, Anthony Richmond, DM-PSS, JWC; Kei Tiggs, MHS, Older Adults; Pastor Sunny Wilamart

AGENDA ITEM	DISCUSSION	ACTION
I. WELCOMING	Myriam opened the meeting by welcoming and thanking everyone for attending the meeting.	
II. INTRODUCTIONS	Myriam asked that everyone present introduce themselves, naming the organization they represent and also to briefly discuss their experience with diverse communities as an organization.	
III. A SUMMARY OF THE ROLES FOR THE COMMITTEE	Membership issues were discussed. Roles of the Committee: Discussion was initiated.	
IV. SETTING THE TONE: CREATING A SAFE ENVIRONMENT	Group discussed issues and meeting protocols to ensure everyone's participation.	
V. DEVELOPING A JOINT PURPOSE	A question was asked of the members: "What would you like or want to see done in this process"? and the group came up with: 1. How the Department functions 2. Flow Chart 3. What other Committees are out there 4. Department's demographics	Group agreed to have these items for next meeting's agenda.

AGENDA ITEM	DISCUSSION	ACTION
V. **CONTINUED:** **DEVELOPING A JOINT** **PURPOSE**	Myriam asked the group to: 1. Look over the membership list 2. Read the CORE Statement 3. Trust Issue: Group welcoming each other. 4. How do you see yourself in the community's mental health organizations? The group as asked to think about the training, i.e. logic model.	Group was assigned to review these issues.
VI. ADJOURNMENT AND **NEXT MEETING DATE**	Meeting was adjourned at 11:10AM The next meeting is scheduled for **Wednesday, September 23rd, at DPSS Kidd St., 1st. Floor Conference Room B, 10281 Kidd Street, Riverside, CA 92503**	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY/REDUCING DISPARITIES COMMITTEE MEETING

September 23, 2009

PRESENT: , Myriam Aragon, Alfredo Huerta, Moises Ponce, Alison Emery, Jennifer Blakely, Yolanda Fullinwider, , Rudy Perez, Pamela Vass, Benita Ramsey, Adonis Parker, , Ninfa Delgado, Javier Rosales, , Carmelo Isales, Manuel Aguilar, Bob Martinez, Anthony Richmond, Ben Jauregui, Anna Rodriguez.

ABSENT: Brandon Lee, Claudia Espinoza, William Harris, Cindy Claflin, Keith Boone, Lisa Jackson, Leonel Contreras, Maria Dyer; Maggie Hawkins, Robert Hernandez, Leticia Troncoso, Veronica Hilton, Jason Lee; Felix Minjarez,, Kei Tiggs, Pastor Sunny Wilanart, Consuelo Durazo, Dr. Renda Dionne, Mike Madrigal,.

AGENDA ITEM	DISCUSSION	ACTION
I. WELCOMING	Myriam opened the meeting by welcoming and thanking everyone for attending the meeting.	
II. INTRODUCTIONS	Myriam asked that everyone present introduce themselves, naming the organization they represent and also to briefly discuss their experience with diverse communities as an organization.	
III. HOW THE DEPT. OF MENTAL HEALTH WORKS. ORGANIZATION CHART	Myriam made a power point presentation, which depicted population of Riverside County by age, region, the population projection from 2000-2011 by race & ethnicity. The power point also showed Mental Health organization chart and its different committees.	
IV. GROUP STRUCTURE/ ROLES AND FUNCTIONS OF THE COMMITTEE	The need for someone from the group to share the committee was discussed. Also discussed what name to give the committee but it was decided that the name would stand as is, but instead of "&" it would be "/" between: "Cultural Competency/Reducing Disparities" Three work groups were put together to discuss the following: **Membership** – Javier Rosales, Benita Ramsey and Adonis Parker **Responsibilities** – Moises Ponce, Pam Vass and Yolanda Fulliwinder **Purpose** – Carmelo Isales, Jennifer Blakely and Ninfa Delgado	
V. FINAL THOUGHTS AND NEXT MEETINGS	**Final Thoughts:** a. Teaching/training needs for group. b. October is LGBT month c. Suggestion was made that the group bring their favorite ethnic dish to the meeting. The group decided to continue meeting on Wednesdays at 9AM. **Next meeting will be Weds. October 14, 2009, 9AM-11AM** **Location: DPSS Kidd St., Bldg., 10281 Kidd St., 2ⁿᵈ Floor Conference Rm. 2A**	

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCY/REDUCING DISPARITIES COMMITTEE MEETING

October 14, 2009

PRESENT: Myriam Aragon, Alfredo Huerta, Moises Ponce, Brandon Lee, Dr. Renda Dionne, Jennifer Blakely, Yolanda Fullinwider, , Pamela Vass, Ninfa Delgado, Leticia Troncoso, Claudia Espinoza, Mike Madrigal, Anna Rodriguez.

SPECIAL GUESTS: Donna Dahl, Assistant Director and Bill Brenneman, Manager MHSA.

AGENDA ITEM	DISCUSSION	ACTION
I. WELCOMING & INTRODUCTIONS	Myriam opened the meeting by welcoming and thanking everyone for attending the meeting.	
MHSA: INNOVATIONS OVERVIEW – BILL BRENNEMAN & DONNA DAHL	Bill Brenneman, Manager for MHSA introduced and talked about the MHSA Innovations Overview. Donna Dahl spoke on the PEI which was approved and are now working on the implementation.	
II. GROUP STRUCTURE/ ROLES AND FUNCTIONS OF THE COMMITTEE	Group discussed the structuring and the roles and functions of the committee. Myriam distributed the "Draft for Discussion", which included report from each of the key groups: Purpose, Membership and Responsibilities.

Purpose: To develop, recommend and maintain a formal practice, through a participatory process in partnership and collaboration with the community; for the purpose of implementing and optimizing the State mandated Cultural Competency Plan that ensures fairness and equality across systems in order to reduce mental health disparities in Riverside County.

Items under "Work Group Recommendations" were discussed and some changes were made. Myriam is to revise these recommendations and discuss at next meeting.

Also discussed were the following items:
1. Meeting Schedule for year 2010: 2nd Wednesday of the month; hours: 9AM – 11AM
2. Officers – Brandon Lee, chair and Moises Ponce, co-chair are to remain as head of the committee until the end of the year 2009. New officers will be voted on at the first meeting in January, 2010. The new officers will consist of two (2) co-chairmen, one (1) internal to represent Mental Health staff and one external, representing the community.
3. Special committees or task forces were discussed. These subcommittees will be formed to address specific issues or committee needs – these will be formed as needed basis. | Myriam will work on making revision and/or changes to recommendations on "Draft for Discussion" |
| **IV. NEXT MEETING** | There will not be a meeting in November, due to holiday on the 11th (Wednesday).

The next meeting will be held on **Wednesday, December 2nd at the DPSS Kidd Street Bldg., 10281 Kidd Street, 1st Floor Conference Room "B" (9AM – 11:00AM)** | |

ATTACHMENT #32

CBMCS Multicultural Training Program Evaluation

Riverside County
Department of Mental Health
Research and Evaluation

Executive Summary

A pilot implementation of the California Brief Multicultural Competence Scale (CBMCS) Multicultural Training was conducted in May, June, and July of 2008 to train Riverside County Department of Mental Health (RCDMH) staff on culturally appropriate services for a diverse population of mental health consumers and family members.

CBMCS Training Goals

The CBMCS training is designed to build skills on four factors: multicultural knowledge; awareness of cultural barriers; sensitivity and responsiveness to consumers; awareness and knowledge of socio-cultural diversity.

CBMCS Training Program

Participants were provided training during four, one – day modules, each covering a specific domain of cultural competency.

Module I– Multicultural knowledge
Module II – Awareness of cultural barriers
Module III – Sensitivity and responsiveness to consumers
Module IV – Awareness and knowledge of socio-cultural diversity

Training Participants

A total of 50 RCDMH staff took part in two waves of CBMCS training. In both waves, the staff attending were racially and ethnically diverse and had a broad range of educational attainment. Attendees entered training with a wide variation in total years of experience working for RCDMH.

Data Collection

Staff completed the California Brief Multicultural Competence Scale (CBMCS) at the beginning of training and at the conclusion of the training. In addition at the conclusion of each module staff completed an evaluation specific to that module. Evaluation of modules included: content appropriateness, applicability to the job, logistics/process, and trainers skills. Not all staff completed both a pre and post CBMCS survey.

Key Findings from the California Brief Multicultural Competency Scale

- Staff demonstrated increased knowledge of multicultural factors.
- Staff showed increased understanding about the types of cultural barriers experienced by diverse populations.
- There was a slight increase in staff sensitivity and responsiveness to consumers. However, staff were already sensitive and responsive before the training based on their CBMCS pre-test scores.
- Staff showed an increased understanding of socio-cultural diversity which includes information about other groups in society where race/ethnicity is not the focus (e.g., age, gender, sexual orientation, social class, physical-mental intactness and disability status).

Key Findings from the Evaluation of the Training Modules

Overall, attendees reported high levels of satisfaction with:
- The appropriateness of the training content.
- The trainers skills and style of teaching.
- Applicability of the training to their jobs.

- Staff written feedback indicated enjoyment for the Module I skits. Staff comments noted the helpfulness of the Module III role-play and the helpfulness of the consumers perspective in Module IV.

Satisfaction ratings and written feedback indicated that the following are the areas that need the most adjustment or improvement:

- The discussion of "white privilege" received the worst satisfaction scores; 47% of attendees were dissatisfied with this topic area. This rating was dramatically lower than ratings across all other items.

- Across modules II and III attendees showed lower satisfaction with clinical implications for mental health practice (Module II 82.1%, Module III 78.6%).

- Compared to other rating of content appropriateness in Wave 1, attendees showed lower satisfaction with the discussion of sexism (69%) in Module II; also satisfaction ratings were lower (83.3%) for the discussion on guiding principles for sensitive and responsive mental health practice in Module III .

- Staff feedback suggested that the duration of all modules be lengthened to cover more material, provide more detail, discuss clinical issues, fully explore and discuss topics, and to slow down the pace so that classes don't seem rushed.

- Staff feedback suggested there be more examples, elaboration, and definitions on specific topics in Module III, that Module II learning should have greater applicability in clinical settings, and that the experiential level of Module IV be used across all four modules.

- Feedback from both waves indicated that White staff felt uncomfortable due the instructor's reaction to another participants' comments during Module II.

- Staff commented on some of the training logistics including comfort in the training classroom due to the temperature in the classroom.

CBMCS Multicultural Training Program Wave 1 Evaluation

Overview

Across two waves of training, a total of 50 RCDMH employees participated in a Cultural Competency Training Program in May, June, and July 2008. The training program consisted of four distinct modules. Attendees completed the California Brief Multicultural Competency Scale (CBMCS) at the beginning and end of the cultural competency training. In addition attendees evaluated each of the modules as it was completed.

- **Background Information:** Basic demographic information was collected at the beginning of the program.

- **California Brief Multicultural Competence Scale (CBMCS):** The California Brief Multicultural Scale (CBMCS) is a validated self-report scale that measures the staff's self-perceived cultural competence. The CBMCS assesses competency on four domains—multicultural knowledge, awareness of cultural barriers, sensitivity and responsiveness to consumers, and socio-cultural diversities.

- **Module Evaluations:** Participants completed an evaluation (content appropriateness, applicability to their jobs, logistics/process, trainers skill) at the completion of each module.

Module I– Multicultural knowledge: Information about minority groups and the sources of bias that have resulted in inadequate services and curtailed utilization of services available to these groups. Empirical sources of information on the mental health status of minority groups and how to provide culturally competent services (assessments, diagnosis, treatment).
Module II – Awareness of cultural barriers: Analyze cultural self-awareness and awareness of racism, discrimination and oppression and its impact on service delivery.
Module III – Sensitivity and responsiveness to consumers: Providers expectations and the therapeutic relationship and appreciation of the multiple roles of advocacy in stimulating hope and faith in multicultural consumers. Awareness of the pervasive, chronic and personal effects of racism on consumers of mental health services and an introduction to provider behaviors that can mitigate the effects of consumers experiences with racism.
Module IV – Awareness and knowledge of socio-cultural diversity: Information about members of socio-cultural groups in which ethnicity may not be the major or immediate focuses of professional attention: age, gender, sexual orientation, social class, physical-mental intactness and disability status. Explanation of bias, oppression and discrimination experienced by members of socio-cultural groups. Information about best practices and treatment considerations for members of socio-cultural groups.

The following report details the results of each aforementioned measure for two training waves. Pre- and post-test data from the CBMCS are presented to show changes in participants' knowledge of cultural competency. Evaluations from each module were aggregated to provide information on overall satisfaction (content appropriateness, trainers, job applicability, and logistics/process) and satisfaction with individual aspects of content, trainer skill, and job applicability.

Demographic Information (Wave 1)

Thirty-five employees (21 female, 14 male) completed the cultural competency training in Wave 1. Participant ages ranged from 25 to 65-years-old, with an average age of 42. The majority of respondents were born in the United States (83%). The following graphs further illustrate participants' demographic backgrounds.
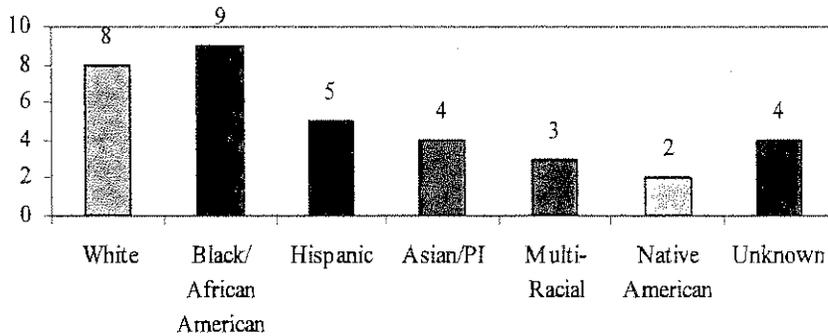
Race/Ethnicity

Race/ethnicity was diverse with more attendees identifying as Black.

Highest Degree Obtained	Freq.	%
High School	7	20%
Bachelor's Degree	7	20%
Master's Degree—MFT	6	17%
Master's Degree—Social Work	9	26%
Master's Degree—Other	3	8%
Doctorate—Clinical/Counseling	2	6%
Doctorate—Other	1	3%

Years of Experience

Foreign Language Skills

Yes 37%

No 63%
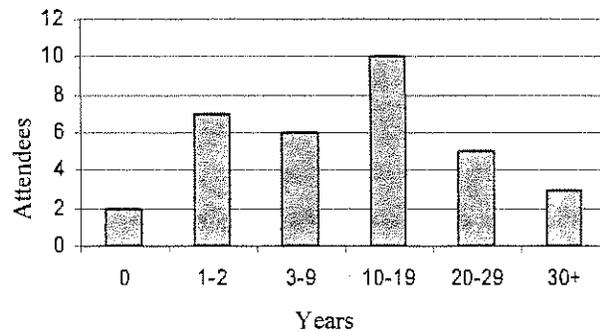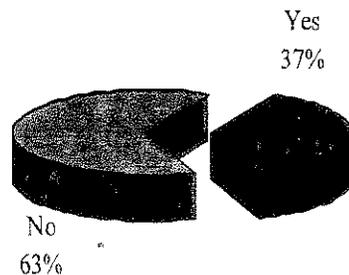
Multicultural Experience		
Coursework	Freq.	%
Yes	23	66%
No	12	34%
Workshops	Freq.	%
Yes	23	66%
No	12	34%

Pre- to Post-Test (CBMCS) (Wave 1)

The California Brief Multicultural Scale (CBMCS) is a validated scale[1] that measures the cultural competency of mental health practitioners. The CBMCS assesses competency on four domains—multicultural knowledge, awareness of cultural barriers, sensitivity and responsiveness to consumers, and socio-cultural diversities. Participants identified the extent to which they agreed or disagreed with 21 statements on 4-point Likert-scales, with higher scores (4) indicating a higher degree of cultural competency. The following three pages illustrate employees' cultural competency before and after completing the training program.

Overall Impact of the Pre-to Post-test Multicultural Training

Participants scored higher on their level of cultural competency upon completion of the training program. A total of 35 participants completed the CBMCS Multicultural Training . However, due to data attrition (i.e., inability to match pre-post test scores or incomplete data) a total of 23 attendees pre-post measures were used for analyses. Results indicate that there was a significant increase in participants' cultural competence pre-test to post-test scores (t=5.21, p<.001). Overall, the training program was effective in increasing cultural competency among mental health staff.

Overall Mean Scores
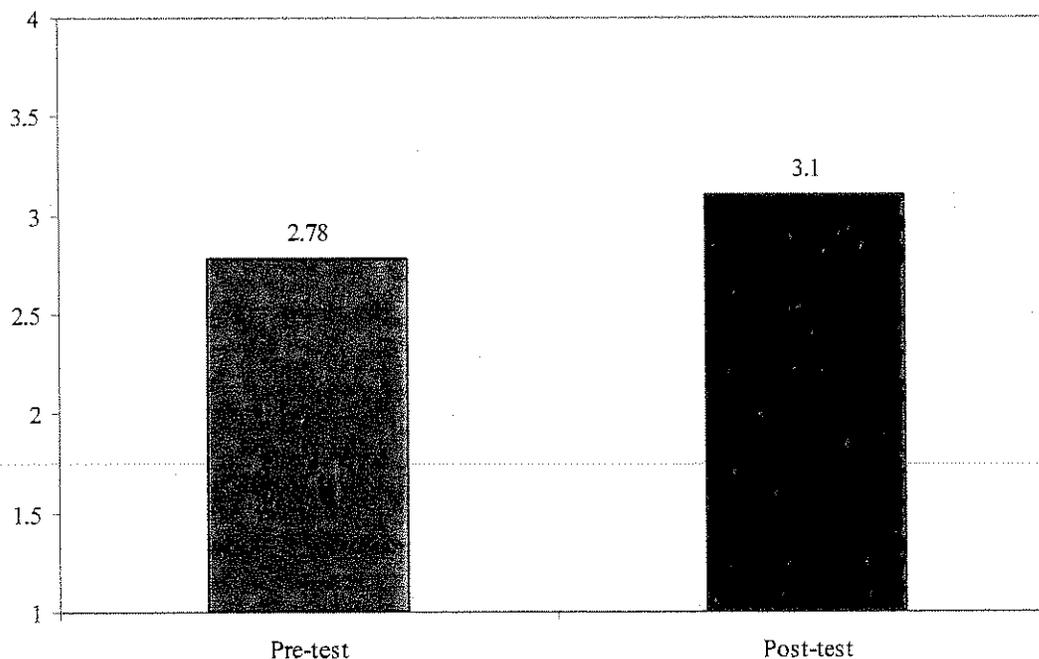
[1] Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martensen, L. (2004). Cultural competency revised: The California Brief Multicultural Competency Scale. *Measurement and Evaluation in Counseling and Development, 37*(3), 163-187.

Pre- to Post-Test (CBMCS) (Wave 1) Continued...

Multicultural Knowledge

Participants scored higher on their knowledge of multicultural issues upon completing the training program. Across participants (n = 23), multicultural knowledge increased from the beginning to the end of the training program. This increase was statistically significant (t=5.13, p<.001), indicating that there was a considerable increase in participant's multicultural knowledge scores.

Mean Scores
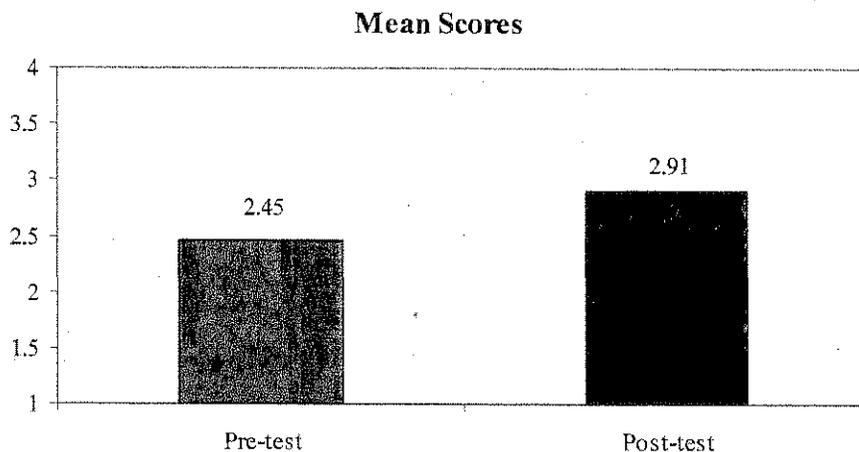
Awareness of Cultural Barriers

Participants scored higher on questions assessing their awareness of cultural barriers after participating in the four modules. Across participants (n = 23), awareness of cultural barriers increased from the beginning to the end of the training program. This change was statistically significant (t=3.51, p<.005), indicating that there was a noteworthy change in their awareness of cultural barriers from pre-test to post-test.

Mean Scores
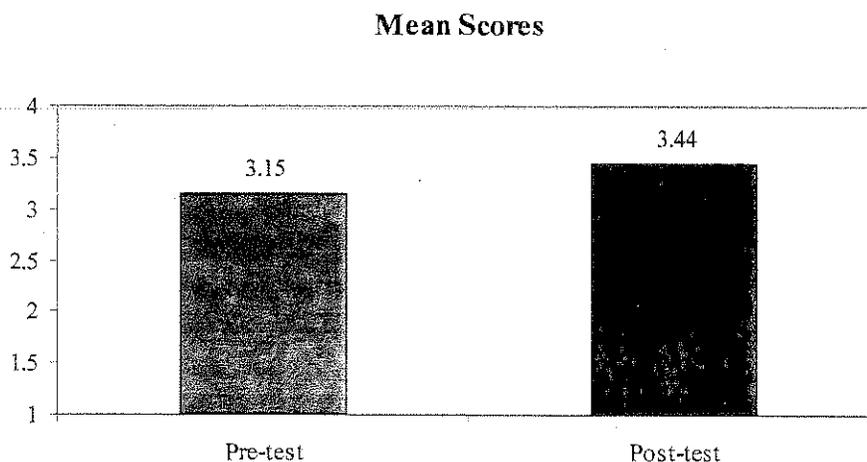
Pre- to Post-Test (CBMCS) (Wave 1)Continued...

Sensitivity and Responsiveness to Consumers

Sensitivity and responsiveness to consumers slightly increased from the beginning to the end of the training program. However, participants pre-scores showed that staff scored high on sensitivity and responsiveness to consumers prior to participating in the training.

Mean Scores
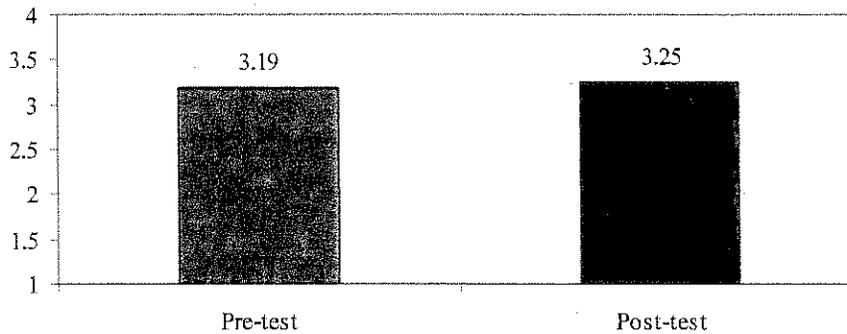
Socio-cultural Diversities

Overall, participants scored higher on questions assessing socio-cultural diversity after participating in the training program. Across participants (n = 23), knowledge of socio-cultural diversity increased from the beginning to the end of the training program. This change was statistically significant (t=3.22, p=.004), indicating that among the participants there was a considerable increase in socio-cultural knowledge scores.

Mean Score
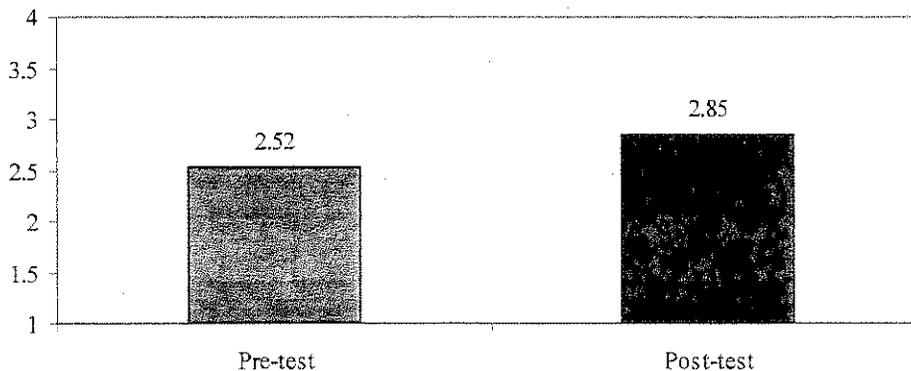
Evaluation: Module I (Wave 1)

Module I -Multicultural Knowledge. Participants completed an evaluation form upon the completion of the module. Participants identified the extent to which they agreed or disagreed with 28 statements on 4-point Likert-scales, with higher scores (4) indicating greater satisfaction.

Content Appropriateness

The majority of participants indicated they felt the content of Module I was appropriate or very appropriate [87.7%; M=3.10]. The following table illustrates the average score and percentage of respondents who felt the content of Module I was appropriate or very appropriate for each item.

Discussion on CBMCS development was adequate.	97.1%	3.35	Discussion on recognizing deficiencies in research conducted on minorities was adequate.	75.8%	2.94
Module I handouts were satisfactory.	97.1%	3.21	Discussion on psychosocial factors to consider when providing services was adequate.	81.8%	3.00
Discussion on cultural competence defined was adequate.	96.9%	3.34	Discussion on providing culturally competent mental health assessment and diagnosis was adequate.	90.3%	3.06
Discussion on the historic and contemporary overview of the 4 major ethnic groups in the U.S. was adequate.	88.2%	3.09	Discussion on understanding and evaluating wellness recovery and resiliency was adequate.	70.0%	2.73
Discussion on health disparities was adequate.	82.4%	2.94	Overall, I found the CBMCS Module I to be effective.	96.9%	3.28

Trainers

Nearly all participants indicated that they felt the trainers, the trainers' styles, and the trainers' skills used in module I were very appropriate [97.6%; M=3.77]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The trainers were very knowledgeable.	100.0%	3.88
The delivery styles of the trainers were appropriate.	97.1%	3.74
The trainers' group management skills were appropriate.	97.1%	3.71
The trainers' responsiveness to difficult topics was appropriate.	100.0%	3.82
The trainers' organization and preparation was appropriate.	94.1%	3.71

Evaluation: Module I (Wave 1) Continued...

Process and Logistics

Most participants indicated that they were satisfied or very satisfied with the process and logistics of Module I [92.1%; M=3.33]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The pace of the Module I was just about right.	79.4%	3.00
I felt safe enough to explore all of the multicultural topics in Module I.	100.0%	3.53
The Module I logistics (room, schedule, etc.) were satisfactory.	97.0%	3.45

Applicability to My Job

The vast majority of participants indicated the information in Module 1 would be applicable to their job [92.6%; M=3.20]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

My level of confidence concerning multi-cultural issues has increased.	91.2%	3.26	I will use the information from Module I in my work.	97.0%	3.45
Module I has helped change my thinking about multicultural issues.	87.9%	3.24	Module I training will help me relate to my clients.	93.9%	3.15
Module I has increased my awareness of my agency's strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	96.9%	3.31	Module I has increased my awareness of my own strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	96.9%	3.28
Module I has increased my confidence in performing consumer case reviews.	87.5%	3.03	Module I has increased my confidence in developing cultural formulations during the treatment planning process.	87.5%	3.03
Module I increased my confidence in discussing diversity issues with my clients.	93.8%	3.19	Module I increased my confidence in discussing diversity issues with my supervisor.	93.8%	3.16

Observations and Suggestions

Participants' comments indicated that:

- The class did not cover all of the topics in Module I.
- Participants enjoyed the skits.
- Participants felt that the room where the class was held was too cold.

Evaluation: Module II (Wave 1)

Module II - Awareness of Cultural Barriers. Participants completed an evaluation form at the completion of the module. Participants identified the extent to which they agreed or disagreed with 28 statements on 4-point Likert-scales with higher scores (4) indicating a greater satisfaction with the module.

Content Appropriateness

The majority of participants indicated they felt the content of Module II was appropriate or very appropriate [87.3%; M=3.10]. The following table illustrates the average score and percentage of respondents who agreed or disagreed with each statement, indicating their perceived adequacy of a topic that was covered or appropriateness of a content area. It is worth noting that the discussion on white privilege received the lowest adequacy/appropriateness rating [47.4%; M=2.53]. Satisfaction with the discussion on sexism was also low (69%).

The discussion on context of barriers was adequate.	96.8%	3.10	The discussion on racism was adequate.	90.6%	3.22
Module II handouts were satisfactory.	100.0%	3.31	The discussion on white privilege was adequate.	47.4%	2.53
The discussion on awareness of self was adequate.	96.9%	3.19	The discussion on sexism was adequate.	69.0%	2.72
The discussion on awareness of others was adequate.	96.9%	3.22	The discussion on clinical implications was adequate.	82.1%	2.86
The discussion on worldview was adequate.	100.0%	3.38	Overall, I found the CBMCS Module II to be very effective.	93.1%	3.17

Trainers

Nearly all participants indicated that they felt the trainers, the trainers' styles, and the trainers' skills used in module II were very appropriate [98.7%; M=3.49]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The trainers were very knowledgeable.	100.0%	3.59
The delivery styles of the trainers were appropriate.	100.0%	3.53
The trainers' group management skills were appropriate.	93.8%	3.34
The trainers' responsiveness to difficult topics was appropriate.	100.0%	3.47
The trainers' organization and preparation was appropriate.	100.0%	3.52

Evaluation: Module II (Wave 1) Continued...

Process and Logistics

Three quarters of participants indicated that they were satisfied or very satisfied with the process and logistics of Module II [74%; M=2.84] The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item. It is worth noting that the logistics of Module II received the lowest rating with just over half (53.8%) of participants reporting satisfaction.

The pace of the module was just about right.	87.5%	3.03
I felt safe enough to explore all of the multicultural topics in Module II.	80.8%	2.96
The Module II logistics (room, schedule, etc.) were satisfactory.	53.8%	2.35

Applicability to My Job

The vast majority of participants indicated that they felt the information they learned in Module II would be applicable to their job [95%; M=3.16]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

My level of confidence concerning multicultural issues has increased.	96.2%	3.15	I will use the information from Module II in my work.	100.0%	3.31
Module II has helped change my thinking about multicultural issues.	96.2%	3.23	Module II training will help me relate to my clients.	92.6%	3.11
Module II has increased my awareness of my agency's strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	96.3%	3.22	Module II has increased my awareness of my own strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	92.6%	3.11
Module II has increased my confidence in performing consumer case reviews.	92.0%	3.12	Module II has increased my confidence in developing cultural formulations during the treatment planning process.	96.0%	3.12
Module II increased my confidence in discussing diversity issues with my clients.	96.0%	3.12	Module II increased my confidence in discussing diversity issues with my supervisor.	92.3%	3.19

Observations and Suggestions
Participants' comments indicated that:

- The room was uncomfortable (i.e., hot).

- Some people wished the class was longer or had more time to cover more material.

- Side conversations during the class were distracting and suggested the training leader do a better job managing the class.

- Some of the White participants felt uncomfortable due to the instructor's reaction to another participants' comments.

Evaluation: Module III (Wave 1)

Module III -Sensitivity and Responsiveness to Consumers. Participants completed an evaluation form at the completion of the module. Participants identified the extent to which they agreed or disagreed with 28 statements on 4-point Likert-scales, with higher scores (4) indicating a greater satisfaction with the module.

Content Appropriateness

The majority of participants indicated they felt the content of Module III was appropriate or very appropriate [89.5%; M=2.97]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each statement, indicating their perceived adequacy of a topic that was covered or appropriateness of a content area. The discussion of clinical implications received lower satisfaction ratings than other areas.

The discussion on sensitivity and responsiveness was adequate.	100.0%	3.13	The discussion on racism effects on consumers was adequate.	90.0%	2.93
Module III handouts were satisfactory.	86.7%	2.93	The discussion on active engagement to ameliorate effects of racism was adequate.	86.7%	2.90
The discussion on communication styles was adequate.	93.3%	3.10	The discussion on guiding principles for sensitive and responsive mental health practice was adequate.	83.3%	2.83
The discussion on stereotyping was adequate.	90.0%	3.07	The discussion on clinical implications was adequate.	78.6%	2.79
The discussion on racism and mental health was adequate.	93.3%	3.00	Overall, I found the CBMCS Module III to be very effective.	93.3%	3.07

Trainers

Nearly all participants indicated that they felt the trainers, the trainers' styles, and the trainers' skills used in module 3 were very appropriate [96.6%; M=3.26]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The trainers were very knowledgeable.	96.7%	3.37 (.56)
The delivery styles of the trainers were appropriate.	96.7%	3.20 (.48)
The trainers' group management skills were appropriate.	96.6%	3.24 (.51)
The trainers' responsiveness to difficult topics was appropriate.	96.7%	3.30 (.48)
The trainers' organization and preparation was appropriate.	96.7%	3.20 (.48)

Evaluation: Module III Continued...

Process and Logistics

Most participants indicated that they were satisfied or very satisfied with the process and logistics of Module III [81.1%; M=2.97]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The pace of the module was just about right.	70.0%	2.83
I felt safe enough to explore all of the multicultural topics in Module III.	76.7%	2.87
Module III logistics (room, schedule, etc.) were satisfactory.	96.7%	3.20

Applicability to My Job

The vast majority of participants indicated the information in Module III would be applicable to their job [92.2%; M=3.09]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

My level of confidence concerning multicultural issues has increased.	93.3%	3.03	I will use the information from Module III in my work.	96.7%	3.23
Module III has helped change my thinking about multicultural issues.	80.0%	2.93	Module III training will help me relate to my clients.	93.1%	3.17
Module III has increased my awareness of my agency's strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	86.7%	3.07	Module III has increased my awareness of my own strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	90.0%	3.10
Module III has increased my confidence in performing consumer case reviews.	96.6%	3.00	Module III has increased my confidence in developing cultural formulations during the treatment planning process.	93.1%	3.03
Module III increased my confidence in discussing diversity issues with my clients.	96.6%	3.17	Module III increased my confidence in discussing diversity issues with my supervisor.	96.7%	3.17

Observations and Suggestions

Participants' comments indicated that:

- More examples and definitions on specific topics would be helpful.
- Frequent breaks may help with fatigue.
- Trainers should have elaborated more on topics.

Evaluation: Module IV

Module IV-Socio-cultural Diversities. Participants completed an evaluation form at the completion of the module. Participants identified the extent to which they agreed or disagreed with 28 statements on 4-point Likert-scales, with higher scores (4) indicating satisfaction with the module.

Content Appropriateness

The majority of participants indicated they felt the content of Module IV was appropriate or very appropriate [91.4%; M=3.07]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each statement, indicating their perceived adequacy of a topic that was covered or appropriateness of a content area.

The discussion on Knowledge, Awareness, and Sensitivity to Socio-cultural Diversities was adequate.	89.7%	3.10	The discussion on Sexual Orientation Identities was adequate.	90.0%	3.07
The Module IV handouts were satisfactory.	93.1%	3.14	The discussion on Socio-economic Status (SES) was adequate.	93.3%	3.07
The discussion on Socio-cultural Diversities was adequate.	93.3%	3.03	The discussion on Persons with Disabilities was adequate.	96.4%	3.07
The discussion on Older Adults was adequate.	90.0%	3.10	The discussion on Interaction Among Multiple Identities was adequate.	88.5%	2.89
The discussion on Men and Women was adequate.	86.7%	3.00	Overall, I found CBMCS Module IV to be very effective.	93.1%	3.17

Trainers

Nearly all participants indicated that they felt the trainers, the trainers' styles, and the trainers' skills used in module IV were very appropriate [89.3%; M=3.23]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The trainers were very knowledgeable.	96.6%	3.38
The delivery styles of the trainers were appropriate.	90.0%	3.23
The trainers' group management skills were appropriate.	86.2%	3.21
The trainers' responsiveness to difficult topics was appropriate.	86.7%	3.13
The trainers' organization and preparation was appropriate.	86.7%	3.20

Evaluation: Module IV (Wave 1) Continued...

Process and Logistics

Most participants indicated that they were satisfied or very satisfied with the process and logistics of Module 4 [87.7%; M=3.08]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The pace of the module was just about right.	83.3%	2.97
I felt safe enough to explore all of the multicultural topics in Module IV.	86.2%	3.00
The Module IV logistics (room, schedule, etc.) were satisfactory.	93.3%	3.23

Applicability to My Job

The vast majority of participants indicated that they felt the information they learned in Module IV would be applicable to their job [94.1%; M=3.27]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

My level of confidence concerning multicultural issues has increased.	96.7%	3.40	I will use the information from Module IV in my work.	100%	3.43
Module IV has helped change my thinking about multicultural issues.	96.7%	3.27	Module IV training will help me relate to my clients.	92.6%	3.37
Module IV has increased my awareness of my agency's strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	92%	3.32	Module IV has increased my awareness of my own strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	96.2%	3.31
Module IV has increased my confidence in performing consumer case reviews.	92.3%	3.15	Module IV has increased my confidence in developing cultural formulations during the treatment planning process.	92.6%	3.11
Module IV increased my confidence in discussing diversity issues with my clients.	92.6%	3.26	Module IV increased my confidence in discussing diversity issues with my supervisor.	88.9%	3.15

Observations and Suggestions

Participants' comments indicated that:

- Trainers should allow for more time to explore and discuss topics fully.
- Trainers should be given freedom to respond to participants' questions.
- Delivery of some information needs to be fine tuned.

CBMCS Multicultural Training Program Wave 2 Evaluation

Demographic Information (Wave 2)

Out of 15 RCDMH staff completing the cultural competency training in Wave 2, 13 staff (9 female, 4 male) completed measures. Attendees ages ranged from 28 to 58-years-old, with an average age of 44. The majority of respondents were born in the United States (85%). The following graphs further illustrate participants' demographic backgrounds.

Race/Ethnicity
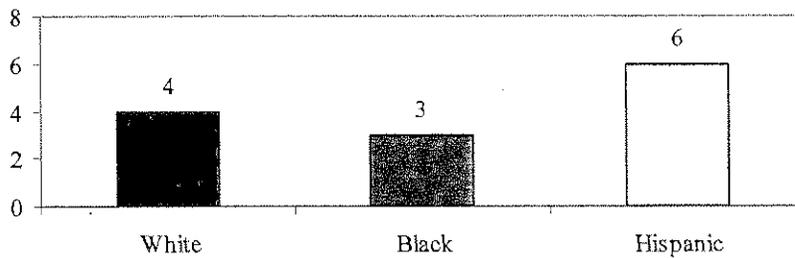
The majority of participants identified themselves as Hispanic (n=6). The smallest proportion of participants identified themselves as Black (n=3).

Highest Degree Obtained	Freq.	%
High School	5	39%
Bachelor's Degree	3	23%
Master's Degree—Social Work	2	15%
Master's Degree—Other	2	15%
Doctorate—Clinical/Counseling	1	5%

Years of Experiences

Foreign Language Skills

No 46%

Yes 54%
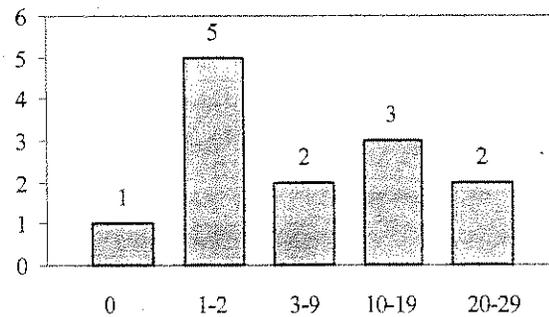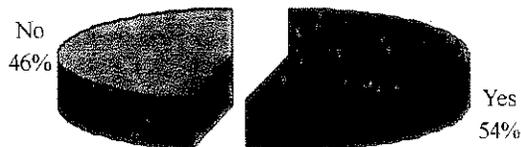
Multicultural Experience		
Coursework	Freq.	%
Yes	7	54%
No	6	46%
Workshops	Freq.	%
Yes	7	54%
No	6	46%

Pre- to Post-Test (CBMCS) (Wave 2)

Similarly to Wave 1, Wave 2 participants completed the CBMCS before and after they completed the Multicultural Training Program. The CBMCS assesses competency on four domains—multicultural knowledge, awareness of cultural barriers, sensitivity and responsiveness to consumers, and socio-cultural diversity. Attendees identified the extent to which they agreed or disagreed with 21 statements on 4-point Likert-scales with higher scores (4) indicating a higher degree of cultural competency. The following three pages illustrate employees' cultural competency before and after completing the training program.

Overall Impact of the Pre-to Post-test Multicultural Training Program

A total of 15 participants completed the CBMCS Multicultural Training Program in Wave 2. However, due to data attrition (i.e., inability to match pre-post test scores or incomplete data) only 13 participants were compared in the pre-post analyses. Overall, the training program was effective in increasing cultural competency among mental health personnel. Results indicate that there was a significant increase in participants' cultural competence as shown in pre-test to post-test scores (t= 4.99, p<.001). Participants reported higher scores on their level of cultural competency upon completion of the training program.

Overall Mean Scores
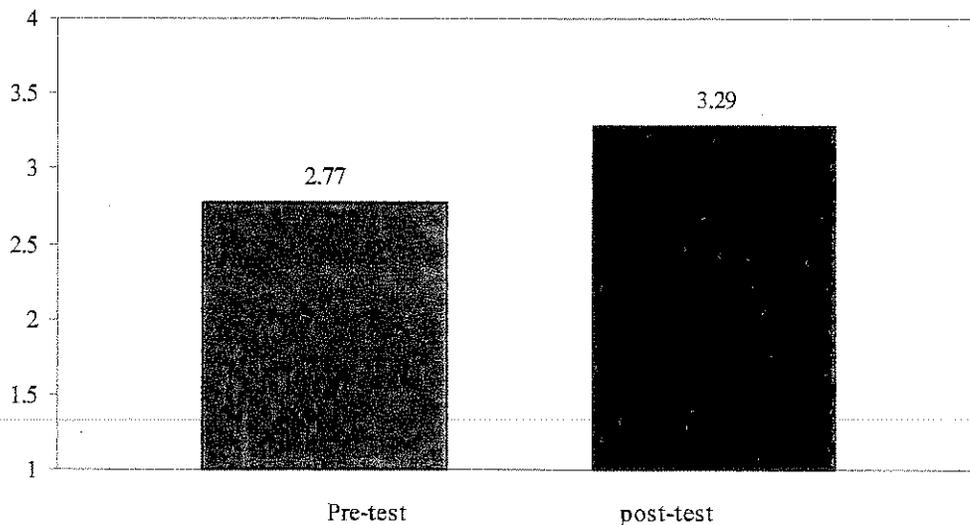
Pre- to Post-Test (CBMCS) (Wave 2) Continued...

Multicultural Knowledge

Participants scored higher on their knowledge of multicultural issues upon completing the training program. This change was statistically significant (t=4.92, p<.001), indicating that there was a considerable increase in participant's multicultural knowledge from pre-test to post-test scores.
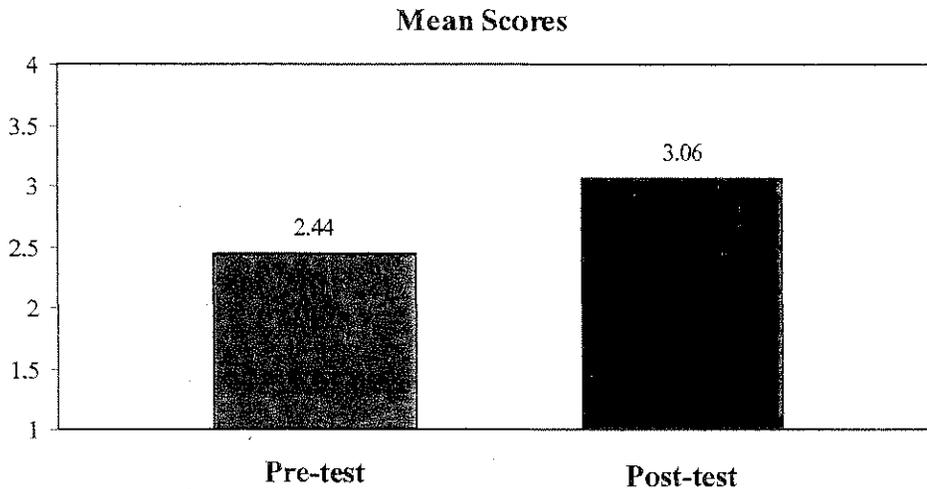
Mean Scores

Awareness of Cultural Barriers

Participants scored higher on questions assessing their awareness of cultural barriers after participating in the four modules. This change in awareness was statistically significant (t=3.998, p<.005), indicating that there was a noteworthy change in participants' awareness of cultural barriers from pre-test to post-test scores.

Mean Scores
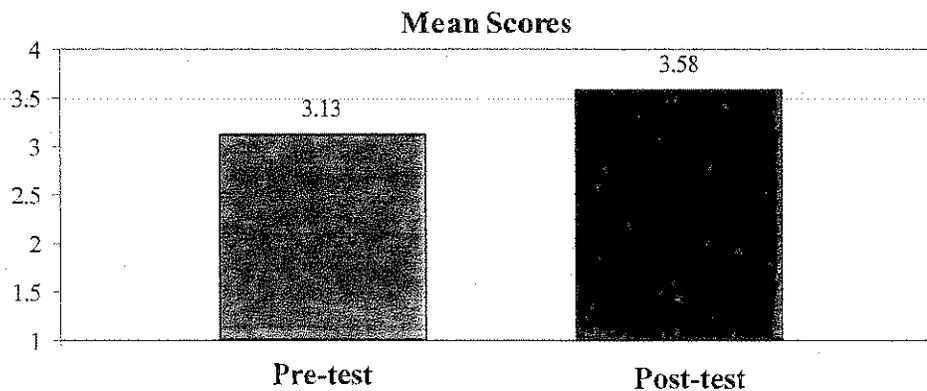
Pre- to Post-Test (CBMCS) (Wave 2) Continued...

Sensitivity and Responsiveness to Consumers

Sensitivity and responsiveness to consumers slightly increased from the beginning to the end of the training program. However, participants pre-scores showed that staff scored high on sensitivity and responsiveness to consumers prior to participating in the training.

Mean Scores
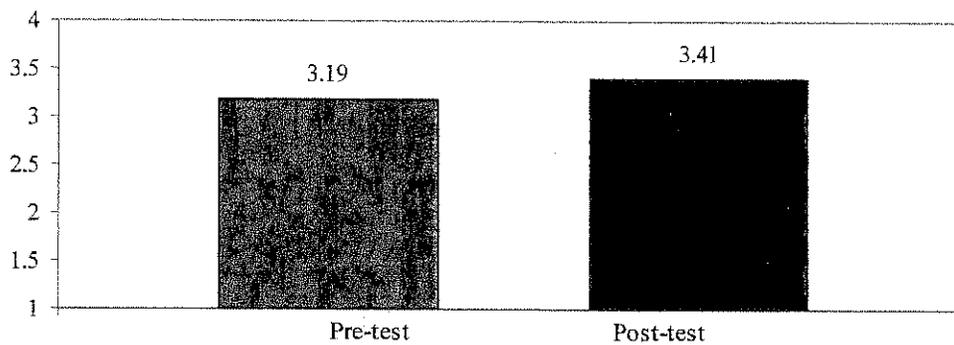
Socio-cultural Diversities

Overall, participants reported higher scores on questions assessing socio-cultural diversity after participating in the training program. This change in socio-cultural diversity was statistically significant (t=5.34, p<.001), indicating a considerable increase in pre-test to post-test scores.

Mean Scores
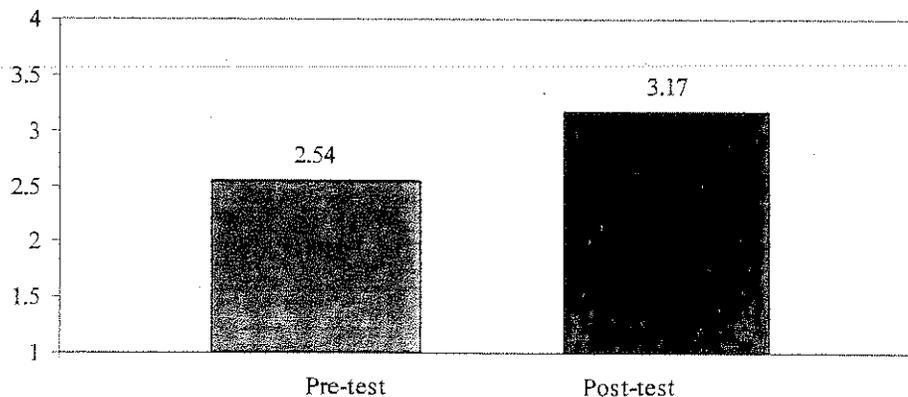
Evaluation: Module I (Wave 2)

Module I - Multicultural Knowledge. Participants completed an evaluation form upon completion of the module. Participants identified the extent to which they agreed or disagreed with 28 statements on 4-point Likert-scales, with higher scores (4) indicating greater satisfaction with the module.

Content Appropriateness

The majority of participants indicated they felt the content of Module I was appropriate or very appropriate [94%; M=3.39]. The following table illustrates the average score and percentage of respondents who felt the content of Module I was appropriate or very appropriate for each item.

Discussion on CBMCS development was adequate.	100%	3.36	Discussion on Recognizing Deficiencies in Research Conducted on Minorities was adequate.	100%	3.64
Module I handouts were satisfactory.	100%	3.43	Discussion on Psychosocial Factors to Consider when Providing Services.	84.6%	3.23
Discussion on Cultural Competence defined was adequate.	100%	3.71	Discussion on Providing Culturally Competent Mental Health Assessment and Diagnosis.	92.3%	3.38
Discussion on the Historic and Contemporary Overview of the 4 major ethnic groups in the U.S.	85.7%	3.21	Discussion on Understanding and Evaluating Wellness Recovery and Resiliency.	92.3%	3.15
Discussion on Health Disparities was adequate.	85.7%	3.21	Overall, I found the CBMCS Module 1 to be effective.	100%	3.69

Trainers

Nearly all participants indicated that they felt the trainers, the trainers' style, and the trainers' skills used in module I were very appropriate [98.3%; M=3.51]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The trainers were very knowledgeable.	100%	3.50
The delivery styles of the trainers were appropriate.	100%	3.50
The trainers' group management skills were appropriate.	100%	3.50
The trainers' responsiveness to difficult topics was appropriate.	100%	3.71
The trainers' organization and preparation was appropriate.	91.7%	3.25

Evaluation: Module I (Wave 2) Continued...

Process and Logistics

Most participants indicated that they were satisfied or very satisfied with the process and logistics of Module I [86.1%; M=3.11]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The pace of the module was just about right.	83.3%	3.00
I felt safe enough to explore all of the multicultural topics in Module I.	83.3%	3.08
The Module I logistics (room, schedule, etc.) were satisfactory.	91.7%	3.25

Applicability to My Job

The vast majority of participants indicated the information in Module I would be applicable to their job [95%; M=3.35 (.39)]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

My level of confidence concerning multicultural issues has increased.	100%	3.18	I will use the information from Module I in my work.	100%	3.55
Module I has helped change my thinking about multicultural issues.	90.9%	3.27	Module I training will help me relate to my clients.	100%	3.55
Module I has increased my awareness of my agency's strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	100%	3.58	Module I has increased my awareness of my own strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	100%	3.58
Module I has increased my confidence in performing consumer case reviews.	91.7%	3.33	Module I has increased my confidence in developing cultural formulations during the treatment planning process.	83.3%	3.33
Module I increased my confidence in discussing diversity issues with my clients.	100%	3.25	Module I increased my confidence in discussing diversity issues with my supervisor.	83.3%	3.00

Observations and Suggestions

Participants' comments indicated that:

- The training had too many presenters and the training was too long.
- The room where the class was held was too cold.
- The session seemed rushed and participants hoped to have more time for discussion.

Evaluation: Module II (Wave 2)

Module II-Awareness of Cultural Barriers. Participants completed an evaluation form at the completion of the module. Participants identified the extent to which they agreed or disagreed with 28 statements on 4-point Likert-scales, with higher scores (4) indicating greater satisfaction with the module.

Content Appropriateness

The majority of participants indicated they felt the content of Module II was appropriate or very appropriate [98.6%; M=3.45]. The following table illustrates the average score and percentage of respondents who agreed or disagreed with each statement, indicating their perceived adequacy of a topic that was covered or appropriateness of a content area.

Trainers

The discussion on Context of Barriers was adequate.	100%	3.53	The discussion on Racism was adequate.	100%	3.60
Module II handouts were satisfactory.	100%	3.60	The discussion on White Privilege was adequate.	93.3%	3.47
The discussion on Awareness of Self was adequate.	100%	3.47	The discussion on Sexism was adequate.	93.3%	3.27
The discussion on Awareness of Others was adequate.	100%	3.47	The discussion on Clinical Implications was adequate.	100%	3.27
The discussion on Worldview was adequate.	100%	3.40	Overall, I found the CBMCS Module II to be very effective.	100%	3.47

All participants indicated that they felt the trainers, the trainers' style, and the trainers' skills used in Module II were very appropriate [100%; M=3.61]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The trainers were very knowledgeable.	100%	3.67
The delivery styles of the trainers were appropriate.	100%	3.60
The trainers' group management skills were appropriate.	100%	3.60
The trainers' responsiveness to difficult topics was appropriate.	100%	3.53
The trainers' organization and preparation was appropriate.	100%	3.67

Evaluation: Module II (Wave 2) Continued...

Process and Logistics

The majority of participants indicated that they were satisfied or very satisfied with the process and logistics of Module II [93.3%; M=3.29] The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The pace of the module was just about right.	93.3%	3.27
I felt safe enough to explore all of the multicultural topics in Module 2.	93.3%	3.27
Module 2 logistics (room, schedule, etc.) were satisfactory.	93.3%	3.33

Applicability to My Job

The vast majority of participants indicated the information in Module II would be applicable to their job [96%; M=3.34 (.40)]. The following table illustrates the average score and percentage of respondents who agreed strongly agreed with each item.

My level of confidence concerning multicultural issues has increased.	100%	3.40	I will use the information from Module II in my work.	100.0%	3.40
Module II has helped change my thinking about multicultural issues.	86.7%	3.20	Module II training will help me relate to my clients.	93.3%	3.40
Module II has increased my awareness of my agency's strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	100%	3.47	Module II has increased my awareness of my own strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	100%	3.47
Module II has increased my confidence in performing consumer case reviews.	93.3%	3.20	Module II has increased my confidence in developing cultural formulations during the treatment planning process.	100%	3.33
Module II increased my confidence in discussing diversity issues with my clients.	100%	3.27	Module II increased my confidence in discussing diversity issues with my supervisor.	86.7%	3.27

Observations and Suggestions

Participants' comments indicated that:

- The room was cold.

- Participants hoped to have more time to cover more details, (skits were ambiguous).

- Learned materials should have greater applicability to clinical settings.

- Some of the White participants felt uncomfortable due the instructor's reaction to another participants' comments.

Evaluation: Module III (Wave 2)

Module III-Sensitivity and Responsiveness to Consumers. Attendees completed an evaluation form at the completion of the module. Participants identified the extent to which they agreed or disagreed with 28 statements on 4-point Likert-scales, with higher scores (4) indicating a greater satisfaction with the module.

Content Appropriateness

The majority of participants indicated they felt the content of Module III was appropriate or very appropriate [100%; M=3.57]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each statement, indicating their perceived adequacy of a topic that was covered or appropriateness of a content area.

The discussion on Sensitivity and Responsiveness defined was adequate.	100.%	3.54	The discussion on Racism Effects on Consumers was adequate.	100%	3.50
The Module III handouts were satisfactory.	100%	3.50	The discussion on Active Engagement to Ameliorate Effects of Racism was adequate.	100%	3.57
The discussion on communication Styles was adequate.	100%	3.64	The discussion on Guiding Principles for Sensitive and Responsive Mental Health Practice was adequate.	100%	3.57
The discussion on Stereotyping was adequate.	100%	3.71	The discussion on Clinical Implications was adequate.	100%	3.57
The discussion on Racism and Mental Health was adequate.	100%	3.43	Overall, I found CBMCS Module 3 to be very effective.	100%	3.62

Trainers

Nearly all participants indicated that they felt the trainers, the trainers' styles, and the trainers' skills used in module 3 were very appropriate [98.6%; M=3.60]. The following table illustrates the average and percentage of respondents who agreed or strongly agreed with each item.

The trainers were very knowledgeable.	100%	3.64
The delivery styles of the trainers were appropriate.	100%	3.64
The trainers' group management skills were appropriate.	100%	3.57
The trainers' responsiveness to difficult topics was appropriate.	100%	3.64
The trainers' organization and preparation was appropriate.	92.9%	3.50

Evaluation: Module III (Wave 2) Continued...

Process and Logistics

Most participants indicated that they were satisfied or very satisfied with the process and logistics of Module III [96.6%; M=3.55]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The pace of the module was just about right.	100%	3.50
I felt safe enough to explore all of the multicultural topics in Module 3.	92.9%	3.50
Module 3 logistics (room, schedule, etc.) were satisfactory.	100%	3.64

Applicability to My Job

The vast majority of participants indicated the information in Module 3 would be applicable to their job [98.6%; M=3.52]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

My level of confidence concerning multicultural issues has increased.	100%	3.36	I will use the information from Module 3 in my work.	100%	3.50
Module 3 has helped change my thinking about multicultural issues.	92.9%	3.36	Module 3 training will help me relate to my clients.	100%	3.50
Module 3 has increased my awareness of my agency's strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	100%	3.69	Module 3 has increased my awareness of my own strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	100%	3.64
Module 3 has increased my confidence in performing consumer case reviews.	100%	3.57	Module 3 has increased my confidence in developing cultural formulations during the treatment planning process.	92.9%	3.50
Module 3 increased my confidence in discussing diversity issues with my clients.	100%	3.57	Module 3 increased my confidence in discussing diversity issues with my supervisor.	100%	3.57

Observations and Suggestions

Participants' comments indicated that:

- Participants felt the workshop went very well and that it flowed better than before.
- One participant felt they needed more time to discuss clinical issues.
- One participant did not feel the role-play was very helpful.

Evaluation: Module IV (Wave 2)

Module IV of the CBMCS Multicultural Competence Training Program covered the Socio-cultural Diversities domain. Participants completed an evaluation form of Module IV at the completion of the module. Participants identified the extent to which they agreed or disagreed with 28 statements on 4-point Likert-scales, with higher scores (4) indicating increased satisfaction with the module.

Content Appropriateness

The majority of participants indicated they felt the content of Module 4 was appropriate or very appropriate [98.5%; M=3.65]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each statement, indicating their perceived adequacy of a topic that was covered or appropriateness of a content area.

The discussion on Knowledge, Awareness, and Sensitivity to Socio-cultural Diversities was adequate.	100%	3.62	The discussion on Sexual Orientation identities was adequate.	100%	3.77
The Module IV handouts were satisfactory.	100%	3.85	The discussion on Socio-economic Status (SES) was adequate.	100%	3.70
The discussion on Socio-cultural Diversities was adequate.	100%	3.77	The discussion on Persons with Disabilities was adequate.	92.3%	3.39
The discussion on Older Adults was adequate.	100%	3.69	The discussion on Interaction Among Multiple Identities was adequate.	92.3%	3.46
The discussion on Men and Women was adequate.	100%	3.54	Overall, I found the CBMCS Module 4 to be very effective.	100%	3.77

Trainers

Many participants indicated that they felt the trainers, the trainers' styles, and the trainers' skills used in module 4 were very appropriate [80%; M=3.80]. The following table

The trainers were very knowledgeable.	84.6%	3.85)
The delivery styles of the trainers were appropriate.	76.9%	3.77
The trainers' group management skills were appropriate.	76.9%	3.77
The trainers' responsiveness to difficult topics was appropriate.	84.6%	3.85
The trainers' organization and preparation was appropriate.	76.9%	3.77

illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

Evaluation: Module IV (Wave 2) Continued...

Process and Logistics

Most participants indicated that they were satisfied or very satisfied with the process and logistics of Module IV [97.2%; M=3.61]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

The pace of the module was just about right.	100%	3.67
I felt safe enough to explore all of the multicultural topics in Module 4.	100%	3.75
Module 4 logistics (room, schedule, etc.) were satisfactory.	91.7%	3.42

Applicability to My Job

The majority of participants indicated that they felt the information they learned in Module IV would be applicable to their job [100%; M=3.77]. The following table illustrates the average score and percentage of respondents who agreed or strongly agreed with each item.

My level of confidence concerning multicultural issues has increased.	100%	3.83	I will use the information from Module 4 in my work.	100%	3.92
Module IV has helped change my thinking about multicultural issues.	100%	3.92	Module IV training will help me relate to my clients.	100%	3.83
Module IV has increased my awareness of my agency's strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	100%	3.58	Module IV has increased my awareness of my own strengths and weaknesses concerning service delivery issues facing diverse consumer populations.	100%	3.67
Module IV has increased my confidence in performing consumer case reviews.	100%	3.75	Module IV has increased my confidence in developing cultural formulations during the treatment planning process.	100%	3.67
Module IV increased my confidence in discussing diversity issues with my clients.	100%	3.75	Module IV increased my confidence in discussing diversity issues with my supervisor.	100%	3.75

Observations and Suggestions

Participants' comments indicated that:

- Participants felt a consumer perspective was helpful.
- One participant felt that more thought should be given to bringing this experiential level to the other modules.
- One participant suggested rewording some of the evaluation questions.

Conclusions

In conclusion, the CBMCS Multicultural Training Program was quite effective in improving the cultural competency of RCDMH staff. That is, results suggest that the training program had a positive impact by increasing the overall level of participant's self-perceived cultural competency.

For RCDMH, the results are promising and are congruent with the results of other counties who have implemented this training program. Specifically, across four other California counties, results indicate that the CBMCS pre-post self-report multicultural competence score improved significantly on three modules (i.e., Multicultural Knowledge, Awareness of Cultural Barriers and Socio-cultural Diversities) and found no change on Module III (Sensitivity and Responsiveness to Consumers). The CBMCS 21-item scale has been used in the past to identify those who need training. Pilot test results from other studies suggest that those who are in most need be "targeted" for training (i.e., those who score relatively low on a given CBMCS subscale measure).

ATTACHMENT #33

Excellent	53
Good	13
Fair	1
Poor	0

1. The best part of this course was:

Knowledge and experience of the instructor.

The information was useful, logical, moved through an appropriate pace.

The discussions.

Core content very relevant and materials were user friendly. Hearing about Melissa's personal experience and lessons learned.

Learn the core components.

Breaking into groups and discussing.

Handouts, examples, and discussion topics.

Text and handout. Presenters were knowledgeable.

Putting to use the skills learned. The guide.

Training materials provided.

Sharing of in-the-field experiences by instructor and attendees

Manual/handouts.

Provided logical and practical information.

The presenter and their extensive experience.

Instruction

Book and CD.

The stories and examples of disasters. What many people have heard about.

both speakers engaged the group and had a lot of knowledge.

Personal experiences of trainers and involvement with disasters - Katrina, etc.

Interactions and discussions.

The opener where PFA was discussed. This helped me understand what the training was all about.

Interactions

Group participation.

The book "Psychological First Aid" and information provided.

Experience of the providers.

Present's knowledge and activities/examples during real events.

The discussion - real life experiences and examples. Scenarios

Class interaction.

Facts and application of the material that was presented.

Use of personal experiences of the trainers.

Concrete structure of concepts.

It was all good.

The PFA book is a great resource to have with others.

Exercises, videos, discussions - variety of examples.

The live examples. Presenter's knowledge of examples. Anecdotes

Handouts, PowerPoint - very valuable information set.

Manual, handouts, and examples.

The book and handouts for future use. Thanks!

The exercises implemented in between lecture time.

Having field guide resource to take.

Group exercises.

The instructor injecting her own experiences with disasters to better help us understand.

Group activity, but one too many. It was trying.

PFA field guide. Dr. Brymer, Excellent

Practical strategies, real experiences.

Using CBT and recovery models so that PFA is similar and related to other
MH Dept. initiatives.

2. I believe this training could be improved by:
Keep up the good work.
Videos
Spanish materials provided at workshop. Include special considerations specific
to Riverside Co. and surrounding communities/counties.
It was great, very informative and engaging.
No suggestions - enjoyed training very much.
Adding a monkey.
Not so long.
Make it a 2-day event.
Make sure those participating have a mike so that everyone can hear them.
The training was too long, need to add more movement. Being that we just sat and
listened, it was easier to dose off.
Increase heat, better use of microphone.
Faster pace.
All audience speakers should have a mike.
More examples specific about cultural differences. Assessment of cultural issues.
More life examples to show concepts and processes.
More video
examples.
Using more videos and group activities.
Would like the Spanish version of the handouts.
More videos with role modeling.
Longer exercises and group discussions.
Spanish version of handouts, need less breakouts in afternoon due to audience fatigue.
Examples in handouts/more examples would help (concrete).
Making it shorter.
Caryll says "you know" a lot. Curbing this may improve flow of lecture.
Longer more in
depth.
Longer
Sometimes too cold, could not hear. Need to have all use the microphone.

3. Other courses I would attend if offered for continuing education hours:
Educational workshop on what the County Psych. ER Response plan is, and how all
agencies work together as well as learning about agencies in charge and their
policies/procedures. Preparatory information and planning sessions.
Child/Elder abuse, dependent adults abuse, domestic violence, law & ethics, HIV/Aids.
Always interested in courses offered through the county.
Dealing with borderline personality d/o.
Treating Anxiety d/o.
More PFA training. Would like to be able to have many other staff attend this
training in case of future critical events where the Dept. may need to send providers
to such incidents.
More on pandemics.
Crisis counseling.
Dealing with death and dying.
Working with self-mutilation (cutting)
Substance abuse, victimization, culture diversity, DSM IV
Treating PTSD as a co morbid dx with other diagnosis that meet medical necessity.
Self-injury behaviors, working effectively with toddlers (0-5)
Delusional disorders.
DSM Diagnostics, drug/alcohol information.

ATTACHMENT #34

Recovery Management Workshop (RM062810)

Monday, June 28, 2010
9:00 a.m. to 4:30 p.m.
(Registration is 8:30 a.m. to 9:00 a.m.)

Center for Government Excellence
Room 13
1111 Spruce Street
Riverside, CA 92507
(nearest cross street – Iowa)

This is an ADA compliant Facility – if you require accommodation, please contact Tina Cho at (951) 358-5389 fourteen days prior to the workshop.

Illness Management Recovery (IMR) is one of the six SAMHSA evidenced based programs. RCDMH will reference this program as Recovery Management (RM).

What is the Recovery Management Program?
- Weekly sessions where practitioners help consumers develop personal strategies for coping with mental illness and moving forward in their lives
- Generally lasts between eight to twelve months
- Individual or group format

How is it different from what we already offer?
- It is a manualized treatment that is structured and step-by-step within 10 topic areas
- It is backed by substantial research
- Provides a learning opportunity for practitioners as much as for consumers
- Encourages mutual responsibility for treatment between consumer and staff
- Encourages the involvement of family and other supporters into treatment
- Keeps a focus on longer-term goals in addition to daily demands

Skills that practitioners will begin to learn through this workshop:
- Person Centered Goal Setting
- Using the Stages of Change
- Motivational Skills
- Educational Skills
- CBT Skills
- Engaging and Orienting consumers into RM
- Working with consumers Natural Supports
- Using a manualized treatment approach
- Using a Strength Based treatment approach

The goal is for the identified staff to be able to offer the RM practice to consumers in ways that will reach good fidelity scores after 12 months of practice. For a program to have the capacity to offer RM services to more than 20% of it's severely mentally ill consumers after 12 months of implementation. This course will be useful to mental health professionals with extensive work experience.

Audience: Mental Health service providers working in the outpatient setting

Course Objectives

Participants will be able to:

1. Describe two ways to use RM materials in working with consumers on their recovery goals
2. Describe at least two specific strategies to effectively engage consumers to attempt RM
3. Identify at least three basic CBT techniques taught to RM practitioners
4. Describe three specific ways that RM is different from current practices at your program
5. List at least five of the ten general topic areas covered in RM
6. Describe how the concept of "Stages of Change" is a key to assessing consumer motivation
7. Identify the three components of the "Stress Vulnerability Model"

Speakers

Michele Hughes, MFT Intern, Indio Mental Health Clinic

Eyrn Parks, Ph.D., Temecula Mental Health Clinic

Sheree Summers, MFT Intern, University and School Liaison

Course Outline

9:00 – 9:15 a.m.	Introduction • What to expect
9:15 – 10:00 a.m.	Overview of recovery concepts • Understanding recovery • Core beliefs in recovery • Effective treatment exists • I am the evidence
10:00 – 10:45 a.m.	Understanding Recovery Management • Definition • Core values • Evidenced-based strategies • Population
10:45 – 11:00 a.m.	Break
11:00 – 12:00 p.m.	• 8 key strategies for practice • 10 topics covered

12:00 – 12:30 p.m.
- RM introduction video clip

12:30 – 1:30 p.m.   Lunch

) – 2:45 p.m.   Implementing Recovery Management
- Materials
- Engagement strategies
- RM video clip
- Orientation
- Structure of sessions

2:45 – 3:00 p.m.   Break

3:00 – 4:15 p.m.
- Doing RM in groups
- Assignments
- RM video clip
- Monitoring the practice

4:15 – 4:30 p.m.   Conclusion
- Questions
- Evaluations

This course meets the qualification for (6.0) hours a day of continuing education (CE) credit for:

LMFT's and LCSW's as required by the California Board of Behavioral Sciences PCE 3777.

The continuing education credit is being provided through Riverside County Department of Mental Health, Workforce
ucation and Training (WET), P.O. Box 7549, Riverside, California 92513.

REGISTRATION: You are required to pre-register **immediately** if you wish to attend this training. The training registration
forms and fees should be received by Wednesday, June 16, 2010. All participants to FAX their completed registration forms
to Jennifer Lantry, Registrar at (951) 358-4723. Please submit your CE credit fee to RCDMH Revenue Unit, Anthony Aguilar.
This workshop is by invitation only.

REGISTRATION CONFIRMATION: You will receive an email or a phone message (if no email) confirming your registration.
Confirmation will not be provided until the registration form and CE payment is received. No confirmation means that space
is not guaranteed.

FEES FOR CONTINUING EDUCATION CREDITS: Continuing education credit is $20.00 for LCSW's and LMFT's.

CE registrations and/or payment received after June 16, 2010 or at the door will result in a late fee of $5.00.

**Please make checks payable to RCDMH and write in memo space on check (RM062810), your check is your
receipt. Please submit to Anthony Aguilar, RCDMH Revenue Unit, Stop #3800 or P.O. Box 7549, Riverside, CA
92513.**

REFUND/CANCELATION POLICY: A refund for the CE credit fee will only be granted if notification is made in writing by
June 16, 2010. Any cancellations made between the registration deadline and 24 hours of the workshop date will receive CE
fee credit towards future CE workshop. Credit must be applied by June 27, 2011. Cancellations within 24 hours of the
workshop date will not receive a refund or future fee credit. No refunds or future CE fee credit will be given to "NO SHOWS."
Tardiness and early departure is not acceptable for continuing education credit.

NO PARTIAL CREDITS

ATTACHMENT #35

JULY 1, 2008 – JUNE 30, 2009   MHSA   REPORT
Parent Support & Training Program

Current Staff In The Parent Support Program

1 Lead Parent Partner , 3 Parent Partner provide assistance, supports to clinicians and families including orientation for parents/caregivers entering the system. 1 Volunteer Services Coordinator coordinates special projects, donated goods, provides outreach, targets culturally diverse populations trains and mentors volunteers, and is bilingual. 1 Parent Partner hired part/time to answer and return calls from the non-crisis Parent to Parent Telephone Support Line (hired under TAP) to provide parent to parent support, information and resources.

Number of unique contacts by type:	Phone	Face to Face
Parent/Caregiver	480	1483
Community	153	320
Youth	0	26
Staff	97	114

Activities/Trainings:

Educate Equip and Support Trainings

Completed   **Total   71**
EES 4/9/0/-7/2/08 Banning   7 Graduated
EES 4/17/08-7/10/08 Riverside 7 Graduated
EES 4/22/08-7/9/08 San Jacinto 7 Graduated
EES 5/14/08-8/6/08 Corona 4   Graduated
EES 7/24/08-10/8/08 Corona – Spanish 6 Graduated
EES 9/10/08-11/26/08 Riverside 9 Graduated
EES 10/2/08-01/15/09 Blythe   10 Graduated
EES 9/22/08-12/8/08 Perris   8 Graduated
EES 2/19/09-5/7/09 Riverside   12 Graduated
EES 4/9/09-6/25/09 Indio   1 Graduated

Focus Groups

Prevention and Early Intervention Focus Groups
20 Focus Groups Facilitated for Parents (15 English 5 Spanish)
3 Focus Groups Facilitated for Staff

Conferences
Fiesta Educativa   02/21/2009   (sponsored 10 parents)
CHMACY   5/13-5/15/2009   (brought 3 parents)

Presentations
NAMI Temecula 3/18/2009 25 Attendees
Western Child Care Consortium 6/17/2009 12 Attendees
Moms Group Riv. Substance Abuse 2/11/2009 20 Attendees
Temecula Parent Group 4/29/2009 10 parents (Spanish speaking)
Rob Reiner Parent Group 2/27/2009 6 parents (Spanish speaking)
Children Treatment Services Parent Group 4/26/2009 4 parents (Spanish speaking)
UNITY Corona Meeting 3/26/2009   35 Attendees
Moreno Valley Collaborative Meeting 5/1/2009   7 Attendees
Parent Partner Program Review in the Desert
1/09/2009   12 Mental Health Staff

Trainings facilitated by staff

"A Workshop for Parents of Special Education Students"
Community Advisory Committee
Lakeside High School   2/28/2009   90 Attendees
Desert Sands Unified School District   4/25/2009   65 Attendees

Parents and Teachers as Allies
Rancho Verde High School VVUSD   10/22/2008   125 School Staff
Riverside County Office of Education 12/05/2008   40 School Staff
Manuel L. Real Elementary VVUSD   01/21/2009   31 School Staff

I.E.P. Workshops
Indio   7/19/2008   4 Attendees
Murrieta 8/16/2008   12 Attendees
Moreno Valley 9/3/2008   11 Attendees

Cultural Competence: World View Exercise
5/22/2009   17 Parents

Facilitators' Booster Training for EES
7/31/2008   10 Attendees (parent partners)

Support Group Facilitator Training
8/8/2008   6 Attended   Riverside (parent partners)
2/17/2009   20 Attended Banning (parent partners)

4th Annual Family Partnership Summit
10/8/2008   120 Attendees

Outreach Events:

- Annual Cesar Chavez Day, Art & Resources Fair- Saturday, April 4, 2009 300 outreach (50)
- Black History Parade, February 14, 2009 150 outreach (50)
- 3rd Annual Community Settlement Health Fair April 30, 2009 100 outreach (35)
- Jurupa Valley Teen Fair, Riverside County Dept. of Health- April 18, 2009 88 outreach (22)
- Health Fair Commission for Women April 14, 2009 200 outreach (50)
- Very Special Art Fair 4/16/2009 500 outreach (15)
- Mothers' & Daughters' Wellness Symposium May 9, 2009 outreach 200 (50)
- Deaf & Hard of Hearing 5/09/2009 outreach 100 (20)
- Kids' Health & Safety Fair 5/09/2009 outreach 300 (24)
- Family Service Association Children Conference - Cal Baptist- May 21, 2009 200 outreach (50)
- 9th Annual Mental Health Open House, May 19, 2009 - 200 outreach (25)
- City of Riverside Neighborhood Conference, May 31, 2008, Cal. Baptist- 413 outreach (50)
- Fiesta Educativa   2/21/2009 outreach 200 (25)
- Families For Success 6/1/2009 100 outreach (15)
- 9th Annual Juneteenth Celebration 6/6/2009 300 outreach (35)
- 4th Annual Healthy Heritage 7/26/2008 outreach 150 (50)
- Path of Life   8/22/2008   500 (50)
- Rob Reiner Health Fair   8/13/2008 200 (25)
- Riverside Pride Festival   9/13/2008 350 (35)
- Arlanza Fair   9/20/2008   200 (40)
- Recovery Happens Fair   9/20/2008   250 (50)
- Perris Health Fair   9/12/2008   300 (25)
- Murrieta Health Fair   9/13/2008   75 (22)
- Breast Cancer Walk Corona   9/27/2008 550 (50)
- Grandparents Raising Grandchildren 10/16/2008 250 (30)
- NAMI Walk 10/25/2008 outreach 250 (22)
- Cal Stat Positive Behavior Intervention 11/13/2008 outreach 280 (3)

Support Groups

- Open Doors Riverside
- Open Doors Corona
- Open Doors Riverside – Spanish
- Open Doors San Jacinto
- Open Doors Blythe
- Open Doors Corona – Spanish (not currently meeting)
- Open Doors Grandparents Raising Grandchildren Riverside
- Families Supporting Families - Co-Facilitating Case Management Support Group

Committees/Boards Community

- Mid-County Child Care Consortium
- Mid-County Mental Health Board
- UACF
- Celebration Committee
- U.N.I.T.Y.
- DOVIA
- RCCV
- Western Child Care Consortium

Committees/Boards RCDMH

- May is Mental Health Month
- Cultural Competency Committee
- Spirituality Committee
- Translation & Interpretation Committee

Contracts that are Monitored

Mentorship Program:
84 youth were referred to the Mentorship Program. 8 of these youth have successfully completed the Program. 43 youth have been in the Mentoring Program at any given time during the last fiscal year. The mentors are mixed with both life experience and education. One of the mentors' is an adult that has been a prior consumer through the childrens' clinic. He has a lot of success in working with the youth that he is assigned, and clinicians' ask for him by name on the Mentor Referral.

Respite Program:
52 children have been referred to the Respite Program this year through the Full Service Partnership Programs. 22 children have been receiving services through the last year. We are anticipating with the growth in the Full Service Partnership Programs this year being able to service more children in this next fiscal year.

Special Project/Events

- Quarterly Newsletter is being developed for parents.
- Logo for Parent Support & Training Program was developed and approved.
- 150 Volunteers have been utilized this last year with outreach events and donation projects.
- Back to School Backpack Project 750 Backpacks distributed to youth at our clinics'.
- Thanksgiving Food Basket Project 130 Food Baskets were distributed to families.
- Holiday Snowman Banner Project 1400 Snowflake Gifts were distributed to youth at our clinics'.
- Holiday Boutique December 3 & 4, 2008
- Mothers' Day Boutique May 6 & 7, 2009

- There is a monthly Parent Partner Meeting that all 24 County-Wide Parent Partner (Mental Health Peer Specialists) attend. Of the 24 Parent Partners' 10 are bi-lingual. We meet the 3rd Tuesday of the month at the Banning Mental Health Clinic. The meeting generally consists of a round table of what is going on in each clinic, and training. Trainings that are beneficial to the Parent Partner's such as: Billing/Zipping by: Maureen Dopson, The Key to Success for any Parent by: Amalia Starr, and Presentations by County and Contracted Programs.

A Parent Partner curriculum is currently being developed for all newly hired and existing parent partners. A META curriculum is under review.

ATTACHMENT #36

RIVERSIDE COUNTY, DEPARTMENT OF MENTAL HEALTH
STIPEND STUDENTS
2009-2010

NAME	DEGREE	SCHOOL	ETHNICITY	LANGUAGE (other than English)	Family-Member Lived Experience	Consumer Lived Experience	Notes
Allen, Shareela	MSW	CSUSB	African-American	None	No	No	Actively interviewing with RCDMH
Carlson, Deborah	MFT	LLU	Caucasian	American Sign	Yes	Yes	
Corona, Nayeli	MSW	CSUSB	Hispanic	Spanish	No	No	Accepted position with county Wraparound Program
Crane, Susan	MSW	CSUSB					
Enriquez, Annjudel	MFT	LLU					
Henderson, Larann	MSW	CSUSB	Caucasian	None	No	No	Actively interviewing with RCDMH
Hollimon, Dimietri	MFT	LLU	African-American	None	Yes	No	
Kelley, Michelle	MSW	CSUSB					
Li, Beryl	MSW	LLU	Chinese	Mandarin Cantonese	Yes	No	
Llamas, Lilliana	MSW	CSUSB	Hispanic	Spanish	No	No	Accepted position with county Wraparound Program
Natsume, Art	MSW	CSUSB	Japanese	None	No	Yes	
Norton, Hannah	MSW	CSUSB	Caucasian	None	No	Yes	
Sanchez, Elizabeth	MSW	LLU					
Smith, Federick	MSW	CSUSB	African-American	None	Yes	No	

All students that were contacted have/are applying for employment with Riverside County Department of Mental Health.

ATTACHMENT #37

Interpretation Service Available

English Translation:
Point to your language. An interpreter will be called.
The interpreter is provided at no cost to you.

Arabic عربي 👉 أشر إلى لغتك. وسوف يتم جلب مترجم فوري لك. سيتم تأمين المترجم المذاور مجاناً.	**Korean** 한국어 👉 귀하께서 사용하는 언어를 지적하시면 해당 언어 통역 서비스를 무료로 제공해 드립니다.
Armenian Հայերէն 👉 Ցոյց տուէք ո՞ր մէկ լեզուն կը խօսիք. Թարգմանիչ մը կանչել կը տանք. Թարգմանիչը կը տրամադրուի անվճար.	**Laotian** ພາສາລາວ 👉 ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້. ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້ ທ່ານບໍ່ຕ້ອງເສັຍເງິນຄ່າແປໃຫ້ແກ່ນາຍແປພາສາ.
Cantonese 廣東話 👉 請指認您的語言， 以便為您提供免費的傳譯服務。	**Mandarin** 國語 👉 請指認您的語言， 以便為您提供免費的口譯服務。
French Français 👉 Pointez vers votre langue et on appellera un interprète qui vous sera fourni gratuitement.	**Polish** Polski 👉 Proszę wskazać swój język i wezwiemy tłumacza. Tłumacza zapewnimy bezpłatnie.
German Deutsch 👉 Zeigen Sie auf Ihre Sprache. Ein Dolmetscher wird gerufen. Der Dolmetscher ist für Sie kostenlos.	**Portuguese** Português 👉 Indique o seu idioma. Um intérprete será chamado. A interpretação é fornecida sem qualquer custo para você.
Hindi हिंदी 👉 अपनी भाषा पर इंगित करें और एक दुभाषिया बुलाया जाएगा। दुभाषिये का प्रबन्ध आप पर बिना किसी खर्च के किया जाता है।	**Russian** Русский 👉 Укажите язык, на котором вы говорите. Вам вызовут переводчика. Услуги переводчика предоставляются бесплатно.
Hmong Hmoob 👉 Taw rau koj hom lus. Yuav hu rau ib tug neeg txhais lus. Yuav muaj neeg txhais lus yam uas koj tsis tau them dab tsi.	**Spanish** Español 👉 Señale su idioma y llamaremos a un intérprete. El servicio es gratuito.
Italian Italiano 👉 Puntare sulla propria lingua. Un interprete sarà chiamato. Il servizio è gratuito.	**Tagalog** Tagalog 👉 Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.
Japanese 日本語 👉 あなたの話す言語を指して下さい。 無料で通訳を提供します。	**Thai** ไทย 👉 ช่วยชี้ที่ภาษาที่ท่านพูด แล้วเราจะจัดหาล่ามให้ท่าน การใช้ล่ามไม่ต้องเสียค่าใช้จ่าย
Khmer (Cambodian) ខ្មែរ (កម្ពុជា) 👉 សូមចង្អុលភាសាខ្មែរ ។ យើងនឹងហៅអ្នកបកប្រែភាសាខ្មែរជូន ។ អ្នកបកប្រែភាសានឹងជួយអ្នកដោយមិនគិតថ្លៃ ។	**Vietnamese** Tiếng Việt 👉 Hãy chỉ vào ngôn ngữ của quý vị. Một thông dịch viên sẽ được gọi đến, quý vị sẽ không phải trả tiền cho thông dịch viên.

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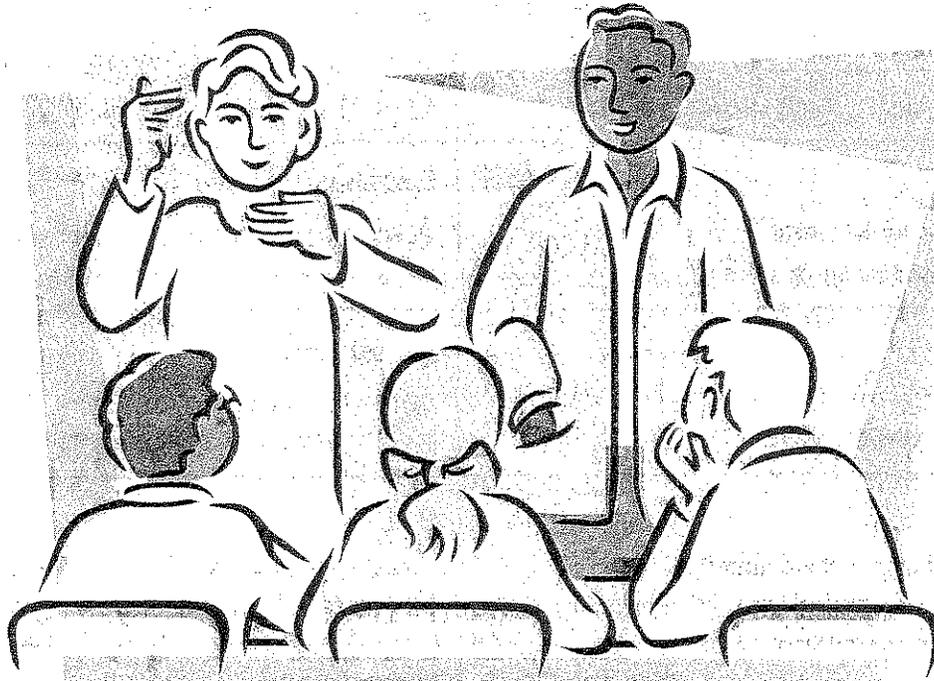
INTERPRETATION SERVICES
AVAILABLE AT NO COST TO YOU !

¡SERVICIOS DE INTERPRETACIÓN
GRATUITOS!

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH

Jerry A. Wengerd, Director

Reply to: Mental Health Administration
P.O. Box 7549
Riverside, CA 92513

DATE: June 16, 2010

TO: Program Managers and Supervisors

FROM: Cultural Competency Office

RE: Interpreting Services

Effective October 1, 2009 the Department has a new interpreting services contract with Interpreters Unlimited. The services that are provided by Interpreters Unlimited are face to face interpreting and telephone interpreting services for all languages other than sign language.

I. Telephone Interpreting:

You will not need any special equipment to use your telephone interpreters, just a regular speaker phone call.

To obtain a phone interpreter, you dial 800/726-9891 and provide the Mental Health Department's Customer I.D. 9306 and your program's specific user I.D. Attached is the list of specific program I. D. numbers.

II. Face to Face Interpreting:

To request a face to face interpretation service you need to do the following:

1. Complete an "Interpreter Request Form (see attachment) and get the approval of supervisor.
2. Contact Interpreters Unlimited at 877/652-6482 and let them know what you are requesting. Currently, the contact person is Ana Aguilar Rubio (Ext. 119).
3. Fax your request to:
   a.   Interpreters Unlimited
   b.   Materiel Management

4. Interpreters Unlimited will contact you with confirmation.
5. Make sure you get confirmation at least three days prior to the service requested.

III. Sign Language Interpretation

Please note that Interpreters Unlimited will no longer provide sign language interpreters.

To Request for Sign Language Interpreter:

There are two contracts in place specifically for sign language interpreting. These are the vendors that do only sign language:

Dayle McIntosh Interpreting
714/620-8341 (Carrie, Lilly, Michelle)

Life Signs
951/275-5035

1. Call one of the sign language interpreting companies listed and let the person you speak to know that you want to request a sign language interpreter, give the information as far as the:

   a. Date and time of function/event
   b. Name of function/event and address

2. Fill out the Interpreter Appointment Request Form
3. Fax it to the interpreting company
4. Fax Request Form also to Material Management, Attention: Cynthia Murcio
5. Interpreting company should get back by fax with a confirmation and will include name of the person being assigned.

Call Interpreting Company a few days before to make sure that an interpreter was assigned to you.

ATTACHMENT #39

Providing Interpretation Services

Myriam Y. Aragón, LMFT
Cultural competency/ Ethnic Service Manager
Riverside County Department of Mental Health

Introductions

- Expectations: What do you expect to learn from this training?
- Conocimiento Exercise
  - Your name
  - Your program
  - Language and number of year providing interpretation services or providing services via interpreters.
  - Share one of your experience in providing interpretation services or receiving interpretation services.

What are the Basic Qualifications of a Mental Health Interpreter

- The "Basic" qualifications of a Mental Health Interpreter are:
  - Language Proficiency in Both languages (English and the language you are interpreting).
  - Knowledge of mental health terminology.
  - Interpretation skills.
  - Aware of legal and ethical issues related to interpretation.

The Art of Interpretation

Interpretation: Transmission of **Oral** communication from on language to another.

Simultaneous Interpretations: As one party speaks, the interpreter is interpreting to the other (two people are always taking at once).

Consecutive Interpretation: The interpreter waits until one party finishes and then interprets to the other (only one person speaks at a time).

The Law

- Title VI of civil Rights Act of 1964: Medical facilities receiving federal funds must provide equal services to all people, even if they do not speak English.
- Presidential Executive Order August 200: federally funded programs must serve people with limited English Proficiency (LEP).
- CLAS Standards publish 2001: "Culturally and Linguistically Appropriate Services"

Title VI

Civil Right Act of 1964 with respect to the enforcement of the responsibilities of recipients of Federal financial assistance form health and Human Services to person with Limited-English Proficiency (LEP) (Review of Guidance Memorandum).

Bilingual Fluency

- The Interpreter must be fluent in two languages, with one of them English. The interpreter should be able to speak, understand, and write both languages fluently.

Exercise I

Culture and Language Definitely Matter when Assessing Mental Health

- We tend to see the world through our own cultural filters.
- Culture patterns of thing, feelings, and behaviors in both obvious and subtle ways.
- Culture plays a major role in determining: what we eat, how we work, how we relate, how we celebrate holidays, how we feel about life, death and illness.
- How we respond to illness.

Language

- Language use is affected by:
  - Regional variations
  - Social Class
  - Education
  - Migration
  - Multiculturalism

Language

- During Crisis a Limited English or bilingual individual will most often revert to their primary language where emotions and feelings are embedded. Some emotions are not subject to translation.

Ethical Dilemmas

- **Neutrality:** the interpreter needs to remain neutral and should not screen the client's comments or messages for fear of offending the provider, or because it may reflect poorly on the consumer.
- **Limits of expertise:** interpreter must ask for clarification immediately if she/he does not understand either the provider or the consumer.

The Therapeutic Triad

- The interpreter must be skilled in facilitating communication between the consumer and the provider without becoming a barrier to building a treatment relationship.
- The provider must be skilled in conducting his intervention by using interpreters to facilitate the process of interpretation

Provider ←—→ Consumer

The Therapeutic Relationship

- The Provider and the consumer need to address each other directly. It is recommended to face each other.
- The interpreter needs to use the same form of speech as the speaker (first person).

Exercise 3

Interpreter ←—→ Consumer

- Inform the client that the interpreter's function is to guarantee the right of the consumer to consult with the provider in a direct manner as possible.
- Do not talk about the consumer in their presence. If you need clarification form the provider, explain to the consumer what you will be doing.

Interpreters Competencies

- Must be familiar with the mental health setting and the mental health system.
- Must be familiar with the vocabulary specific to mental health services.
- Must be familiar with the terminology of the interpretation, or with slight translation.

The Interpretation in Mental Health

- Interpreter should be familiar with the terminology in both English and the non-English language, such as:
  - Diagnosis and symptoms
  - Medications and side effects
  - Terminology used on the different forms that a consumer is required to complete and/or sign.
  - Need to ask the provider to describe the concept in different words.

Interpreter Style

- **Simultaneous Interpreting:** it means the interpreter follows just a few words behind the speaker. Both the interpreter and the speaker are speaking at the same time.
- It is recommended when the client is not able to speak in short sentences and cannot stop to the interpreter time to translate.

Interpreter Style

- **Relay Interpreting:** The technique used when it is the only way to communicate with the client. It is used when the client speaks a language with no bilingual staff is found. In this case two interpreters are needed.

Consumer Speak Portuguese

Interpreter 1 translates Portuguese to Spanish

Interpreter 2 translates Spanish to English

Designation of Bilingual Positions
Guidelines

To establish positions as eligible for one of the bilingual levels, the department must designate a position as eligible for bilingual pay at either level 1, 2, or 3 *. The department must verify that the position requires the use of a second language at least five times per week or once per day. Testing is required for all levels and designation occurs only once approved by the Department and Human Resources.

The authorization for bilingual compensation is tied to the individual's position. Therefore, any changes in employee position, including transfer to other programs, will result in the loss of bilingual pay and a new designation form would be required.

Bilingual Levels	Example of Activities
Level 1: Basic oral communication such that employees performs bilingual interpretation(oral) and/ or provide services in a second language as part of their job function and regular duties at least five times per week or once per day.	• Provide services in the bilingual language designated for the position. (For example, Bilingual Spanish employee providing services in Spanish to a Monolingual Spanish Consumer.) • Provide interpretation services in the bilingual language designated for the position. (Staff providing interpretation service is required to receive training on providing interpretation services). • Services in the designated language need to be provided at least five times per week. i.e. Phone calls, conversations with consumers, family members and other providers, interpretation services.

Level 2: Basic oral and written communication: Employees at this level perform bilingual interpretation as described in level 1 as well as do written translations. These are provided as part of their job function and regular duties at least five times per week or once per day.	• Provide interpretation as described in Level 1 • Complete first translation prior to sending a document to the translation committee. • Communicate in written form with monolingual consumers. • Assist monolingual consumers in filling out forms in both English and another language.
Level 3: Complex written and/or oral Medical Legal Interpretation: Employees at this level perform complex verbal and written translations. Employees at this level perform complex verbal interpretation (simultaneous interpretation for a group of people) and written translations of documents and other written information by participating in the translation committee.	• Provide legal and medical interpretation or translation before an officially convened court, appeals board, and commission or hearing body in addition to their regular duties assigned to a position designated as requiring bilingual skills. • Performs level 1 and level 2 activities

* Bilingual Levels 1, 2, 3 applies only to Spanish speaking bilingual staff.

Note: It is a goal of the Department of Mental Health, as part of the Cultural Competency Plan, to have a minimum of 50% bilingual staff in each job classification within each clinic, and more if clinic needs require it.

Culturally and Linguistic Appropriate Services (CLAS)
Issued by the Office of Minority Health

Standard 1.
Health care organizations should ensure that patients/consumers receive from all staff members' effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2.
Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3.
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4.
Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5.
Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6.
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7.
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8.
Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, and operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9.
Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes based evaluations.

Standard 10.
Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11.
Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12.
Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13.
Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14.
Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

ATTACHMENT #40

TRANSLATIONS FY 2009-2010

NAME OF DOC	LANGUAGE
"AB-1424" Brochure	English/Spanish
"My Family Member Has Been Arrested"	English/Spanish
"We've Been There, We Can Help"	English/Spanish
CapFac Feedback Form (PEI Community Survey)- "MHSA- Prevención e intervención temprana encuenta para la comunidad"	English/Spanish
Community Forum Write In Sheet - "Foro comunitario y recomendaciones para la intervencion y prevencion temprana"	English/Spanish
Consent Form - "Departamento de salud mental del condado de riverside consentimiento para el uso de medicamentos psiquiátricos"	English/Spanish
Consiguendo que sus necesidades - "Padres y encargados de niños ¡Necesitamos sy ayuda!"	English/Spanish
FAP Western Region Cover Letter	English/Spanish
Guide to Services	English/Spanish
IEP Assessment - "Evaluacion de Salud Mental"	English/Spanish
Dept. of MH Calworks/Gain Division Letter - "Departamento de salud mental calworks/Gain Division 2009"	English/Spanish
Manejo de enfermedad y recuperacion - "Informacion Educativo - El uso de drogas y alcohol"	English/Spanish
Manejo de enfermedad y recuperacion - "Informacion Educativo - Reduciendo recaidas"	English/Spanish
May is MH month flyer 2009	English/Spanish
MHSA - "Cansado (a) de que no le escuchen? Nosotros le estamos escuchando!"	English/Spanish
Multidimentional Family Therapy- "Equipo de Terapia Familiar Multidimensional"	English/Spanish
Parent Orientation to Wraparound - "Orientación para padres del proceso wraparound"	English/Spanish
Peer Specialist Flyer	English/Spanish
PEI Executive Summary	English/Spanish
PEI Flow Chart - " Prevencion e intervention temprana"	English/Spanish
PEI RFP Training Flyer- "Oportunidad!"	English/Spanish
PET Flyer	English/Spanish
Phone Message in Spanish After Hours	English/Spanish
Sign -In Sheet PEI Focus Group - "Prevención e intervención temprana (Hoya de Registro del grupo de enfoque)"	English/Spanish
Statement of Operating Beliefs and Principals - "Departamento de salud mental del condado de riverside declaracion de creencias operativas y principios"	English/Spanish
Summit Evaluation Form - "¡Entreque este formulario pra recibir sus boletos para la rifa!"	English/Spanish
Support Group Information - "Grupos de apoyo en el condado de Riverside E Información adicional"	English/Spanish
The Impact of Childhood Disability - "El impacto de las imcapacidades de la niñez"	English/Spanish
Trama Tool - "Identificación de la lista de síntomas de un trauma"	English/Spanish
May is Mental Health Month Map- " El Med de Mayo se Dedica a la Salud mental Celebracion Annual"	English/Spanish
"I am a Survivor of Domestic Violence"- Spanish Version	English/Spanish

"Ask us about Peer Support" -Spanish Version	English/Spanish
"What is Peer Support"	English/Spanish
"What is WRAP?"	English/Spanish

ATTACHMENT #41

Riverside County Department of Mental Health
Performance Outcomes Quality Improvement (POQI) Report
May 2009 Data Collection Period
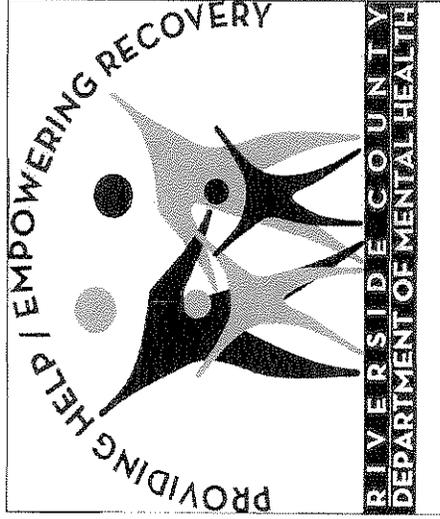
PROVIDING HELP / EMPOWERING RECOVERY

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH

The California Department of Mental Health requires each county to survey consumers of mental health services for a two-week period during the months of May and November to monitor the effectiveness of mental health services. Youth, their parent/caregiver(s), adults, and older adults who receive face to face mental health services from county operated clinics are asked to complete a survey. Surveys are provided in English and Spanish, and are available in additional languages .

This report provides a summary of the Riverside County Department of Mental Health POQI data collected between May 1 and May 12, 2009. The report is divided into four primary sections: the results for youth and parent/caregivers of youth receiving services, adult results, and older adults results. All reported findings are based solely on data provided by respondents who chose a valid response.

RCDMH Research & Evaluation

Youth Satisfaction Across Domains

Percent of respondents who agreed or strongly agreed they were satisfied with services.

Domains

General Satisfaction with Services
"Overall, I am satisfied with the services I received."

Satisfaction with Social Connectedness
"I know people who will listen and understand me when I need to talk."

Satisfaction with Functioning
"I am better able to do the things I want to do."

Overall Satisfaction with Outcomes of Services
"I am better at handling daily life"

Satisfaction with Treatment Planning
"I helped to choose my treatment goals."

Satisfaction with Staff Cultural Sensitivity
"Staff was sensitive to my cultural/ethnic background."

Satisfaction with Access to Services
"The location of services was convenient for me."

Note: Each domain listed above is comprised of several items. Items shown are a representative sample.

Bar chart (Domains vs. percentage):
- General Satisfaction – 78%
- Social Connectedness – 81.9%
- Functioning – 74.3%
- Outcomes – 71%
- Participation in Treatment Planning – 69.8%
- Cultural Sensitivity – 84.1%
- Access to Services – 78%

(Axis: 0% 20% 40% 60% 80% 100%)

Youth Demographics:

Gender
- Male - 64.9%
- Female - 34.3%
- Other gendered - 0.8%

Race
- Hispanic/Latino - 48%
- White - 21.1%
- Black - 7.9%
- Asian - 1%
- Native American - <1%
- Pacific Islander - 0%
- Other race - 2.3%
- Unknown - 15.8%
- Multiracial - 3.3%

Age
- 13 yrs - 11.9%
- 14 yrs - 15.5%
- 15 yrs - 23.1%
- 16 yrs - 23.1%
- 17 yrs - 26.4%

Length in Service
- One visit - 4.9%
- More than one visit, but less than one month - 8.2%
- 1 to 2 months - 14.2%
- 3 to 5 months - 25.5%
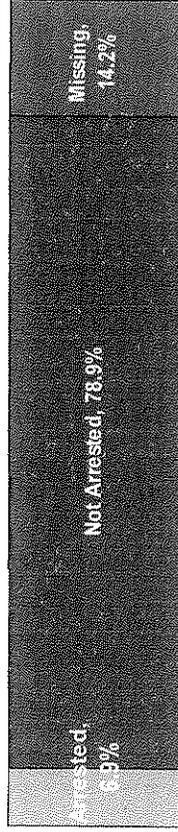- 6 months to 1 year - 25.1%
- More than 1 year - 22.1%

Language
Services provided in language you prefer ?
- Yes 97%
- No   3%

Written information available to you in a language you prefer?
- Yes 96%
- No   4%

Arrests & Encounters with Police

In addition to satisfaction the youth survey includes questions on arrests and encounters with police for youth with less than one year of services and youth with more than one year of service.

Encounters with Police Since Services Began:
Less than One Year of Mental Health Services

N = 208

- Been Reduced, 27.9%
- Stayed the Same, 12.0%
- Increased, 2.4%
- Not Applicable, 42.3%
- Missing, 15.4%

Encounters with Police in the Last 12 Months:
More than One Year of Mental Health Services

N = 52

- Been Reduced, 16.9%
- Stayed the Same, 15.3%
- Not Applicable, 55.9%
- Missing, 11.9%

Arrests Since Services Began:
Youth with Less than One Year of Mental Health Services
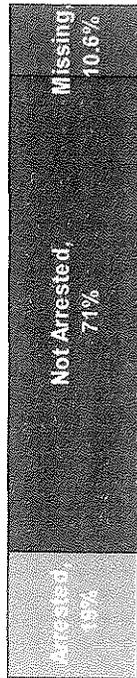
N = 208

- Not Arrested, 71%
- Missing, 10.6%
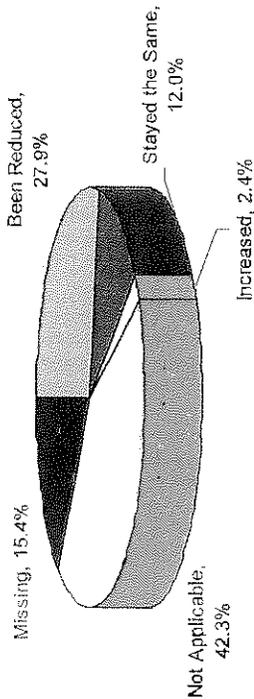
Arrests in the Last 12 Months:
Youth with More than One Year of Mental Health Services

N = 59
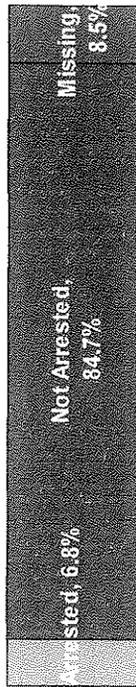
- Not Arrested, 84.7%
- Missing, 8.5%
- Arrested, 6.8%
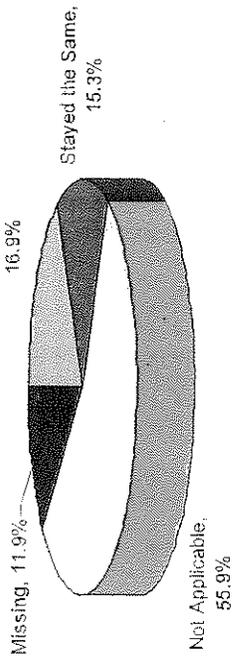
School Expulsions/Suspensions & School Attendance

Data on school suspensions and expulsions and changes in school attendance are also part of the survey.

Estimated Number of Days in School Since Services Began:
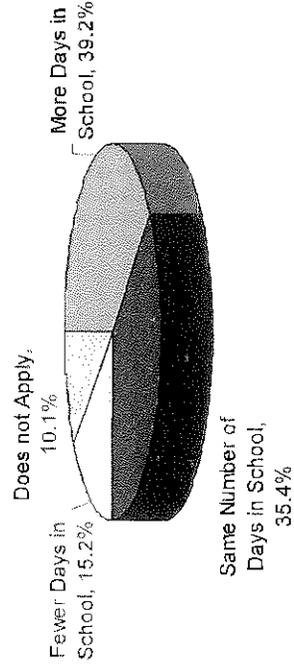### Less than One Year of Mental Health Services

N = 117

- Does not Apply 15%
- More Days in School 37%
- Same Number of Days in School 37%
- Fewer Days in School 11%

Estimated Number of Days in School in the Last 12 Months:
More than One Year of Mental Health Services

N = 50

- Does not Apply, 22.0%
- More Days in School, 28.0%
- Same Number of Days in School, 40.0%
- Fewer Days in School, 10.0%
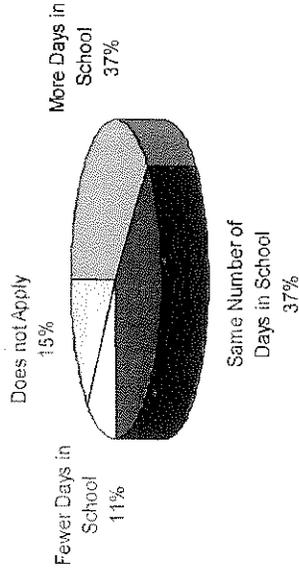
School Expulsions or Suspensions Since Services Began:
Less than One Year of Mental Health Services

N = 143

- Not Suspended or Expelled, 78.7%
- Suspended or Expelled, 21.3%
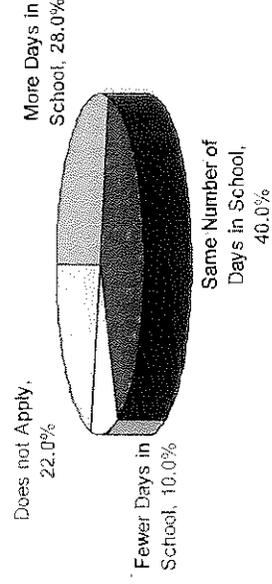
School Expulsions or Suspensions in the Last 12 Months:
More than One Year of Mental Health Services

N = 53

- Neither Suspended nor Expelled, 75.5%
- Suspended or Expelled, 24.5%

Parent/Caregiver Satisfaction

Domains

Percent of respondents who agreed or strongly agreed they were satisfied with services.

Domain	Percent
General Satisfaction	88.3%
Access to Services	87.8%
Cultural Sensitivity	97.4%
Participation in Treatment Planning	91.6%
Outcomes of Services	64.4%
Functioning	67.7%
Social Connectedness	89.1%

General Satisfaction with Services
"Overall, I am satisfied with the services my children received."

Satisfaction with Youth Access to Services
"Services were available at times that were convenient for us."

Satisfaction with Cultural Sensitivity
"Staff members treated me with respect."

Satisfaction with Participation in Treatment Planning
"I helped to choose my children's services."

Satisfaction with Outcomes of Services for Youth
"My child is better at handling daily life."

Satisfaction with Youth Functioning
"My child is better able to do things he or she wants to do."

Parents/Caregivers Satisfaction with Their Own Social Connectedness
"In a crisis I would have the support I need from family or friends."

Note: Each domain listed above is comprised of several items. Items shown are a representative sample.

Youth Demographics as Reported by Parents/Caregivers:

Gender
- Male - 70.6%
- Female - 29.4%

Race
- Hispanic/Latino - **49.7%**
- White - 25.3%
- Black - 9.5%
- Asian - 0.5%
- Native American - 1.2%
- Pacific Islander - 0%
- Multi-racial - 4.6%
- Other race - 1.6%
- Unknown - 7.7%

Age
- > 5 - 11.3%
- 5 to 8 - 14.6%
- 9 to 12 - 24.4%
- 13 to 14 - 15.5%
- **15 to 17 - 34.3%**

Length in Service
- One visit - 5.0%
- More than one visit, but less than one month - 8.3%
- 1 to 2 months - 14.3%
- 3 to 5 months - 22.4%
- 6 months to 1 year - 22.6%
- **More than one year - 27.4%**

Language
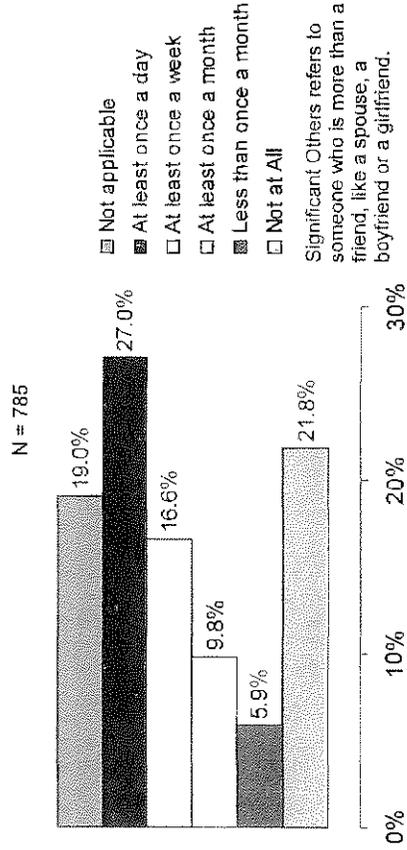
Services provided in language you prefer?
- Yes 98.5%
- No 1.5%

Written information available to you in a language you prefer?
- Yes 97.7%
- No 2.3%

Arrests & Encounters with Police

Parents/caregivers were also surveyed about their youth's arrests and their youth's encounters with police.

Their Youth's Encounters with Police Since Services Began:
Less than One Year of Mental Health Services

N = 289

- Been Reduced 16%
- Stayed the Same 6%
- Increased 2%
- Not Applicable 50%
- Missing 26%

Their Youth's Encounters with Police in the Last 12 Months:
More than One Year of Mental Health Services

N = 109

- Been Reduced, 11.0%
- Stayed the Same, 5.5%
- Increased, 3.7%
- Not Applicable, 56.0%
- Missing, 23.9%

Youth's Arrests Since Services Began:
Less than One Year of Mental Health Services

N = 289

- Not Arrested, 78.9%
- Missing, 14.2%
- Arrested, 6.9%

Youth's Arrests Since Services Began:
More than One Year of Mental Health Services

N = 109

- Not Arrested, 79.8%
- Missing, 11.0%
- Arrested, 9.2%

Data on suspensions and expulsions and changes in school attendance are also part of the survey.

Estimated Number of Days in School Since Services Began:
Less than One Year of Mental Health Services

N = 205

More Days in
School, 27.8%

Same Number of
Days in School,
36.6%

Fewer Days in
School, 7.8%

Does not Apply,
27.8%

Estimated Number of Days in School in the Last 12 Months:
More than One Year of Mental Health Services

N = 79

More Days in
School, 39.2%

Same Number of
Days in School,
35.4%

Does not Apply,
10.1%

Fewer Days in
School, 15.2%

School Expulsions or Suspensions:
Less than One Year of Mental Health Services

N = 241

Suspended or
Expelled,
15.4%

Neither
Suspended
nor Expelled,
84.6%

School Expulsions or Suspensions:
More than One Year of Mental Health Services

N = 88

Suspended
or Expelled,
39.8%

Neither
Suspended
nor Expelled,
60.2%

Adult Satisfaction with Services

Percent of respondents who agreed or strongly agreed they were satisfied with services.

Domains	
General Satisfaction	86.9%
Access to Services	82.7%
Quality & Appropriateness	89.5%
Participation in Treatment Planning	78.0%
Outcomes	71.1%
Functioning	65.5%
Social Connectedness	65.4%

(chart axis: 0% 20% 40% 60% 80% 100%)

General Satisfaction with Services
"If I had other choices, I would still get services at this agency"

Satisfaction with Access to Services
"Staff were willing to see me as often as I felt was necessary"

Satisfaction with Quality & Appropriateness of Services
"Staff here believe I can grow, change, and recover"

Satisfaction with Participation in Treatment Planning
"I, not staff, decided my treatment goals"

Satisfaction with Outcomes of Services
"I am better able to control my life"

Satisfaction with Functioning
"My symptoms are not bothering me as much"

Satisfaction with Their Own Social Connectedness
"I feel I belong in my community"

Note: Each domain listed above is comprised of several items. Items shown are a representative sample

Adult Demographics:

Gender
- Male - 49.8%
- Female - 49.9%
- Other Gendered - >1%

Race
- Hispanic/Latino - 27.3%
- White - 45.2%
- Black - 9.8%
- Asian - 0.9%
- Native American - 0.6%
- Pacific Islander - 0.5%
- Multi-racial - 4.6%
- Other race - 2.7%
- Unknown - 8.4%

Age
- 18 to 25 - 18.3%
- 26 to 35 - 23.3%
- 36 to 45 - 25.4%
- 46 to 59 - 33%

Length in Service
- First visit - 3.4%
- More than one visit, but less than one month - 3.6%
- 1 to 2 months - 5.4%
- 3 to 5 months - 11.5%
- 6 months to 1 year - 22.9%
- More than 1 year - 53.2%

Language
Services provided in language you prefer?
- Yes 97.3%
- No 2.7%
Written information available to you in a language you prefer?
- Yes 97.2%
- No 2.8%

quality of life

Average Quality of Life Ratings
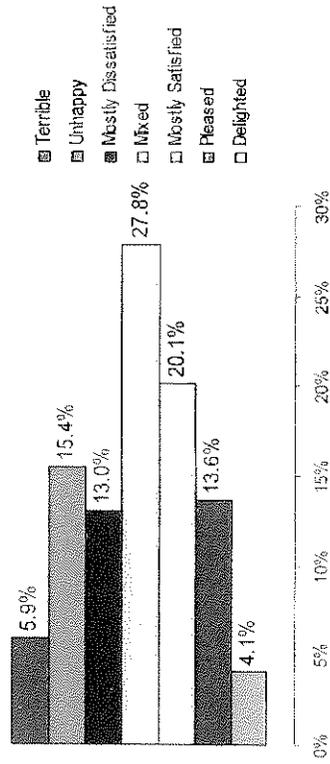Averages on a 1 - 7 Scale where "Terrible" = 1 and "Delighted" = 7
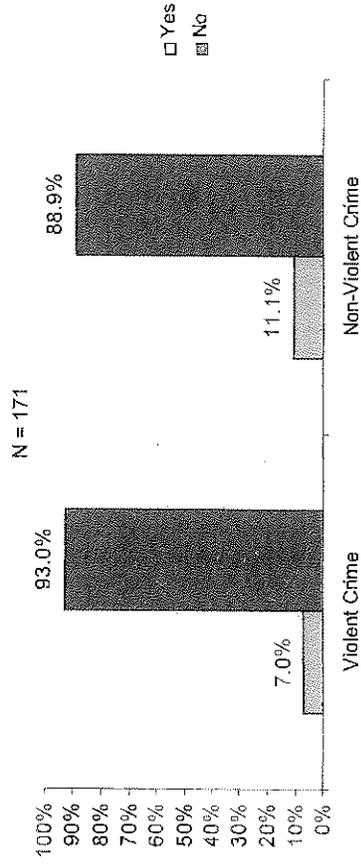An overall mean of 5 = mostly satisfied
An overall mean of 4 = mixed feelings   N = 823

Living Situation: 5
Daily Activities & Functioning: 5
Relationship to Family Members: 5
Social Relations: 5
Personal Safety: 5
Health: 4

Quality of Life: Frequency of Family Visits
N = 783

- 3.8%
- 32.3%
- 22.2%
- 18.1%
- 11.4%
- 12.1%

Legend:
- No Family/NA
- At least once a day
- At least once a week
- At least once a month
- Less than once a month
- Not at All
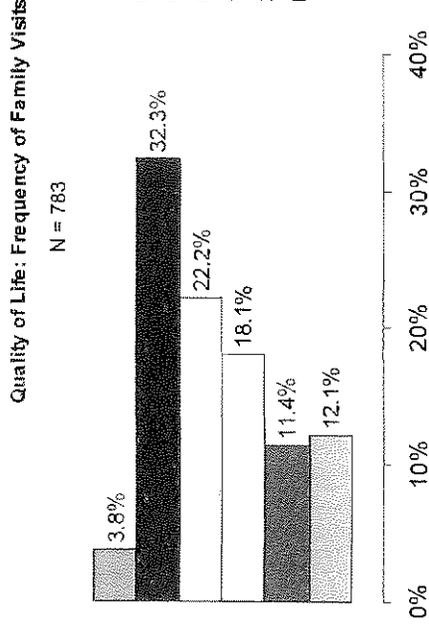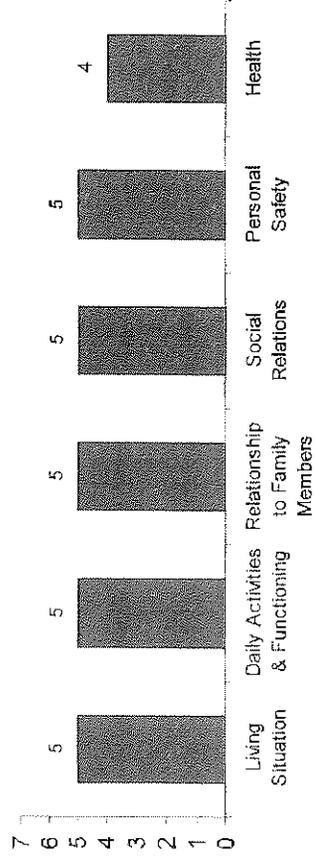
Quality of Life: Spend Time with Significant Others
N = 785

- 19.0%
- 27.0%
- 16.6%
- 9.8%
- 5.9%
- 21.8%

Legend:
- Not applicable
- At least once a day
- At least once a week
- At least once a month
- Less than once a month
- Not at All

Significant Others refers to someone who is more than a friend, like a spouse, a boyfriend or a girlfriend.

Quality of Life: Frequency of Visits with People Outside the Immediate Family
N = 800

- 3.5%
- 17.1%
- 33.4%
- 21.9%
- 9.0%
- 15.1%

Legend:
- Not applicable
- At least once a day
- At least once a week
- At least once a month
- Less than once a month
- Not at All
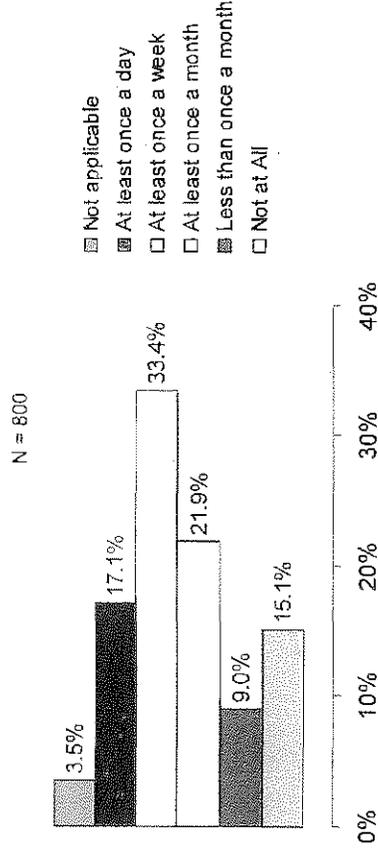
Arrests and Encounters with Police

Adults were also surveyed on their arrests and their encounters with police.

Encounters with Police Since Services Began:
Less than One Year of Mental Health Services

N = 373

Been Reduced, 19.8%
Stayed the Same, 10.5%
Increased, 4.0%
Not Applicable, 49.1%
Missing, 16.6%

Encounters with Police in the Last 12 Months:
More than One Year of Mental Health Services

N = 425

Missing, 7.1%
Been Reduced, 16.0%
Stayed the Same, 8.9%
Increased, 2.6%
Not Applicable, 65.4%

Arrests Since Services Began:
Less than One Year of Mental Health Services

N = 373
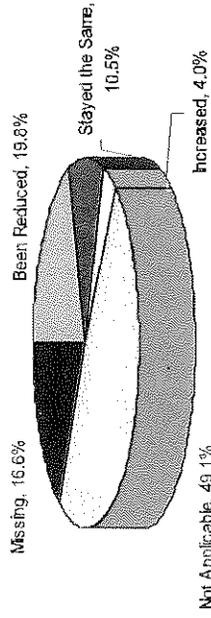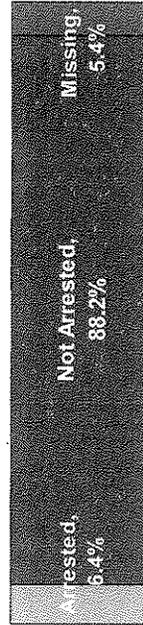
Not Arrested, 75.3%
Missing, 15.0%
Arrested, N/a

☐ Arrested
▣ Not Arrested
☐ Missing

Arrests in the Last 12 Months:
More than One Year of Mental Health Services

N = 425

Not Arrested, 88.2%
Missing, 5.4%
Arrested, 6.4%

☐ Arrested
▣ Not Arrested
☐ Missing
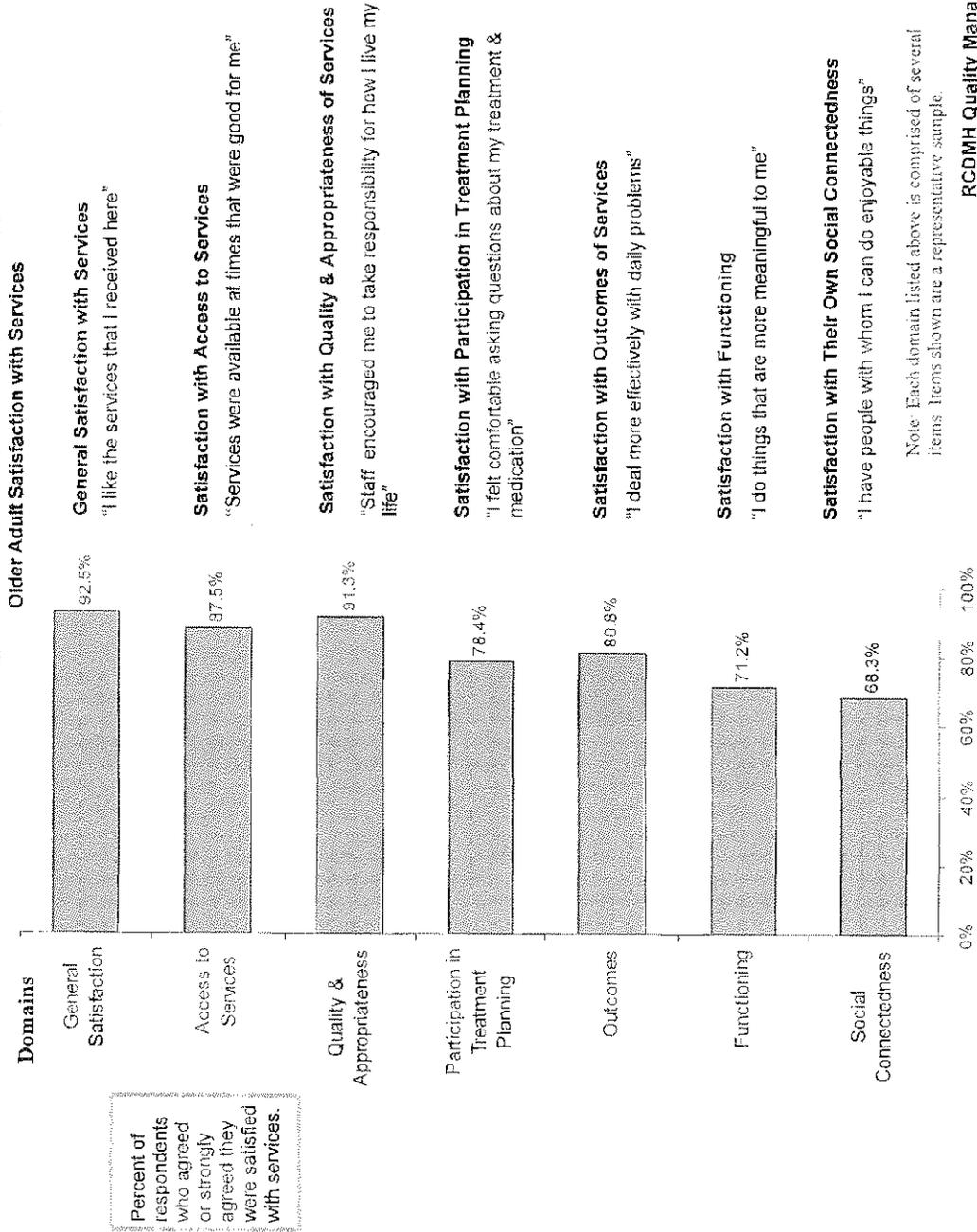
Older Adult Demographics:

Gender
- Male - 34.1%
- **Female - 65.9%**

Race
- Hispanic/Latino - 23.2%
- **White - 55.8%**
- Black - 6.6%
- Native American - 0.6%
- Multi-racial - 2.2%
- Other race - 4.4%
- Asian - 1.1%
- Unknown - 6.1%

Age
- **60 to 69 - 83.9%**
- 70 to 79 - 14.4%
- 80 to 89 - 1.7%

Length in Service
- First visit - 1.9%
- More than one visit, but less than one month - 3.7%
- 1 to 2 months - 9.3%
- 3 to 5 months - 9.9%
- 6 months to 1 year - 16.7%
- **More than 1 year - 58.6%**

Language

Services provided in language you prefer?
- Yes 98.1%
- No   1.9%

Written information available to you in a language you prefer?
- Yes 98.1%
- No   1.9%

Older Adult Satisfaction with Services

General Satisfaction with Services
"I like the services that I received here"

Satisfaction with Access to Services
"Services were available at times that were good for me"

Satisfaction with Quality & Appropriateness of Services
"Staff encouraged me to take responsibility for how I live my life"

Satisfaction with Participation in Treatment Planning
"I felt comfortable asking questions about my treatment & medication"

Satisfaction with Outcomes of Services
"I deal more effectively with daily problems"

Satisfaction with Functioning
"I do things that are more meaningful to me"

Satisfaction with Their Own Social Connectedness
"I have people with whom I can do enjoyable things"

Note: Each domain listed above is comprised of several items. Items shown are a representative sample.

Percent of respondents who agreed or strongly agreed they were satisfied with services.

Domains

- General Satisfaction — 92.5%
- Access to Services — 97.5%
- Quality & Appropriateness — 91.3%
- Participation in Treatment Planning — 78.4%
- Outcomes — 80.8%
- Functioning — 71.2%
- Social Connectedness — 68.3%

0%   20%   40%   60%   80%   100%

Quality of Life Indicators

Average Quality of Life Ratings
N = 172

Avearages on a 1-7 Scale where "Terrible"=1 and De,ighted =7
An overall Mean of 5 =mostly staisfied
An Overall Mean of 4=mixed feelings

Living Situation: 5
Daily Activities & Functioning: 4
Relationship to Family Members: 5
Social Relations: 5
Personal Safety: 5
Health: 4

Quality of Life: Feelings About Health in General
N = 169

- Terrible
- Unhappy
- Mostly Dissatisfied
- Mixed
- Mostly Satisfied
- Pleased
- Delighted

5.9% 15.4% 13.0% 27.8% 20.1% 13.6% 4.1%

Quality of Life Indicators

Quality of Life: Victim of Violent or Non - Violent (Property) Crime
N = 171

Legend:
- ☐ Yes
- ▨ No

Violent Crime: 93.0% / 7.0%
Non-Violent Crime: 88.9% / 11.1%

Encounters with Police Since Services Began:
Less than One Year of Mental Health Services
N = 67

- Been Reduced, 10.4%
- Increased, 3.0%
- Not Applicable, 55.2%
- Missing, 31.3%

Encounters with Police in the Last 12 Months:
More than One Year of Mental Health Services
N = 95

- Stayed the Same, 1.1%
- Been Reduced, 2.1%
- Missing, 12.6%
- Not Applicable, 84.2%
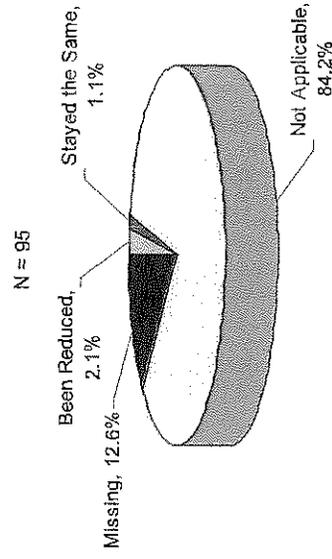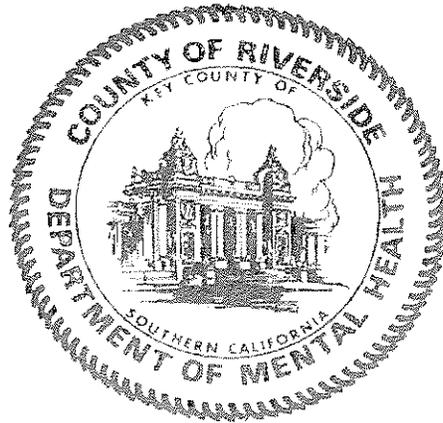
Managed Care
Client Satisfaction
Phone Survey Results

Executive Summary

Background

The Riverside County Department of Mental Health strives to establish and maintain provider and client satisfaction by continuously evaluating services and implementing quality improvement initiatives. As part of these efforts, a telephone survey was administered to Managed Care clients to measure their satisfaction with the mental health services they have received through the County. Specifically, the Managed Care Client Satisfaction Phone Survey measured satisfaction with:

- Access to Services
- Appropriateness of Care
- Perceived Outcomes
- Overall Satisfaction with Services

Survey respondents rated their level of satisfaction using a four-point scale ranging from 1 (Dissatisfied) to 4 (Very Satisfied). Satisfaction measures were aggregated to create subscale scores for each of the four service areas.

Out of the 2,511 numbers dialed, 1,046 were reachable (i.e. "valid" in that the phone was still connected and was associated with the client's home). The phone was answered and the client was available in 270 of the client households dialed. Among the clients reached, 198 completed surveys. This represents a completion rate of 19% for valid telephone numbers, and 73% for clients who were reached and asked to participate in the study.

Forty-one of the 198 completed surveys (21%) were by Spanish speaking clients. A Spanish speaking interviewer administered these surveys.

Client Satisfaction

Countywide, the majority of clients reported being satisfied with managed care services. Roughly 85% were satisfied with access to care, appropriateness of care and the perceived outcomes of their care. Eighty percent of the clients reported overall satisfaction with managed care services.

Results for individual managed care providers were generally similar to the countywide results, however, sometimes a provider received scores on individual survey items that were lower than "Satisfied" (under 2.75). The less than "Satisfied" scores suggest areas that may benefit from efforts to improve services. Items that sometimes received less than satisfactory scores include:

- Have the services you received helped you to deal more effectively with your problems?
- To what extent has your provider met your needs?
- Did you get the kind of services that you wanted?
- How satisfied are you with the amount of help you received?

It should be noted that clients sometimes interpreted "the amount of help you received" to mean the frequency or duration of services, which may be beyond the provider's ability to address.

Cultural Competency

Seventy-eight percent of the clients surveyed preferred to speak and read English. Overall, 76.8% of the clients surveyed reported that their provider was sensitive to their cultural background and they felt comfortable talking about family traditions.

Of Spanish-speaking clients, 17.1% reported that an interpreter would have been helpful to them in treatment. Of these respondents, only 21.2% were actually provided with an interpreter. Ninety-eight percent of Spanish-speaking clients reported feeling that their provider was sensitive to their cultural background and they felt comfortable talking about their family traditions.

Service Access and Patient's Rights Information

- When client's first sought treatment, 26.8% contacted the therapist directly, 27.8% called the Central Access Team and 43.7% reported referral through another method (e.g. emergency room, social worker, DPSS).
- On average, clients reported they waited 19 days between first contact for services and the first appointment.
- Overall Sixty-one percent reported they were offered written information regarding client rights. Of those receiving the information, 51% felt it was understandable to them.
- Fifty-six percent of Spanish-speakers reported being offered written information regarding client rights. Of those receiving information, only 9.8% reported that the information was understandable to them.

Report Organization

A detailed results page is provided for the County overall and for Spanish-speaking clients. Each provider with at least one completed survey will receive a copy of their results. A sample of an individual provider report is shown on pages 6 and 7. In instances where the number of clients served by a provider threaten client confidentiality (e.g. only one client was served), results for that individual provider will not be made available.

Results are shown in graphs for the four service area subscales: Access to Services, Appropriateness of Care, Perceived Outcomes, and Overall Satisfaction with Services. Each results page also includes a table showing the average level of satisfaction for individual survey items that comprise the subscales.

Client comments are shown in Appendix A for individual provider versions of the report. Appendix B in this version of the report (internal version) includes all client comments.

Methodology

Clients served by Riverside County Department of Mental Health Managed Care Providers. A file containing managed care clients, their name, provider and client phone number was provided for the survey. During data preparation, client records were eliminated from the study due to missing phone number, missing digits or obviously invalid numbers (i.e., 999-999-9999). In addition, only one service record was retained for clients who were served by more than one provider. The date of last service was retained. A total of 5,623 client records were eliminated in this process. The remaining 3,287 were provided to interviewers for random dialing. Of the 3,287 numbers, 2,511 were dialed. The clients who were identified as Spanish speaking (217) were made available to a Spanish speaking interviewer. Twenty-four of the clients designated as Spanish Speaking were identified as such during the English interview process and were told they would be contacted by someone who could speak Spanish.

Call Disposition for Dialed Numbers

	Total	Spanish	%
Completed	198	41	21%
Refused	48	3	6%
Unavailable	177	18	10%
Answering Machine/Busy Signal	593	22	4%
Disconnected	272	16	6%
Invalid Number*	632	47	7%
Death	6	0	0%
Bad Number*	561	63	11%
Incomplete	20	7	35%
Client Impaired*	4	0	0%
Total	2511	217	9%

* Invalid numbers include institutional numbers, wrong numbers or wrong provider; Bad numbers are those that can not be connected as dialed; Client impaired means the client was willing but cognitively unable to respond to the survey questions.

# All Providers
Number Served = 8,910
Number Surveys Completed = 198
## Sampled = 2,511

1=Dissatisfied, 2=Mildly Dissatisfied, 3=Satisfied, 4=Very Satisfied
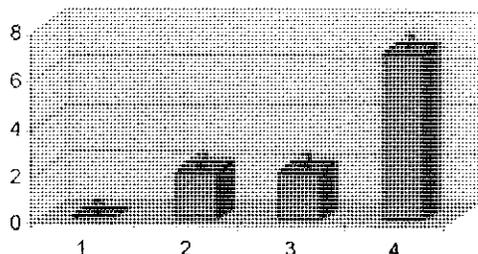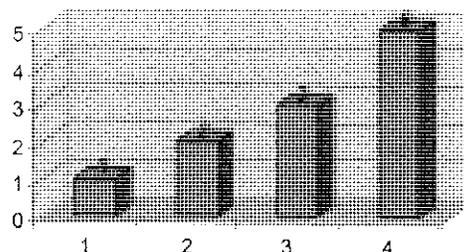
Satisfaction Scales

Access to Care

Appropriateness of Care

Perceived Outcomes
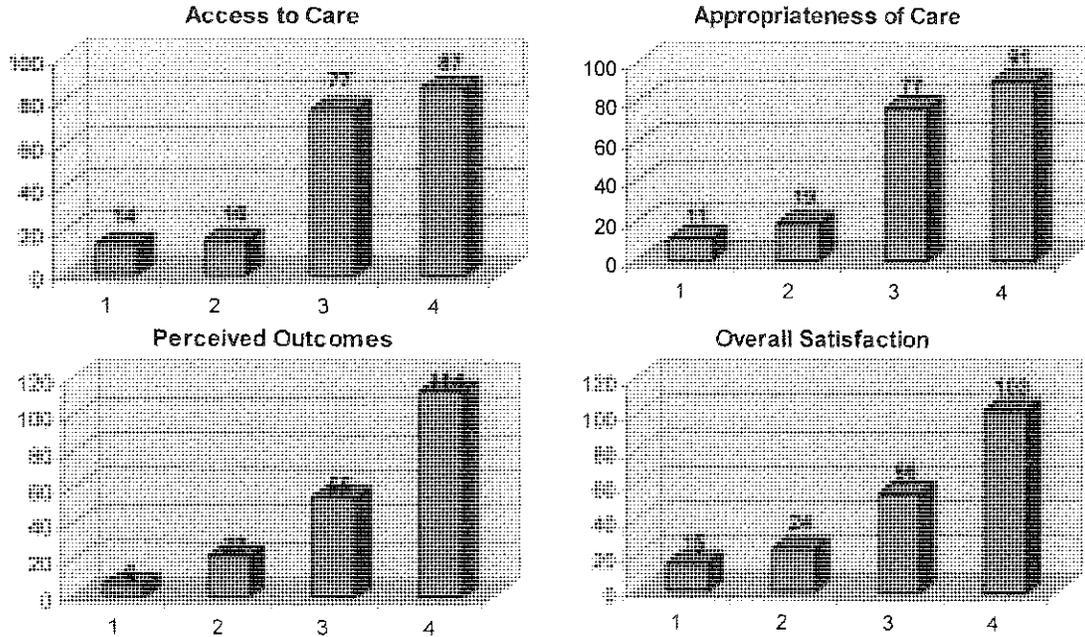
Overall Satisfaction

Satisfaction Scale	Question	Average Score
Access to Care	Generally, are you able to get services when you need them?	3.23
Appropriateness of Care	Did you receive the kind of services that you wanted?	3.26
	To what extent has your provider met your needs?	3.07
	Have the services helped you to deal more effectively with your problems?	3.32
	How would you rate the quality of services you received from your provider?	3.29
	If a friend were in similar need of help, would you recommend your provider to them?	3.25
	How satisfied are you with the amount of help you received?	3.15
	Overall, how satisfied are you with the services you received?	3.24
	If you were to seek help again, would you return to your provider?	3.25

* If a client received services from more than one provider, the last service date was retained.

All Providers—Spanish Speaking Clients Only
Number Served = 349
Number Surveys Completed = 41
Sampled = 217

1=Dissatisfied, 2=Mildly Dissatisfied, 3=Satisfied, 4=Very Satisfied
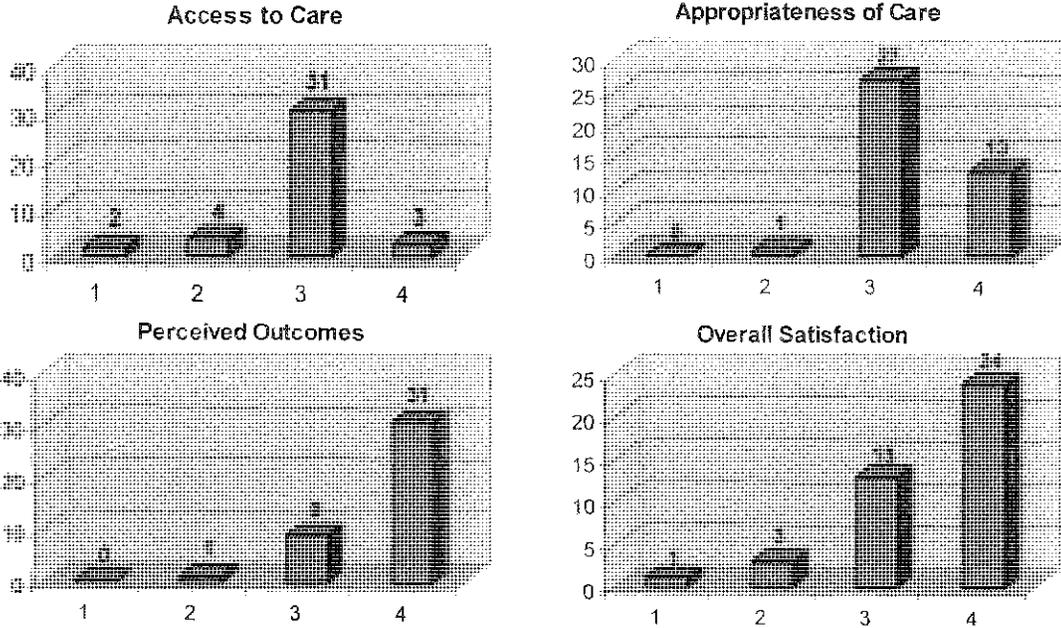
Satisfaction Scales

Access to Care

Appropriateness of Care

Perceived Outcomes

Overall Satisfaction

Access to Care	Generally, are you able to get services when you need them?	2.88	3.33
Appropriateness of Care	Did you receive the kind of services that you wanted?	3.26	3.26
	To what extent has your provider met your needs?	3.27	3.07
Perceived Outcomes	Have the services helped you to deal more effectively with your problems?	3.61	3.32
	How would you rate the quality of services you received from your provider?	3.64	3.23
	If a friend were in similar need of help, would you recommend your provider to them?	3.61	3.26
	How satisfied are you with the amount of help you received?	3.56	3.15
	Overall, how satisfied are you with the services you received?	3.41	3.24
	If you were to seek help again, would you return to your provider?	3.54	3.29

* If a client received services from more than one provider, the last service date was retained.

Sample Individual Provider Report

Number Served = 381
Number Surveys Completed = 11
Sampled = 95

1=Dissatisfied, 2=Mildly Dissatisfied, 3=Satisfied, 4=Very Satisfied
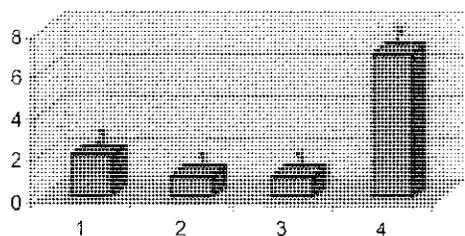
Satisfaction Scales
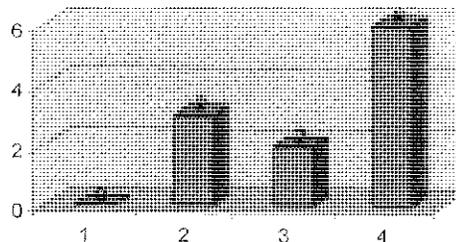
Access to Care

Appropriateness of Care

Perceived Outcomes

Overall Satisfaction

Satisfaction Scale	Question	Individual Score	
Access to Care	Generally, are you able to get services when you need them?	3.15	3.22
Appropriateness of Care	Did you receive the kind of services that you wanted?	3.27	3.35
Perceived Outcomes	To what extent has your provider met your needs?	3.81	3.07
	Have the services helped you to deal more effectively with your problems?	3.45	3.32
	How would you rate the quality of services you received from your provider?	3.27	3.23
	If a friend were in similar need of help, would you recommend your provider to them?	3.00	3.23
Overall Satisfaction	How satisfied are you with the amount of help you received?	3.00	3.15
	Overall, how satisfied are you with the services you received?	3.00	3.24
	If you were to seek help again, would you return to your provider?	3.09	3.39

***Client comments available in Appendix A.

Appendix A: Sample Individual Provider Comments

- Provider X does not go by appointments, so when an appointment time was not honored and others were seen first. Do not seem together in business practice. Not happy with counseling services. Showed up for appointment and therapists forgot.

- Goes for depression. Each time she stopped going and took herself off meds, they didn't call to see what happened to her. Providers should check to see if patient is okay. No show could be sign of patient in danger of self.

- Psychiatrist is a joke. He is always late (not leaving his home on time) so that ALL appointments are late. He espouses his philosophy but doesn't really try to help. Consumers as a group in the waiting room would speak of this.

- Pleased with Provider X and has made arrangements for her son to go there also since her own experience has been so positive.

- They always will cancel her appointments. She is very unsatisfied.

- Psychiatrist doesn't really listen. He won't help with sleeping disorder and gives meds that make her stay awake even more.

Appendix B: Client Comments by Provider

Provider 1

o Wants more services, but CAT won't authorize. Slips if daughter doesn't see therapist regularly. Loves the therapist.

Provider 2

o Just wants to thank them for being there for her like they are and making her feel comfortable. Even the front desk.

Provider 3

o Not happy with Therapist, releases client early, no feedback from therapist. Guardian not happy with therapist techniques, refuses to have family therapy. Therapist too passive.

Provider 4

o Dr. X was effective, and gave me the answers I was looking for.

o We only had one appointment. The therapist said that I waited too long to get help for him. He [therapist] was not helpful at all.

Provider 5

o Her services were well administered, gained a lot from her and she (therapist) is a caring person.

Provider 6

o Should have more frequent sessions.

Provider 7

o Client mentioned that she needed more treatment but unfortunately it was not approved.

Provider 8

o She would never go again to Provider X, but has now found a good provider at Provider 8 and is very pleased.

o She has had good experiences with a new provider at Provider 8.

Provider 9

○ Provider 9 does not go by appointments, so when an appointment time was not honored and others were seen first. Do not seem together in business practice. Not happy with counseling services. Showed up for appointment and therapists forgot.

○ Goes for depression. Each time she stopped going and took herself off meds, they didn't call to see what happened to her. Providers should check to see if patient is okay. No show could be sign of patient in danger of self.

○ Dr. X is a joke. He is always late (not leaving his home on time) so that ALL appointments are late. He espouses his philosophy but doesn't really try to help. Consumers as a group in the waiting room would speak of this.

○ Pleased with Provider 9 and has made arrangements for her son to go there also since her own experience has been so positive.

○ They always will cancel her appointments. She is very unsatisfied.

○ Provider 9 doesn't really listen. He won't help with sleeping disorder and gives meds that make her stay awake even more. I miss XX

Provider 10

○ Client would like to continue therapy for herself and both children. The case has been closed but would like to be open again.

Provider 11

○ The main problem is there is only one doctor and he often does not shows up. So the client needs to get meds from primary doctor. If there is any other providers that are in the desert area please call client.

Provider 12

○ He was a good counselor, but the location was bad. Parent was there but they/child was distant. She wasn't personally involved. Parent was. She just drove him there. Wouldn't return because too far away.

Provider 13

○ Comment refers to question #17: Interviewee's problem here is not with Dr. X, who is willing to see her as needed, but is with Medi-Cal requirements that are so strict. (M-Cal only allows for so many visits.) This is a real problem for client.

○ The therapist has not been very helpful, she doesn't provide the help that I need.

- There was a miscommunication that stopped the therapy. I missed an appointment and then XX didn't call me back for, like, 2 months. So I only had about three appointments and we just got started.

Provider 14

- She was very understanding to client's needs, and good to daughter. Great person. Caring and understanding.

Provider 15

- Mom says therapist is very nice person and very good therapist. Problem is that she can't depend on therapist to be on time/to honor the meeting time. She has received several calls an hour or so before the session saying she has to cancel and reset.

Provider 16

- XX tried hard to help her daughter.

- Got all the help I needed! Helped save my life!

Provider 17

- Counselor was wonderful. Excellent. No pressure. Would still like to see him but no longer funded.

Provider 18

- A few visits. Withheld info about son and XX felt that he couldn't trust her (XX).

Provider 19

- Insensitive to race - Hispanic. A quack. Judgmental. Needs to learn to listen instead of pre-judging.

Provider 20

- Has an answering machine so I can get a hold of her.

- She is a very good therapist and does very good job with his son. Keeps parents very informed and they are very satisfied.

- Sometimes its better to look around awhile instead of settling right away on a doctor.

Provider 21

- More of a down-home type of guy [meaning you could easily talk with him], very nice.

Provider 22

- ER is very slow and had to wait too long but the care received was the best care.

- Fewer group sessions, and more time to do other activities and projects (e.g., crafts)

- XX Hospital didn't help her much. Long ago it was a really good hospital.

Provider 23

- Client was very happy with the service provided by Dr. X. However, she was very unhappy with the services provided by social workers. In her opinion, they lack the tact and professionalism to handle her case.

Provider 24

- When first starting, slow process, lots of paperwork. Hard for individual. Once getting services, he can't complain. He's getting help.

Provider 25

- People nice and interested but only up to a point. 3 out 5 times couldn't get into building. Didn't bother them. Why didn't they wait when they knew someone was coming. Couldn't reach by phone. This was after hour care. Then dropped him.

Provider 26

- Make sure therapists look at medicine prescribed by medical doctor before prescribing their own medicine.

Provider 27

- Dr. X is very hard to understand. But X is very helpful.

- Would like to be able to increase the visits to once per week instead of every other month.

Provider 28

- She was one of the best persons that she could have in the whole process. She was not happy with the CPS services. The social workers do not spend enough time to analyze each individual cases to provide better service.

Provider 29

- She is worried that she will be cut off. Medi-Cal. Has a heart problem. Does have an appointment at the end of January.

Provider 30

- "I don't do surveys because there are so many people who misrepresent themselves." (He rates Counselor X as excellent but terminates interview after two questions.)

Provider 31

- She had a crisis in her family (son had a kidney failure) and she stopped going to Dr. X. But she was quite pleased with the appointments that she had.

Provider 32

- Client feels survey isn't really going to help, her problem is not really with the services received from Provider 32, but that because their Provider 32 refuses services based on the fact that they are covered under Medi-cal

- K has Downs and autism.

- Satisfied with the services while client was in the hospital but very dissatisfied once she was released. Follow-up services were not available.

Provider 33

- Great help and doctors answered all our questions. Gave us options for where to go afterwards.

- Very attentive and kept parent informed of what they wanted to do

Provider 34

- Stole her meds. She'll never go back. Asked for different therapist. Liked the Psychiatrist XX, but wasn't permitted to see her beyond the hospitalization.

Provider 35

- Medication helped very much

- Only one complaint. His Dr died, and the new one can only schedule appointments to see him on Saturday. Parent wants the Dr to be available during the week and at different hours.

- She feels that in addition to medications, her son needs therapy.

- They always rushed. They only were interested in giving her medicine. Didn't act concerned about her problems.

- While Dr. X was at Provider 35, it was very good. Then Dr. X left and they have no doctor at Provider 35! We were forced to go to Provider XX which is dirty with no working toilet and terrible condition. She wants to call CAT about Provider XX and I encouraged her.

Provider 36

- Prior to Provider 36, was with Provider YY and experience was so unfair that filed a grievance. Asked to be in the socialization program (PALS) and they acted like she was a danger. Then she was forced out. Staff favoritism. XX is Sup.

Provider 37

- She didn't respond well to XX although she was good. She also was seeing a psychiatrist who prescribed meds -- she got better -- and they stopped going to XX.

- She refused to go back to this counselor. Got another one.

Provider 38

- I got all the help I needed. It's been a good experience.

Provider 39

- Office was nice. He wasn't comfortable with the way the Dr. was putting on meds. Changing meds in way he was uncomfortable for him.

Provider 40

- DPSS should be more in line with needs. They were supposed to help with in home care. Etc. and no help is coming. Insurance problem so isn't receiving services with Dr. now. Wants them reinstated. Dr. is great.

Provider 41

- My daughter's therapist was not very experienced. His limited experienced hindered some of the issues.

- Please call to give phone number of a therapy service that take medical. cell XXXX

- Timing of appointments was somewhat difficult because the children had to miss school. It would be nice to have Saturday appointments.

Provider 42

- Therapist had no connection. Felt services were not appropriate tried to utilize sand play therapy with 14 year old and lost window of time to make connection. Wanted to play with army people in sand and kid did not like it.

- They were very effective with the trouble maker daughter.

Provider 43

- I only met with the therapist (XX) for 20 minutes and realized that it wasn't going to work out -- that he was wrong for me, it was not good.

- Really satisfied with the services

Provider 44

- Great services, was able to get all the help I needed.

Provider 45

- Happy for the most part with what has been done.

Provider 46

- Feels real comfortable with him. Easy going. Doesn't trust men but trusts him.

- He is the most knowledgeable of anyone I've talked with about dissociative disorder who doesn't have the disorder himself. I like him very much.

Provider 47

- Dr. XX and associates are a life saver.

- He is better than dealing with the county.

- Medical approval is taking too long. Had to have private insurance step in. Lapse in meds caused terrible problems at school. Took two months to get approval. Dr. doesn't seem too concerned. Doesn't spend time with her son.

- Staff didn't call back, or help him well. The Dr. was good once he got into the office.

Provider 48

- Can get appointments easily, but has transportation difficulties.

- In hospital staff did not interact with clients and did not provide therapists service. Provided prescription and referred to own physician.

Provider 49

- Great therapist. Would highly recommend.

Provider 50

- You obtain licensed therapist care. XX is good, but not licensed. Never met or been able to get licensed care. Need more licensed care for children. Gone through grievance process and won't get resolved.

Provider 51

- She was great with me, but did not give her wife's side and this was for marriage therapy. It is hard to rate her on this. She was great with me but not for the marriage therapy

Provider 52

- Commented that she needed services more frequently. Once a week rather than once every two weeks to a month.

- Dr. XX is okay but I need to know what is wrong with my son. I don' t think he is a good match for my son.

- Sees therapist XX every other Friday. He is a good one.

- Would like more time only able to see him only twice a month due to insurance reasons

Provider 53

- Was very pleased with XX.

Provider 54

- Should get a variety of counselors. I sometimes had problems getting regular appointments.

Provider 55

- Services provided by County and XX were good.

Provider 56

- Not enough appointments were allowed for us to complete our treatment goal.

Provider 57

- During the week the sessions are 45 minutes and her Saturday sessions are only 30 minutes and you can't get much done in 30 minutes.

ATTACHMENT #42

Reports Available on Computer Desktops
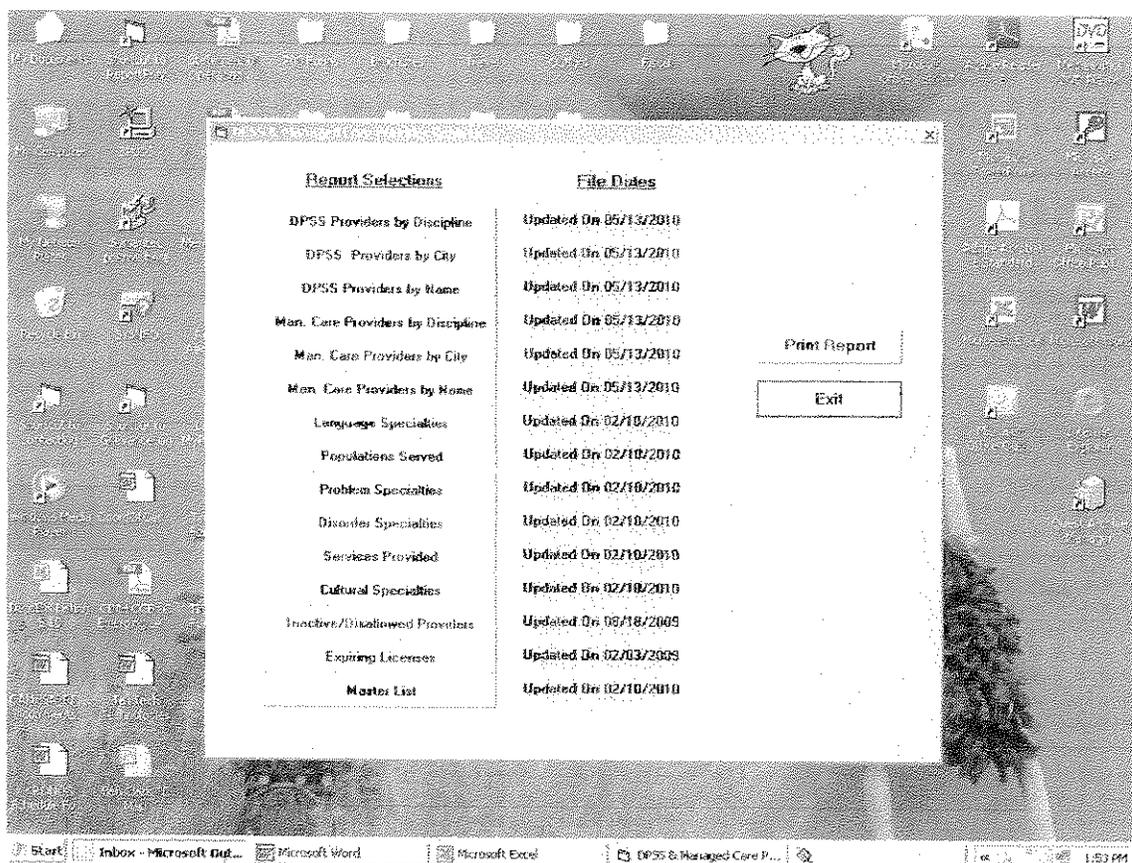
1. DPSS Providers by Discipline
2. DPSS Providers by City
3. DPSS Providers by Name
4. Man. Care Providers by Discipline
5. Man. Care Providers by City
6. Man. Care Providers by Name
7. Language Specialties
8. Populations Served
9. Problem Specialties
10. Disorder Specialties
11. Services Provided
12. Cultural Specialties
13. Inactive/Disallowed Providers
14. Expiring Licenses
15. Master List

ATTACHMENT #43

October 2007 Welcoming Plan – Blaine Clinic

Engagement/Reception/Intake

Goal	Strategy(ies)	Baseline Measure	Outcome Measure	Needed Supplies	Est. Add'l Cost/Fund
Establish a welcoming facility & lobby that conveys dignity & respect to all those who enter via physical, structural & environmental enhancements	Provide educational materials & entertainment reading materials in the lobby to lessen anxiety/agitation while waiting	Consumer/Family Survey Staff Self Assessment	Consumer/Family Survey Staff Self Assessment	Magazine racks/basket	MHSA allocation
	Provide healthy snacks to clients who have been waiting as stand–by's/walk–ins longer than 30 mins.–1 hour to avert hunger and medical problems (diabetes)	Consumer/Family Survey Staff Self Assessment	Consumer/Family Survey Staff Self Assessment	Healthy snacks	MHSA allocation
	Play movies in the lobby to provide entertainment while waiting to be called into appointments	Consumer/Family Survey Staff Self Assessment	Consumer/Family Survey Staff Self Assessment	Library of PG–PG–13 movies	MHSA allocation
	Add plants/trees to lobby to add more warmth and cheerfulness to the lobby décor	Consumer/Family Survey Staff Self Assessment	Consumer/Family Survey Staff Self Assessment	Plants/Trees	MHSA allocation
	Clean building front/exterior to increase by power washing cement, move trash can 15' away from entry, add plastic chairs/tables outside	Consumer/Family Survey Staff Self Assessment	Consumer/Family Survey Staff Self Assessment	Power washer to clean exterior walls; Portable plastic table/chairs to bring in/out daily	MHSA allocation

10/3/07 Final

October 2007 Welcoming Plan – Blaine Clinic
Engagement/Reception/Intake

Goal	Strategy(ies)	Baseline Measure	Outcome Measure	Needed Supplies	Est. Add'l Cost/Fund
To establish a welcoming service environment that conveys dignity & respect to all those who enter to receive services	Implement a "Who's Who" by hanging pictures of staff with brief bio in the lobby to assist clients in getting to know staff or describe staff who have assisted them in the past	Consumer/Family Survey Staff Self Assessment	Consumer/Family Survey Staff Self Assessment	Framing photos & pictures of staff	MHSA allocation
	Decorate lobby during the major holidays	Consumer/Family Survey Staff Self Assessment	Consumer/Family Survey Staff Self Assessment	Holiday decorations	MHSA allocation
	Provide a "Welcome Center" by PSS, that includes "Welcome Groups" & "T.R.E.D." (Try Recovery Every Day) Groups, as a means to engage & create bonds with clients and lend itself to the overall "welcoming" practice	Pre-implementation N/S survey measuring baseline N/S rate for a month	N/S rate tracking to evaluate rate of decrease in N/S by minimum of 10%	Training/Group supplies/Furniture for Welcome Center room	MHSA allocation

October 2007 Welcoming Plan – Blaine Clinic

Engagement/Reception/Intake

	Pre–implementation	Post–implementation		
Monitor length of wait time in the lobby to decrease time between arrival and appt. with provider with the goal of limiting the wait no more than 15 minutes after scheduled appt. time	Pre–implementation "Wait Time" time study	Post–implementation "Wait Time" time study, repeated quarterly	N/A	N/A
Callers are linked to outside referrals/agencies within the DMH via "Warm Line transfers" to ward off frustration and being "bounced around"	Consumer/Family survey	Consumer/Family survey	Staff training	N/A
PSS/OA staff to assist new Intake clients in completing forms, if needed	Consumer/Family survey	Consumer/Family survey	N/A	N/A
Reminder & f/u calls for next–day M.D. appts/Intakes/N/S's	Measure N/S rate for a baseline month	Decrease N/S rate by 10%	N/A	N/A
Callers are greeted warmly by staff answering the phones via a script that includes the intro greeting, clinic name, staff name, and phrases such as, "How may I help you?"	Consumer/Family Survey Staff Self Assessment	Consumer/Family Survey Staff Self Assessment	Staff training	N/A

September 2007 Welcoming Plan – Central Adult Clinic

Phase I – Engagement/Reception/Intake

Goal	Strategy(ies)	Baseline Measure	Outcome Measure	Needed Supplies	Est. Add'l Cost/Fund
To establish a welcoming facility & lobby that conveys dignity and respect to persons entering service and/or receiving ongoing services via physical structural and environmental improvements & enhancements.	Increase parking for consumers. Staff and county vans to begin parking off-site.	Consumer/Family Survey Staff Self Assessment	Consumer/Family Survey Staff Self Assessment	Parking alternatives	
	Play movies in lobby to provide entertainment while visitors are waiting to be called in.	Consumer/Family Survey	Consumer/Family Survey	PG and PG13 movies	Staff to provide
	Provide magazines and educational material in lobby.	Consumer/Family Survey	Consumer/Family Survey	Magazine racks or basket	MHSA Funded
	Replace worn furniture either through new purchase or surplus	Current lobby chairs torn and badly worn.	Consumer/Family Survey	12 lobby chairs	MHSA Funded
	Clean up "outside area" so that is appears professional and respectful; followed by Daily checks by Clinic Supervisor and OA Supervisor	Current discarded furniture, trash, cigarette butts in front of building.	External appearance to remain clean daily. Staff Self Assessment	Daily calls to Building Services as needed	None
	Provide cold water to persons waiting in lobby, especially at departure for those taking bus.	Consumer/Family Survey	Consumer/Family Survey	Water cooler & bottled water?	$100–$150 annually
To establish a welcoming service environment that conveys dignity and respect to persons entering services and/or receiving ongoing services via compassionate and professional	Monitor length of wait time in lobby to decrease time between arrive and face to face appointment with provider(s). Goal to limit wait to no more than 15 minutes after scheduled appt time.	Pre implementation "Wait Time" time study	Post implementation "Wait Time" study, repeated quarterly.		N/A
	Improve phone response, using "warm line" transfers when callers are referred to outside program/agency	Consumer/Family Survey	Consumer/Family Survey Staff Self Assessment	Staff training in how to transfer call	N/A

Welcoming Plan – West Clinic
Engagement/Reception/Intake

Goal	Strategy(ies)	Baseline Measure	Outcome Measure	Needed Supplies	Est. Add'l Cost/Fund
To establish a welcoming facility lobby that conveys dignity - and respect to persons entering service and/or receiving ongoing services via physical structural and environmental improvements & enhancements.	Provide magazines of entertainment value in addition to educ & inform materials related to mental health disorders		Consumer/Family Survey	Magazine racks or basket	
	Make lobby more "kid-friendly", set up "play corner/area" w/children's books, toys & games		Consumer/Family Survey	Toy chest/ toys	MHSA Allocation
	Hang pictures of all staff with brief bio in the lobby		Consumer/Family Survey	Framing Photos	MHSA Allocation
	Decorate lobby during holidays		Consumer/Family Survey	Decorations	MHSA Allocation
	Distribute $1 holiday "gifts" during special holidays		Consumer/Family Survey	$1 gifts	MHSA Allocation
	Provide water to persons waiting in lobby, including on departure.		Consumer/Family Survey	Bottled Water?	MHSA Allocation
To establish a welcoming service environment that conveys dignity and respect to persons entering services and/or receiving ongoing services via compassionate and	Monitor length of wait time in lobby to decrease time between arrive and face to face appointment with provider(s). Goal to limit wait to no more than 15 minutes after scheduled appt time (?).	Pre implementation "Wait Time" time study	Post implementation "Wait Time" study, repeated quarterly.		
	Callers are provided with staff name who is answering phone. Staff communicate clearly, professionally	Pre-implementation QI Test Call Report	QI Test Call Report		

Created on 9/11/2007 6:10 PM

Welcoming Plan – West Clinic
Engagement/Reception/Intake

professional interpersonal customer service	and politely to callers				
	Callers, notably 1st time callers, are linked to outside referrals via active support (e.g. warm line transfer) to avoid being "bounced" and frustrated	?	?		
	PSS to provide appt "reminder" calls for MD and Intake appointments.	Pre-Implementation N/S survey			
	PSS to provide f/u calls to consumers who "no-show" to intake or 1st appt.	N/S survey	N/S tracking		
		?	?		
Customer Service QI Plan	Provide suggestion box to solicit Feedback/ suggestions for improved & better service	Consumer/Family Survey	Consumer/Family Survey	Suggestion Box/ Suggestion form/card	MHSA Allocation?

September 2007 Welcoming Plan – Central Adult Clinic

Phase I – Engagement/Reception/Intake

interpersonal customer service				
	Improve customer service attitude and professionalism through "feedback" mirrors for Business Office staff to self monitor tone & affect (facial and body language).	Consumer/Family Survey Staff Self Assessment	Consumer/Family Survey Staff Self Assessment	N/A	N/A
	PSS to provide appt "reminder" calls for MD and Intake appointments.	8/2007 MHS 904 Report indicated MD N/S rate of 36%	Decrease N/S rate by 25% or to MHS 904 N/S rate of 27%	N/A	N/A
	PSS to provide f/u calls to consumers who "no-show" to intake or 1st appt.	8/2007 MHS 904 Report indicated MD N/S rate of 36%	Decrease N/S rate by 25%	N/A	N/A
	PSS to assist new consumers in lobby complete forms if needed.	Consumer/Family Survey	Consumer/Family Survey	N/A	N/A
	Increase & improve customer service from all staff (business office and provider staff)	Staff Self Assessment	Staff Self Assessment	Training and ongoing discussions	N/A

ATTACHMENT #44

West Adult Services Program
How Are We Doing?

We've created this survey to find out how we are doing in providing a respectful, comfortable and welcoming environment where recovery is promoted and experienced by everyone. Please take a couple of minutes to complete it. We would like to hear your opinion.

---

1. On a scale of 1-5, with 1 meaning the least welcoming and 5 meaning the most, how welcomed do you feel when entering our building and waiting in the lobby?

    1   2   3   4   5
    ☹   😐   ☺

2. How clean, neat and comfortable is the rest of our building?

    1   2   3   4   5
    ☹   😐   ☺

3. How pleasant was your first interaction with our professional office staff?

    1   2   3   4   5
    ☹   😐   ☺

4. How friendly, courteous and respectful are the other staff (your doctor, case manager, therapist, etc)?

    1   2   3   4   5
    ☹   😐   ☺

5. How well were your needs listened to today?

    1   2   3   4   5
    ☹   😐   ☺

6. How accurate is the statement: I received something today that will help me with my recovery (e.g. information, referral, appointment, support, tools, etc.)?

    1   2   3   4   5
    ☹   😐   ☺

7. Do you have any suggestions on how we can improve our service environment or make your visit here more comfortable?

_____

_____

_____

8. How can we make your time here with us more welcoming?

_____

_____

_____

Please Circle One: Consumer   Family   Other   Name (Optional): _____

ATTACHMENT #45

Riverside County Department of Mental Health
Leased Building Management Spreadsheet
March 2010

Region	Services/Unit	Site ID #	Address	Street	City	Zip	Manager	Hours of Operation	Are they located by a bus or train line?	collocated site (yes or no)- What Type	ADA Accessible (yes or no)- What Type? Wheelchair ramp, Blind, Deaf	Multilingual (yes or no)- What type (Hispanic, Asian, Russian, Portuguese, etc.)	Misc. Cultural Competency Services (magazines, posters, décor, signs, etc.)
OVERALL													
	Patient Accounts	RV245	9707-9731	Magnolia Ave.	Riverside	92503	J. Zamora	8:00am - 5:30pm M-Th	Yes- Bus line	Yes - Admin, Children's Region, Western Children's	Yes- Wheel Chair Ramp, Elevator, All signs in brail.	Yes-Bilingual Staff Members. For other languages clients are referred to an interpreter.	Signs, Flyers, and Magazines in Spanish. Cassette Tapes in Spanish that is a guide to consumer services
	Managed Care Financing	RV245	9707-9731	Magnolia Ave.	Riverside	92503	R. Quist	8:00am - 5:30pm M-Th	Yes- Bus line	Yes - Admin, Children's Region, Western Children's	Yes- Wheel Chair Ramp, Elevator, All signs in brail.	Yes-Bilingual Staff Members. For other languages clients are referred to an interpreter.	Signs, Flyers, and Magazines in Spanish. Cassette Tapes in Spanish that is a guide to consumer services
	Managed Care Client Records	RV245	9707-9731	Magnolia Ave.	Riverside	92503	R. Quist	8:00am - 5:30pm M-Th	Yes- Bus line	Yes - Admin, Children's Region, Western Children's	Yes- Wheel Chair Ramp, Elevator, All signs in brail.	Yes- Multilingual staff who speak Spanish and Bengali. For other languages clients are referred to consumer services	Signs, Flyers, and Magazines in Spanish. Cassette Tapes in Spanish that is a guide to consumer services
	Research and Evaluation	RV245	9707-9731	Magnolia Ave.	Riverside	92503	R. Quist	8:00am - 5:30pm M-Th	Yes- Bus line	Yes - Admin, Children's Region, Western Children's	Yes- Wheel Chair Ramp, Elevator, All signs in brail.	Yes-Bilingual Staff Members. For other languages clients are referred to an interpreter.	Signs, Flyers, and Magazines in Spanish. Cassette Tapes in Spanish that is a guide to consumer services
	Patient Rights	RV250	3840	Myers St.	Riverside	92503	M. Stetkevich	8:00am - 5:30pm M-Th	Yes- Bus and Train	No	Yes- Wheel Chair Ramp	Yes- Bilingual staff for Spanish. For other languages they lead client to interpreting services	Signs in English and Spanish
	Quality Management Regional Admin	RV250	3840	Myers St.	Riverside	92503	R. Quist	8:00am - 5:30pm M-Th	Yes- Bus and Train	No	Yes- Wheel Chair Ramp	Yes- Bilingual staff for Spanish. For other languages they lead client to interpreting services	Signs in English and Spanish
	Provider Support	RV250	3840	Myers St.	Riverside	92503	R. Quist	8:00am - 5:30pm M-Th	Yes- Bus and Train	No	Yes- Wheel Chair Ramp	Yes- Bilingual staff for Spanish. For other languages they lead client to interpreting services	Signs in English and Spanish
	QI Outpatient	RV250	3840	Myers St.	Riverside	92503	R. Quist	8:00am - 5:30pm M-Th	Yes- Bus and Train	No	Yes- Wheel Chair Ramp	Yes- Bilingual staff for Spanish. For other languages they lead client to interpreting services	Signs in English and Spanish
	CARES Line	RV250	3840	Myers St.	Riverside	92503	R. Quist	8:00am - 5:30pm M-Th	Yes- Bus and Train	No	Yes- Wheel Chair Ramp	Yes- Bilingual staff for Spanish. For other languages they lead client to interpreting services	Signs in English and Spanish
CHILDREN'S REGION													
Children's	Preschool MH Services	PR026	2221	South "A" Street	Perris	92571	E. Daily	8:00am - 5:30pm M-Th	Yes- Bus line	No	Yes- Wheel chair ramp.	Yes- Bilingual Staff for Spanish. For other languages they lead client to interpreting services	Signs in English and Spanish
Children's	Children's Admin.	RV245	9707-9731	Magnolia Ave.	Riverside	92503	E. Daily	8:00am - 5:30pm M-Th	Yes- Bus line	Yes - Admin, Children's Region, Western Children's	Yes- Wheel Chair Ramp, Elevator, All signs have brail.	Yes-Bilingual Staff Members. For other languages clients are referred to an interpreter.	Signs, Flyers, and Magazines in Spanish. Cassette Tapes in Spanish that is a guide to consumer services
Children's	TRAC Program	RV245	9707-9731	Magnolia Ave.	Riverside	92503	E. Daily	8:00am - 5:30pm M-Th	Yes- Bus line	Yes - Admin, Children's Region, Western Children's	Yes- Wheel Chair Ramp, Elevator, All signs have brail.	Yes-Bilingual Staff Members. For other languages clients are referred to an interpreter.	Signs, Flyers, and Magazines in Spanish. Cassette Tapes in Spanish that is a guide to consumer services
Children's	CPSS Assessment Team	RV245	9707-9731	Magnolia Ave.	Riverside	92503	E. Daily	8:00am - 5:30pm M-Th	Yes- Bus line	Yes - Admin, Children's Region, Western Children's	Yes- Wheel Chair Ramp, Elevator, All signs have brail.	Yes-Bilingual Staff Members. For other languages clients are referred to an interpreter.	Signs, Flyers, and Magazines in Spanish. Cassette Tapes in Spanish that is a guide to consumer services

Riverside County Department of Mental Health
Leased Building Management Spreadsheet
March 2010

Region	Services/Unit	Site ID #	Address	Street	City	Zip	Manager	Hours of Operation	Are they located by a bus or train line?	collocated site (yes or no)- What Type	ADA Accessible (yes or no)- What Type? Wheelchair ramp, Blind, Deaf	Multilingual (yes or no)- What type (Hispanic, Asian, Russian, Portuguese, etc.)	Misc. Cultural Competency Services (magazines, posters, décor, signs, etc.)
			OVERALL										
Children's	Child Case Management	RV245	9707-9731	Magnolia Ave.	Riverside	92503	E. Daily	8:00am - 5:30pm M-Th	Yes- Bus line	Yes -Admin, Children's Region, Western Children's	Yes- Wheel Chair Ramp, Elevator, All signs have brail	Yes-Bilingual Staff Members. For other languages clients are referred to an interpreter.	Signs, Flyers, and Magazines in Spanish. Cassette Tapes in Spanish that is a guide to consumer services
Children's	MHSA-FSP-MDPC-Children's	RV245	9707-9731	Magnolia Ave.	Riverside	92503	E. Daily	8:00am - 5:30pm M-Th	Yes- Bus line	Yes -Admin, Children's Region, Western Children's	Yes- Wheel Chair Ramp, Elevator, All signs have brail	Yes-Bilingual Staff Members. For other languages clients are referred to an interpreter.	Signs, Flyers, and Magazines in Spanish. Cassette Tapes in Spanish that is a guide to consumer services
Children's	Preschool MH Services	RV310	769	Blaine St., Suite #A	Riverside	92507	E. Daily	8:00am - 5:30pm M-Th	Yes- Bus line	Yes - Children's Region, Western Adult Region	Yes- Wheel Chair Ramp, Elevator, All signs have brail	Yes- Bilingual Staff members speak spanish.	Signs, Flyers, and Magazines in Spanish
Children's (Total)													
CULTURAL COMPETENCY REGION													
Cultural Competency /MHSA	Indio Cultural Competency (MHSA PEI Planning)	ME004	91-275	Avenue 66	Mecca	92254	M. Aragon	8:00am - 5:30pm M-Th	No	Yes - Cultural Competency Region, Sublease (incoming Revenue)	Yes - Wheel Chair Accessible	Yes-Bilingual Staff Members. For other languages clients are referred to an interpreter.	Information printed in english and spanish.
Cultural Competency / MHSA (Total)													
DESERT REGION													
Desert	Banning MHS	BA021	1330	W. Ramsey	Banning	92220	D. Lundquist	7:30am - 6:00pm M-Th	Yes- Bus line	No	Yes- Wheel Chair accessible	Yes- Bilingual staff members(Spanish); Myra Hernandez, and Carmen Krause. Other languages clients are referred to interpreting services	Signs, Flyers etc. in Spanish. Everything they have in English they have in Spanish.
Desert	Blythe MHS	BL034	1297	W. Hobsonway	Blythe	92225	D. Lundquist	8:00am - 6:30pm M-Th	No	Yes- Desert Region, Substance Abuse, Sublease	No	Yes- Their OAII, Angelica speaks, and a few other employees speak Spanish.	Signs, Flyers etc. in Spanish. Everything they have in English they have in Spanish.
Desert (Total)													
DETENTION REGION													
Detention	MH Court Linkage - Indo	IN089	82-652	Highway 111, #A-3	Indio	92201	M. Malone	8:00am - 5:00pm M-Th	No	No	Yes- Wheel Chair accessible	Yes- Bilingual Staff members speak spanish	Signs and forms are in English and Spanish.
Detention	Riverside Detention	RV367	3833	10th St.	Riverside	92501	M. Malone	7:30am - 5:00pm M-Th	Yes- Bus line near	No	Yes- Wheel Chair accessible	Yes- Bilingual Staff members speak spanish	Signs and forms are in English and Spanish.
Detention	Riverside Detention (MHSA funded)	RV367	3833	10th St.	Riverside	92501	M. Malone	7:30am - 5:00pm M-Th	Yes- Bus line near	No	Yes- Wheel Chair accessible	Yes- Bilingual Staff members speak spanish	Signs and forms are in English and Spanish.
Detention	Riverside Detention - Admin	RV367	3833	10th St	Riverside	92501	M. Malone	7:30am - 5:00pm M-Th	Yes- Bus line near	No	Yes- Wheel Chair accessible	Yes- Bilingual Staff members speak spanish	Signs and forms are in English and Spanish.
Detention (Total)													
MODULAR													
MHSA Administration	Compliance/HIPAA	304643	4060A	County Circle Drive	Riverside	92503	M. Statkevich	8:00am - 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff members speak spanish	Signs and flyers printed in English and Spanish
MH-SA Administration	MHSA Prevention & Early Intervention (PEI)/ Cultural Competency	304643	4060A	County Circle Drive	Riverside	92503	B. Brenneman	8:00am - 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff members speak spanish	Signs and flyers printed in English and Spanish
MHSA Administration	MHSA Administration	304643	4060A	County Circle Drive	Riverside	92503	B. Brenneman	8:00am- 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff members(Spanish); Myriam Aragon, Anna Rodriguez, Maria Algarin	Signs and flyers printed in English and Spanish
MHSA Administration	MHSA Workforce Education and Training (WET)	304643	4060A	County Circle Drive	Riverside	92503	B. Brenneman	8:00am - 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff members speak spanish	Signs and flyers printed in English and Spanish
MHSA Administration	MHSA Consumer Advocate	304643	4060A	County Circle Drive	Riverside	92503	A. Emery	8:00am - 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff members speak spanish	Signs and flyers printed in English and Spanish
MHSA Administration	MHSA Family Advocate	304643	4060A	County Circle Drive	Riverside	92503	M. Aragon	8:00am - 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff members speak spanish	Signs and flyers printed in English and Spanish
MHSA Administration (Total)													
MID-COUNTY REGION													

Riverside County Department of Mental Health
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OVERALL													
Mid County	Hemet MHS	HM027	650	N. State St.	Hemet	92543	L. Zapata	8:00am - 5:30pm M-Th	Yes- Bus line	Yes- Mid-County Region, Substance Abuse, Western Adult Region	Yes- Wheel Chair accessible.	Yes- Bilingual staff members(Spanish); Alex Viaz, Aricefi Muott, Emilia Avena, American sign language.	Everything they print is both in English and Spanish.
Mid-County	MHSA Hemet	HM027	650	N. State St.	Hemet	92543	L. Zapata	8:00am - 5:30pm M-Th	Yes- Bus line	Yes- Mid-County Region, Substance Abuse, Western Adult Region	Yes- Wheel Chair accessible.	Yes- Bilingual Staff members speak spanish	Everything they print is both in English and Spanish
Mid-County	MHSA-FSP-MDFT- Lake Elsinore	LE026	31946	Meskka Trail, Suite B	Lake Elsinore	92530	L. Zapata	8:00am - 5:00pm M-Th	No	Yes- Mid-County Region, Older Adult, Sublease	No	Yes- 10 bilingual staff members speak spanish. Other languages referred to interpreting services	Signs and flyers are printed in English and Spanish
Mid-County	Mid-County Regional Admin	PR012	1688	N. Perris Blvd, L7-L11	Perris	92571	L. Zapata	8:00am - 5:30pm M-Th	Yes- Bus line	Yes- Mid-County Region, Older Adult	Yes- Wheel chair ramps	Yes- 5 Bilingual staff members speak Spanish, Other languages are referred to interpreting services	Yes signs inside the buildings are in English and Spanish.
Mid-County	MHSA Perris MHS	PR012	1688	N. Perris Blvd, L7-L11	Perris	92571	L. Zapata	8:00am - 5:30pm M-Th	Yes- Bus line	Yes- Mid-County Region, Older Adult	Yes- Wheel chair ramps	Yes- Bilingual Staff members speak spanish	Yes signs inside the buildings are in English and Spanish.
Mid-County	Perris MHS	PR012	1688	N. Perris Blvd, L7-L11	Perris	92571	L. Zapata	8:00am - 5:30pm M-Th	Yes- Bus line	Yes- Mid-County Region, Older Adult	Yes- Wheel chair ramps	Yes- 5 Bilingual staff members speak. Spanish. Other languages referred to interpreting services	Yes signs inside the buildings are in English and Spanish.
Mid-County	MHSA-MDFT FSP Mid County	PR012	1688	N. Perris Blvd, L7-L11	Perris	92571	L. Zapata	8:00am - 6:30am M-Th	Yes- Bus line	Yes- Mid-County Region, Older Adult	Yes- Wheel chair ramps	Yes- Bilingual Staff(Spanish), Daisy Hernandez, Eppie Abejon, Dr. Valdez For other languages they get an interpreter.	Yes signs inside the buildings are in English and Spanish.
Mid-County	Mt. San Jacinto MHS - Children's	SJ310	950	N. Ramona, #1-3	San Jacinto	92582	L. Zapata	8:00am - 5:30pm M-Th	Yes- Bus line	No	Yes- Wheel chair ramps		Yes signs inside the buildings are in English and Spanish.
Mid-County (Total)													
OLDER ADULT REGION													
Older Adult	Older Adult - Desert	CC014	66-625	Perez Road Suites 11 & 12	Cathedral City	92234	B. Mitchell	8:00am - 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff speak spanish. Clients who speak another language are referred to the interpreting services	Signs and flyers are printed in English and Spanish
Older Adult	Older Adults - Smart - Desert	CC014	66-625	Perez Road Suites 11 & 12	Cathedral City	92234	B. Mitchell	8:00am - 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff speak spanish. Clients who speak another language are referred to the interpreting services	Signs and flyers are printed in English and Spanish
Older Adult	MHSA Older Adults - Mid-County	LE026	31946	Mission Trail, Suite B	Lake Elsinore	92530	B. Mitchell	8:00am - 5:00pm M-Th	No	Yes- Mid-County Region, Older Adult, Sublease	No	Yes- 10 bilingual staff members speak spanish. Other languages referred to interpreting services	Signs and flyers are printed in English and Spanish
Older Adult	Older Adults - Tyler Village	RV361	10182, 10190, 10226	Indiana Blvd	Riverside	92503	B. Mitchell	8:00am - 5:00pm M-F	Yes- Bus and Train	No	Yes- Wheelchair ramps, Hand railings, Brail on front door for contact information	Yes- Bilingual staff (Spanish) Gretchen Hillman, Peter Ruiz. Tagalog	Signs and flyers are printed in English and Spanish
Older Adult	Smart Team-West	RV361	10182, 10190, 10226	Indiana Blvd	Riverside	92503	B. Mitchell	8:00am - 5:00pm M-F	Yes- Bus and Train	No	Wheelchair ramps, Hand railings, Brail on front door for contact information	Yes- Bilingual Staff members who speak spanish; Gretchen Hillman, Peter Ruiz	Signs and flyers are printed in English and Spanish
Older Adult	MHSA-FSP-Smart - Mid-County	SJ314	1370	S. State St.	San Jacinto	92582	B. Mitchell	8:00am - 5:00pm M-F	Yes- Bus line	No	Yes- Wheelchair ramps	Yes- Bilingual staff(Spanish), Jesue Serrato, Evelyn Warfel, Sausto Sanchez, and Fabiola Miranda	Signs and flyers are printed in English and Spanish
Older Adult	Older Adult - Mid-County	PR012	1688	N. Perris Blvd, L7-L11	Perris	92571	L. Zapata	8:00am - 5:30pm M-Th	Yes- Bus line	Yes- Mid-County Region, Older Adult	Yes- Wheel chair ramps	Yes- 5 Bilingual staff members speak spanish. Other languages are referred to interpreting services	Signs and flyers are printed in English and Spanish
Older Adult (Total)													
PUBLIC GUARDIAN REGION													

Riverside County Department of Mental Health
Leased Building Management Spreadsheet
March 2010

Region	Services/Unit	Site ID #	Address	Street	City	Zip	Manager	Hours of Operation	Are they located by a bus line or train line?	collocated site (yes or no)- What Type	ADA Accessible (yes or no)- What Type? Wheelchair ramp, Blind, Deaf	Multilingual (yes or no)- What type (Hispanic, Asian, Russian, Portuguese, etc.)	Misc. Cultural Competency Services (magazines, posters, décor, signs, etc.)
OVERALL													
Public Guardian	LPS Investigations	RV149	3190	Chicago Ave.	Riverside	92507	B. VanDerPoorten	7:00am - 5:30pm M-Th	Yes- Bus line	No	Yes- Wheel chair ramps, and Hand rails	Yes: Bilingual Staff(Spanish) Sharleen Fernandez, Marco Medrano, Laura Gomez, and Even Mostly. Tagilog Teesie Ko	Signs and flyers are printed in English and Spanish
Public Guardian	Probate	RV149	3190	Chicago Ave.	Riverside	92507	B. VanDerPoorten	7:00am - 5:30pm M-Th	Yes- Bus line	No	Yes- Wheel chair ramps, and Hand rails	Yes- Bilingual Staff members speak spanish.	Signs and flyers are printed in English and Spanish
Public Guardian	LPS Conservatorship	RV149	3190	Chicago Ave.	Riverside	92507	B. VanDerPoorten	7:00am - 5:30pm M-Th	Yes- Bus line	No	Yes- Wheel chair ramps, and Hand rails	Yes- Bilingual Staff members speak spanish.	Signs and flyers are printed in English and Spanish
Public Guardian	Regional Administration - PG	RV149	3190	Chicago Ave.	Riverside	92507	B. VanDerPoorten	7:00am - 5:30pm M-Th	Yes- Bus line	No	Yes- Wheel chair ramps, and Hand rails	Yes- Bilingual Staff members speak spanish.	Signs and flyers are printed in English and Spanish
Public Guardian (Total)													
SUBSTANCE ABUSE REGION													
Substance Abuse	Blythe Drug Court	BL034	1297	W. Hobsonway	Blythe	92225	K. Kane	8:00am - 5:30pm M-Th	No	Yes- Desert Region, Substance Abuse, Sublease	No	Yes- Bilingual Staff members speak spanish.	Signs, Flyers etc. in Spanish. Everything they have in English they have in Spanish.
Substance Abuse	Blythe Drug Court Aftercare	BL034	1297	W. Hobsonway	Blythe	92225	K. Kane	8:00am - 5:30pm M-Th	No	Yes- Desert Region, Substance Abuse, Sublease	No	Yes- Bilingual Staff members speak spanish.	Signs, Flyers etc. in Spanish. Everything they have in English they have in Spanish.
Substance Abuse	Blythe DAS	BL034	1297	W. Hobsonway	Blythe	92225	K. Kane	8:00am - 5:30pm M-Th	No	Yes- Desert Region, Substance Abuse, Sublease	No	Yes- Their Bilingual staff speaks Spanish as well as other staff members	Signs, Flyers etc. in Spanish. Everything they have in English they have in Spanish.
Substance Abuse	Cathedral City Drug Court Aftercare	CC008	68-915	Perez Rd., Suite 2A	Cathedral City	92234	K. Kane	8:00am - 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff speak spanish	Yes signs inside the buildings are in English and Spanish.
Substance Abuse	Cathedral Canyon DAS	CC008	68-915	Perez Rd., Suite 1, 2A & 7A	Cathedral City	92234	K. Kane	8:00am - 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff speak spanish	Yes signs inside the buildings are in English and Spanish.
Substance Abuse	Cathedral City Drug Court	CC008	68-915	Perez Rd., Suite 1, 2A & 7A	Cathedral City	92234	K. Kane	8:00am - 5:00pm M-Th	Yes- Bus line	No	Yes- Wheel chair accessible	Yes- Bilingual Staff speak spanish	Yes signs inside the buildings are in English and Spanish.
Substance Abuse	Corona DAS	CR012	623	N. Main St.	Corona	91720	K. Kane	7:00am - 5:30pm M-Th	Yes- Bus line and Train line	No	Yes- Wheel Chair accessible, No steps at building.	Yes- 6 Bilingual staff members speak spanish.	signs and flyers printed in English and Spanish
Substance Abuse	Mid-County Substance Abuse	HM027	660	N. State St.	Hemet	92543	K. Kane	8:00am - 5:30pm M-Th	Yes- Bus line	Yes- Mid-County Region, Substance Abuse, Western Adult Region	Yes- Wheel Chair accessible.	Yes- Bilingual staff members(Spanish) Alex Viaz, Aricell Muest, Emilia Avena, American sign language.	Everything they print is both English and Spanish.
Substance Abuse	Desert Comm Drug Team (Indio Sub. Abuse)	IN038	85-912	Avenue 45, #1, 3, 5, 7, 8, 9 & 10	Indio	92201	K. Kane	8:00am - 5:00pm M-Th	No	No	Yes- Wheel chair ramps	Yes- 5 bilingual staff members speak spanish, 1 taglog	Signs and flyers only English, all forms are in Spanish.
Substance Abuse	Start DAS	RV119	1777	Atlanta Ave. #G-1	Riverside	92507	K. Kane	8:00am - 5:30pm M-Th	Yes- Bus line	No	Yes- Wheel Chair Accessible	Yes- Bilingual Staff Members who speak spanish is about 10.	Signs, no flyers some papework in Spanish.
Substance Abuse	Riverside DAS (DUI)	RV119	1777	Atlanta Ave. #G-1	Riverside	92507	K. Kane	8:00am - 5:30pm M-Th	Yes- Bus line	No	Yes- Wheel Chair Accessible	Yes- Bilingual Staff members speak spanish.	Signs, no flyers some papework in Spanish.
Substance Abuse	Prop. 36 Admin.	RV119	1777	Atlanta Ave. #G-1	Riverside	92507	K. Kane	8:00am - 5:30pm M-Th	Yes- Bus line	No	Yes- Wheel Chair Accessible	Yes- Bilingual Staff members speak spanish.	Signs, no flyers some papework in Spanish.
Substance Abuse	Riverside Community Drug Team	RV241	1827	Atlanta Ave. #D1	Riverside	92507	K. Kane	8:00am - 6:00pm M-Th	Yes- Bus line	Yes- Substance Abuse, Western Adult Region, Sublease	Yes- Wheel Chair Ramps. Brail on front door for phone number and address.	Yes- 6 Bilingual Staff members who speak spanish. One American sign language.	English and Spanish. Flyers and pamphlets. Referrals, Applications, Workbooks.

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Leased Building Management Spreadsheet
March 2010

Region	Services/Unit	Site ID #	Address	Street	City	Zip	Manager	Hours of Operation	Are they located by a bus or train line?	collocated site (yes or no) What Type	ADA Accessible (yes or no) What Type? Wheelchair ramp, Blind, Deaf	Multilingual (yes or no) What type (Hispanic, Asian, Russian, Portuguese, etc.)	Misc. Cultural Competency Services (magazines, posters, decor, signs, etc.)
OVERALL													
Substance Abuse	Riverside Drug Court Aftercare	RV241	1627	Atlanta Ave. #G1	Riverside	92507	K. Kane	8:00am - 6:00pm M-Th	Yes- Bus line	Yes- Substance Abuse, Western Adult Region, Sublease	Yes- Wheel Chair Ramps. Brail on front door for phone number and address.	Yes- Bilingual Staff members speak spanish.	English and Spanish. Flyers and pamphlets. Referrals. Applications. Workbooks.
Substance Abuse	Riverside Drug Court	RV241	1627	Atlanta Ave. #D1	Riverside	92507	K. Kane	8:00am - 6:00pm M-Th	Yes- Bus line	Yes- Substance Abuse, Western Adult Region, Sublease	Yes- Wheel Chair Ramps. Brail on front door for phone number and address.	Yes- Bilingual Staff members speak spanish.	English and Spanish. Flyers and pamphlets. Referrals. Applications. Workbooks.
Substance Abuse	DDP (Inlde DAS (DUI)	IN031	45-596	Fargo #6	Indio	92201	K. Kane	8:00am - 5:30pm M-Th	Yes- Bus line	No.	Yes- Wheel chair accessible	Yes- Bilingual Staff members speak spanish.	Printed information is in english and spanish.
Substance Abuse (Total)													
WESTERN ADULT REGION													
Western Adult	Main Street Clinic	CR020	629	N. Main Street	Corona	92880	M. Marquez	8:00am - 5:30pm M-Th	Yes- Bus line	No	Yes- wheel chair accessible	Yes- Employees are bilingual. They speak Spanish. For other languages they refer clients to the interpreting services.	Signs, forms, and flyers are provided in English and Spanish.
Western Adult	HHOPE Program	HM027	650	N. State St.	Hemet	92543	M. Marquez	8:00am - 5:30pm M-Th	Yes- Bus line	Yes- Mid-County Region, Substance Abuse, Western Adult Region	Yes- Wheel Chair accessible.	Yes- Bilingual Staff members speak spanish.	Everything they print is both English and Spanish.
Western Adult	TAY (ISRC-MHSA)	RV241a	1627	Atlanta Ave. #D2	Riverside	92507	M. Marquez	8:00am - 6:00pm M-Th	Yes- Bus line	Yes- Substance Abuse, Western Adult Region, Sublease	Yes- Wheel Chair Ramps. Brail on front door for phone number and address.	Yes- Bilingual Staff members speak spanish.	English and Spanish. Flyers and pamphlets. Referrals. Applications. Workbooks. Receptionist 3 out of 5.
Western Adult	Adult (ISRC-MHSA)	RV241a	1627	Atlanta Ave. # D3	Riverside	92507	M. Marquez	8:00am - 6:00pm M-Th	Yes- Bus line	Yes- Substance Abuse, Western Adult Region, Sublease	Yes- Wheel Chair Ramps. Brail on front door for phone number and address.	Yes- 6 Bilingual Staff members who speak spanish. One American sign language.	English and Spanish. Flyers and pamphlets. Referrals. Applications. Workbooks. Receptionist 3 out of 5.
Western Adult	Western Regional Benefits	RV241a	1627	Atlanta Ave. #D3	Riverside	92507	M. Marquez	8:00am - 6:00pm M-Th	Yes- Bus line	Yes- Substance Abuse, Western Adult Region, Sublease	Yes- Wheel Chair Ramps. Brail on front door for phone number and address.	Yes- Bilingual Staff members speak spanish.	English and Spanish. Flyers and pamphlets. Referrals. Applications. Workbooks. Receptionist 3 out of 5.
Western Adult	MHSA Vocational (use to be Jefferson Wellness Ctr)	RV241n	1627	Atlanta Ave. #D3	Riverside	92507	M. Marquez	8:00am - 6:00pm M-Th	Yes- Bus line	Yes- Substance Abuse, Western Adult Region, Sublease	Yes- Wheel Chair Ramps. Brail on front door for phone number and address.	Yes- Bilingual Staff members speak spanish.	English and Spanish. Flyers and pamphlets. Referrals. Applications. Workbooks. Receptionist 3 out of 5.
Western Adult	Blaine MHSA	RV310	769	Blaine, #B	Riverside	92507	M. Marquez	8:00am - 5:30pm M-Th	Yes- Bus line	Yes- Children's Region, Western Adult Region	Yes- Wheel Chair ramps, inside signs have brail.	Yes- Bilingual Staff members speak spanish.	Signs and flyers are printed in English and Spanish.
Western Adult	Western Regional Administration	RV310	769	Blaine, #B	Riverside		M. Marquez				Yes- Wheel Chair ramps, inside signs have brail.	8 bilingual Staff members(Spanish). Dinery Villegomez, Natasha Sanchez, Rachel Douglas, Brenda Palacios, Zulma espenoza, Isabel Sandili, Marisella Gutierrez, Nisha Elliot. For other languages clients are referred to an interpreting service.	Signs and flyers are printed in English and Spanish.
Western Adult	Blaine - HHOPE	RV310	769	Blaine #B	Riverside	92507	M. Marquez	8:00am - 5:30pm M-Th	Yes- Bus line	Yes- Children's Region, Western Adult Region	Yes- Wheel Chair ramps, inside signs have brail.	Yes- Bilingual Staff members speak spanish.	Signs and flyers are printed in English and Spanish.
Western Adult (Total)													

Riverside County Department of Mental Health
Leased Building Management Spreadsheet
March 2010

Region	Services/Unit	Site ID #	Address	Street	City	Zip	Manager	Hours of Operation	Are they located by a bus or train line?	collocated site (yes or no) What Type	ADA Accessible (yes or no) What Type? Wheelchair ramp, Blind, Deaf	Multilingual (yes or no) What type (Hispanic, Asian, Russian, Portuguese, etc.)	Misc. Cultural Competency Services (magazines, posters, décor, signs, etc.)
OVERALL													
WESTERN CHILDREN'S REGION													
Western Children's	F.A.C.T.	CR007	1195	Magnolia Ave.	Corona	91719	S. Steinberg	8:430m-th	Yes- Bus line		Yes- Wheel Chair Accessible	Bilingual Staff members. Spanish	Signs and forms in Spanish and English
Western Children's	Incredible Kids	MV024	23119	Cottonwood Ave., #A110	Moreno Valley	92553	S. Steinberg	8-530 m-th	Yes- Bus line	No.	Yes- Wheel Chair Accessible	Bilingual Staff members. Spanish	Signs in Spanish and English
Western Children's	Children's Interagency Prgm. (CHIPS)	MV024	23119	Cottonwood Ave., #A110	Moreno Valley	92553	S. Steinberg	6-530 m-th	Yes- Bus line	No.	Yes- Wheel Chair Accessible	Bilingual Staff members. Spanish	Signs in Spanish and English
Western Children's	Western Children's Admin	RV245	3707-9731	Magnolia Ave. #30	Riverside	92503	S. Steinberg	8:00am - 5:30pm M-Th	Yes- Bus line	Yes.. Admin, Children's Region, Western Children's	Yes- Wheel Chair Ramp, Elevator.. All signs in brail.	Yes- Multilingual staff who speak Spanish and Bengali Cassette Tapes in Spanish that is a guide to consumer services	Signs, Flyers, and Magazines in Spanish
Western Children's	West Children's Wraparound Svcs	RV350	6848	Magnolia Ave. #200	Riverside	92506	S. Steinberg	8-530 m-th	Yes- Bus line		Yes- Wheel Chair accessible	Yes- Bilingual staff who speak Spanish.	Paperwork in Spanish. Signs also
Western Children's	West Children's MHSA MDFT	RV350	6848	Magnolia Ave. #200	Riverside	92506	S. Steinberg	8-530 m-th	Yes- Bus line		Yes- Wheel Chair accessible	Yes- Bilingual staff who speak Spanish	Paperwork in Spanish. Signs also
Western Children's (Total)													
SUBLEASE (INCOMING REVENUE)													
Sublease - Desert (County Bldg)	Oasis OCS	IN027	47-915	Oasis Street	Indio	92201	M. Gross	8am-5-30pm	Yes- Bus line	No.	Yes- Wheel Chair accessible	Yes- Bilingual Staff Speaking Spanish. For other languages clients are referred to interpreting Services.	Printed information in English and Spanish.
Sublease - Desert (County Bldg)	Oasis PHF	IN027	47-915	Oasis Street	Indio	92201	M. Gross	8am-5-30pm	Yes- Bus line	No.	Yes- Wheel Chair accessible	Yes- Bilingual Staff Speaking Spanish. For other languages clients are referred to interpreting Services	Printed information in English and Spanish.
Sublease - Desert (County Bldg)	Anka CRT	IN025	47-915	Oasis Street	Indio	92201	C. Withrow	8am-5-30pm	Yes- Bus line	No.	Yes- Wheel Chair accessible	Yes- Bilingual Staff Speaking Spanish. For other languages clients are referred to interpreting Services.	Printed information in English and Spanish.
Sublease - Desert (Leased Bldg)	Family Services of the Desert	BL034	1297	W. Hobsonway	Blythe	92225	D. Lundquist	8.00am - 5.30pm	No	Yes- Desert Region, Substance Abuse, Sublease	No	Yes- Their OAII Angelica speaks Spanish.	All print is done in English and Spanish.
Sublease - Western Adult (Leased Bldg)	Desert JTP Safehaven "The Path"	PG1105	19531	McLane St., Suite B	Palm Springs	92262	M. Marquez	8:00am - 5:00pm M-Th	No	No.	Yes- Wheel chair accessible	Yes- Bilingual Staff. Spanish. For other languages they refer them to interpreting services.	Signs and forms are in Spanish.
Sublease - Mid-County (Leased Bldg)	Anka Adult Treatment Services	LE026	21946	Mission Trail, Suite B	Lake Elsinore	92530	C. Withrow	8:00am - 5:00pm M-Th	No	Yes- Mid-County Region, Older Adult, Sublease	No	Yes- Bilingual spanish(spanish) about 10. Other languages referred to interpreting services	Signs and flyers are printed in English and Spanish
Sublease - Western Adult (Leased Bldg)	JTP Riverside Safehaven 'The Place"	RV351	2800	Hulen Place	Riverside	92507	M. Marquez	8:00am - 5:00pm M-Th	Yes- Bus line	No.	Yes- Wheel Chair accessible	Yes- Bilingual Staff	Signs are posted in Spanish and English.
Sublease - Substance Abuse (Leased Bldg)	Riverside County Probation Department	RV241	1827	Atlanta Ave. #D1	Riverside	92507	K. Kane	8:00am - 6:00pm M-Th	Yes- Bus line	Yes- Substance Abuse, Western Adult Region, Sublease	Yes- Wheel Chair Ramps. Brail on front door for phone number and address.	Yes- Bilingual Staff members 5. Spanish, one American sign language.	All print is done in English and Spanish.
Sublease - Substance Abuse (Leased Bldg)	Riverside Latino Commission	ME004	91-275	Avenue 66	Mecca	92254	L. Contreras	8:00am - 5:00pm M-Th	No	Yes- Cultural Competency Region, Sublease (Incoming Revenue).	Yes- Wheel Chair Accessible	Bilingual Staff Members. For other languages they refer them to an interpreter.	information is printed in English and Spanish.
Sublease (Total)													

ATTACHMENT #46

SERVICE DISPARITIES: UNMET NEED, PENETRATION, and SERVICE TRENDS

Riverside County Department of Mental Health

EXECUTIVE SUMMARY

- The number of mental health consumers served by Riverside County Department of Mental Health (RCDMH) has increased 25.79% since the planning of the Mental Health Services Act began in 2003-2004 fiscal year (from 34,539 in FY0304 to 43,447 consumers in FY0809).

- Despite gains in the number served, overall unmet need has remained constant at 70.67% in FY0809 with only slight improvement from FY0304 (71.40%). Slight decreases in unmet need have occurred for some age groups.

  √ The number of adults served has increased 35.59% and Unmet Need decreased.

  √ The number of older adults served has also increased 39.75% but existing disparities have not yet been eliminated.

  √ The number of youth served has decreased 6.02% adding to existing disparities.

  √ When comparing various ethnic groups, disparities have decreased for some groups, and remained the same or increased for other groups.

- Medi-Cal Penetration Rates: In FY0304 Riverside County had a total penetration rate slightly higher than the state-wide rate. By CY2008 the total penetration rate had dropped below the state-wide rate and below the penetration rates for other large counties.

  √ Medi-cal penetration rates show a pattern of disparities similar to unmet need.

  √ Disparities are present for Medi-Cal eligible youth and older adults with the penetration rate worsening for youth from 2007 to 2008. Older adult rates show slight improvements, but existing disparities are still present.

  √ When comparing various ethnic groups, disparities are evident for Hispanic and Asian/Pacific islander groups while White and Black groups are overrepresented.

- Service Trends: Over the last five years some improvements have been made in narrowing the gaps between ethnic groups served. The number served for some ethnic groups and regions in the county are showing patterns that are reflective of the ethnic groups in the community.

UNMET NEED

'Unmet Need' is an estimate of how many mentally ill individuals there are in the County who are not receiving the mental health services they need[1].

Unmet Need is calculated based on the difference between:
(1) known prevalence rates of mental illness and (2) how many consumers receive mental health services.

RCDMH completed a detailed analysis of Unmet Need when drafting the initial Mental Health Services Act (MHSA) proposal. While changes since then can not be entirely attributed to MHSA implementation it is useful to examine how disparities in Unmet Need have changed.

Department-Wide Unmet Need

The following is a summary of changes from FY0304 to FY0809:

- RCDMH served 25.79% more consumers (34,539 compared to 43,447 consumers).

- The number of youth served has decreased by 6.02% (from 10,521 to 9,887).

- The number of adults served increased by 35.59% (from 22,403 to 31,273).

- The number of Older Adults served increased 39.75% (from 1,615 to 2,287)
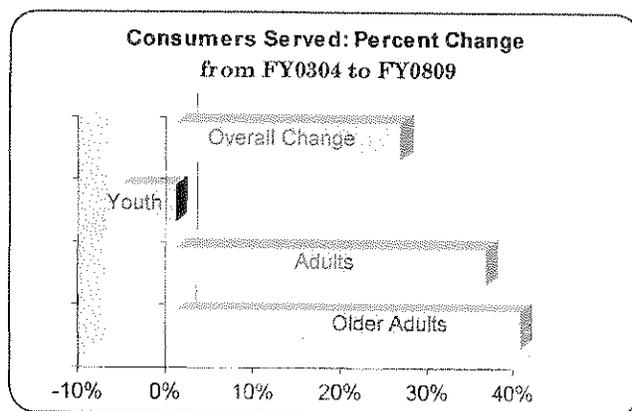
- Population growth in the County continues to effect Unmet Need. Despite gains in the number served, overall unmet need has remained steady at 70.67% in FY0809 with only slight improvement from FY0304 (71.40%).

- Unmet Need for adults is slightly better than the County overall Unmet Need. Adults showed a decrease from 65.03% to 62.15%.

- Older Adults continue to show high Unmet Need, but improvements have occurred, with a decrease from 89% to 86% in Unmet Need in FY0809.

- Due to population growth and reductions in the number of youth served, Unmet Need in Youth increased from 74% to 79% in FY0809.

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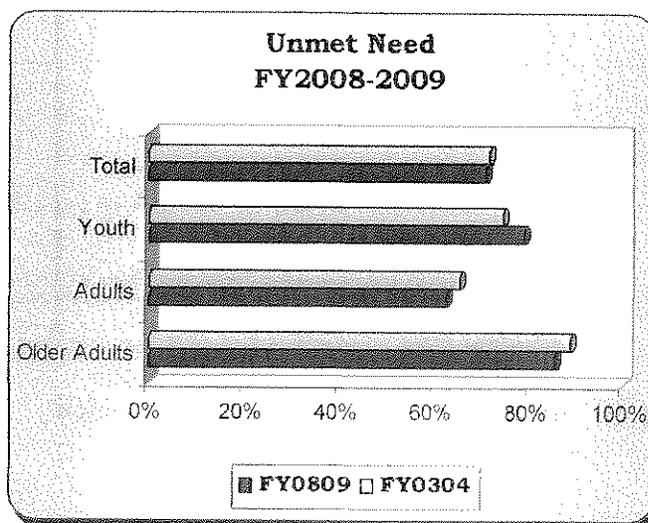
[1]The full updated Unmet Need report for FY0809 is provided in the appendix and includes references for how prevalence estimates were established.

Unmet Need by Ethnicity

As already noted the overall number of consumers served increased by 25.79% from FY0304 to FY0809. However, Unmet Need also increased as the population of the County grew.

To understand current disparities in Unmet Need, the overall unmet need (70.67%) can be used to make comparisons. Ethnic groups with Unmet Need at rates greater than 70.67% are worse off than groups with Unmet Need at less than 70.67%.

The following is a summary of changes[1] from FY0304 to FY 0809:

- Youth Unmet Need increased for all ethnic groups because the number of youth served has <u>decreased</u> while the population of youth has <u>increased</u>.

- Black youth faired somewhat better than the other groups with Unmet Need below the overall 70.69%. However, Unmet Need increased from 52.66% to 64.79% in FY0809.

- Hispanic and Asian/Pacific Islander youth show higher unmet need than the other groups.

Youth <18 Yrs Unmet Need
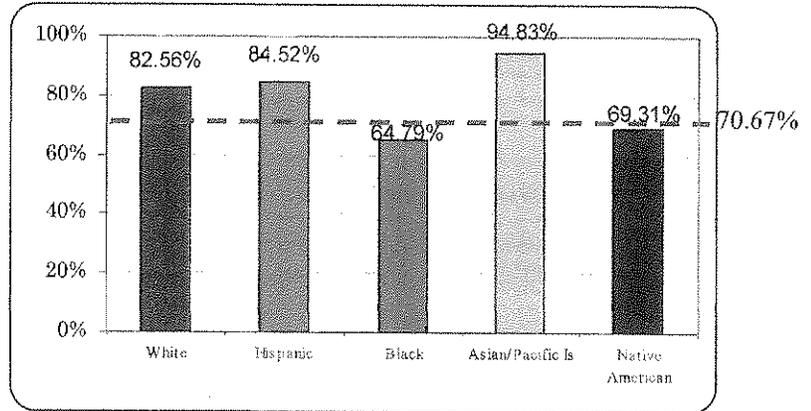
- For White and Black adult groups slight increases in Unmet Need occurred. The Unmet Need for these groups was lower than the overall 70.69%.

- Unmet Need for Hispanic adults remains higher than the overall percentage, but a 5.45% drop in Unmet Need since FY 0304 shows disparities are decreasing.

- Unmet Need increased 6.96% for the Asian/Pacific Islander adults by FY0809. This group has the highest Unmet Need, but represents a smaller proportion of the County adult population.

Adults >18yrs Unmet Need
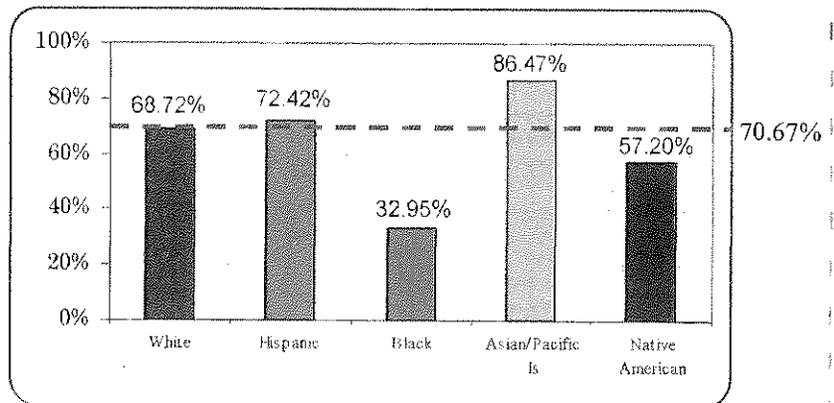
Note: Prevalence data for ethnicity is only available for adults and older adults combined so the Unmet Need for adult ethnic groups includes older adults as well.

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[1]The full updated Unmet Need report for FY0809 is included in the appendix and includes references for how prevalence estimates were established.

PENETRATION RATE

Medi-Cal penetration data are important for understanding what populations need more effective outreach to identify new clients needing services. Historically, in California, penetration data refers specifically to Medi-Cal penetration. This is calculated as the proportion of Medi-Cal consumers served out of the total number of people with Medi-Cal eligibility. The California State Department of Mental Health uses Medi-Cal paid claims to provide penetration rates for each County[2].

Department-Wide Penetration

In FY0304 , Riverside County had a penetration rate slightly higher than the state-wide penetration rate. However, in CY 2008 the penetration rate had dropped below the state-wide rate.

Department-wide Penetration rates decreased from 6.6% to 5.2% because:

- Medi-Cal beneficiaries in Riverside County increased 29.73% from 282,763 to 366,844[3].
- The number of Medi-Cal beneficiaries served increased only 3.64% from 17,894 to 18,547

Penetration for Age Groups:

- The penetration rate for youth (age 6-17) in Riverside County at 6.22% is less than the rate for other large counties (8.01%) and the state (8.0%).

- Also the penetration rate for youth age 6-17 in Riverside County has decreased from 2007 to 2008.

- The rate for adults at 9.28% is higher than the state rate and similar to other large counties while the older adults penetration rate is slightly lower than the state and other large counties.

- The older adults served are disproportionate to their representation in the Medi-Cal population. However, the disparity for older adults has shown slight improvement with the penetration rate increasing from 2.81% in 2007 to 3.05% in 2008.

Penetration by Age for Riverside, Large Counties and the State

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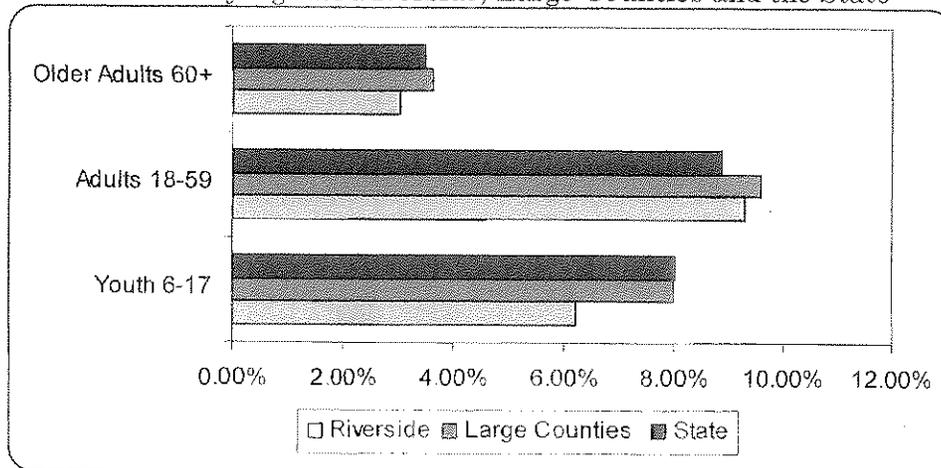
[2] The California State Department of Mental Health changed the time frame for providing Penetration rates in 2006 to calendar year instead of fiscal year.

[3] The data that the state Department of Mental Health provide calculate penetration based on the monthly average number of Medi-Cal beneficiaries. APS health Care analyzes the data for the state.

Penetration for Ethnic Groups

Penetration rates for ethnic groups in Riverside County are less then other large counties and the state.

* Penetration rates for the Hispanic group and the Asian/Pacific Islander group are considerably lower than the rates for other race/ethnic groups.

* Penetration rates for all ethnic groups except Other have decreased since FY0304.

Compasion of Medi-Cal Penetration Rates Riverside County, Large Counties, and State

Legend: □ Riverside County ▨ Large Counties ▨ State
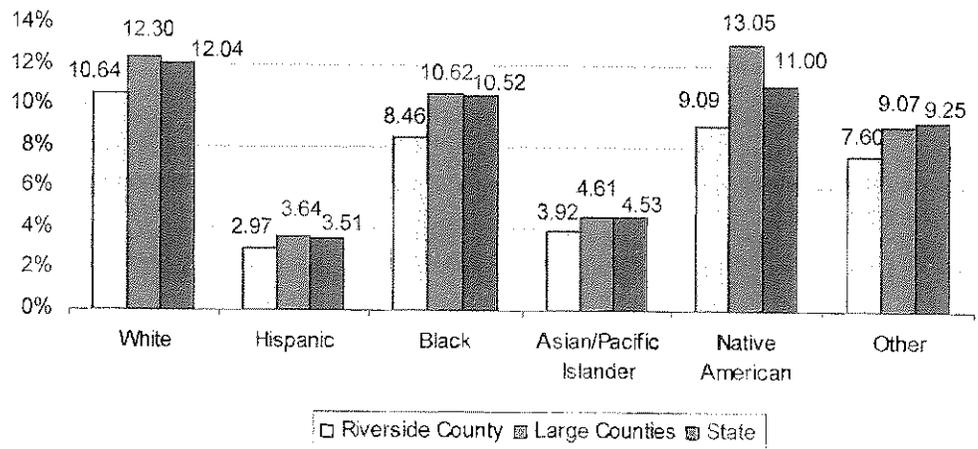
	White	Hispanic	Black	Asian/PI	Native American	Other
FY0304	11.8 %	3.4%	9.7%	5.4%	Unavailable	6.9%
CY2008	10.6%	2.97%	8.46%	3.9%	9.09%	7.6%

The graph below shows the distribution of each race/ethnic group for those in the total Medi-Cal population and the population of RCDMH beneficiaries served. Beneficiaries served by ethnicity/race group showed that more White beneficiaries are served than any other race/ethnic group.

* The white group served is nearly twice the proportion represented in the Medi-Cal population.

* The Hispanic proportion served is just over half the proportion represented in the population.

* The Black group showed an overrepresentation given the proportion in the total Medi-Cal population.

* The Hispanic and Asian/Pacific Islander group show the most disparity although the Asian/Pacific Islander group is a much smaller proportion of the total Medi-Cal Population.

Comparasion of Medi-Cal Eligible to Medi-Cal Served by Race/Etnicity

Legend: ▨ % Medi-Cal Total Population □ % Medi-Cal Served
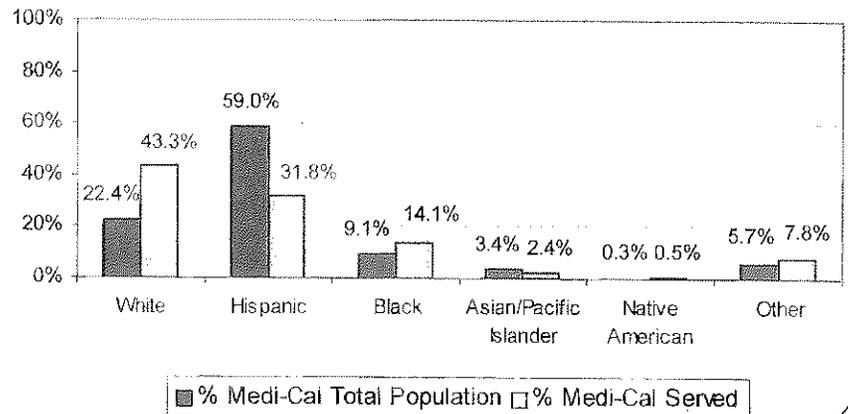
SERVICE TRENDS

Unmet Need and Medi-Cal Penetration rates are only part of the picture of disparities in the County. Changes in disparities over time are also evident from an analysis of service trends for all consumers served. Trends for the number of consumers served by age, ethnicity and region show a more detailed picture of gaps and improvements.

The following graphs show the trends for the number of youth served in each region by ethnicity.

- Disparities for Hispanic youth have decreased with the number served increasing over time and better reflecting the population of youth in the County.

36% White
51% Hispanic
6% Black
4% Asian/PI
.4% Native American
3% Multirace

- All regions showed improvement in disparities between White and Hispanic youth.

- The number of Black youth served has remained relatively constant. Given the proportion of Black youth in the population this group is overrepresented at 6% of the County population and 11% of the consumers served in FY08/09.

- The number of Asian/Pacific Islanders served is small and has remained constant over the years. Disparities have remained with Asian/Pacific Islanders at 4% of the population and only 1% of the consumers served in FY 0809.

- The number of Native American youth served has also remained constant, however slightly more Native American youth were served in FY0809 (1%) than are present in the population(.4%).

Youth Western Region
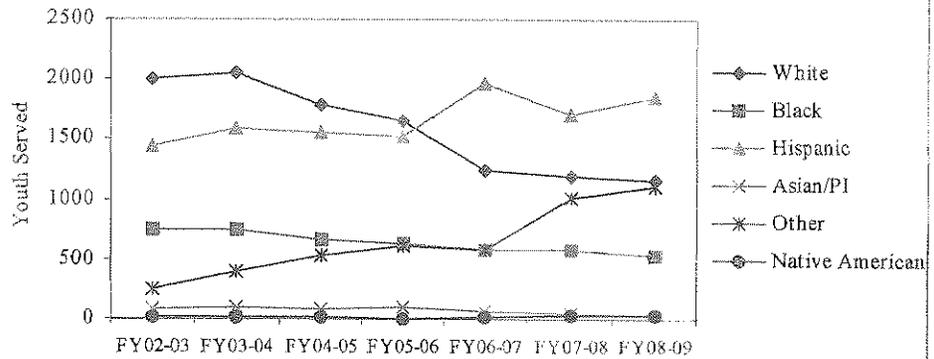
Youth Mid-County Region

Youth Desert Region

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Riverside County Department of Mental Health
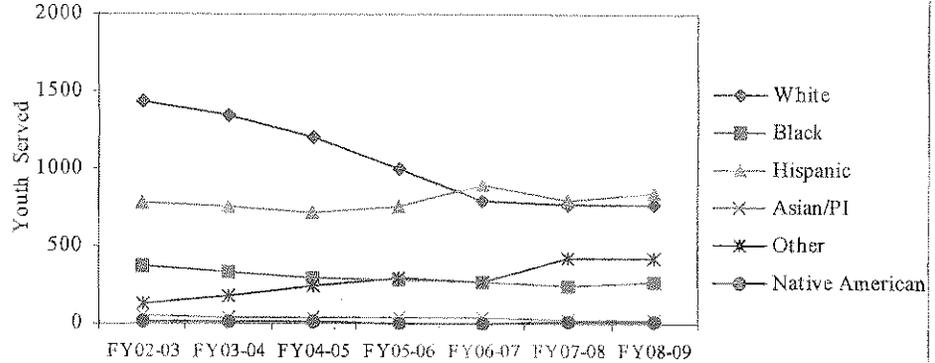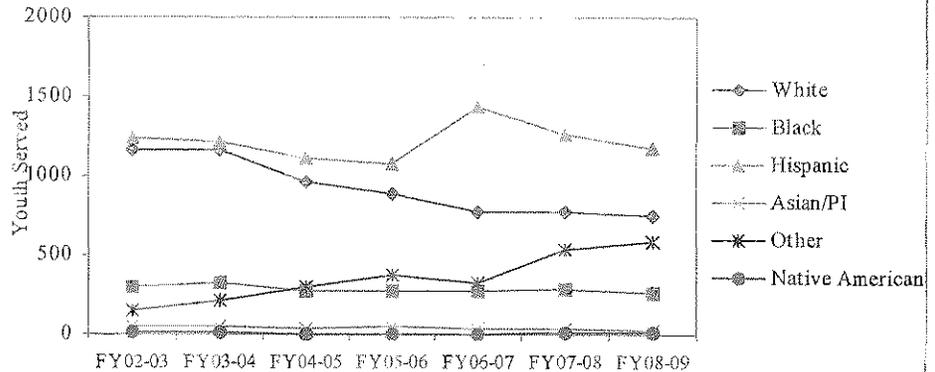
SERVICE TRENDS

The following graphs show the trends for the number of adults served in each region by ethnicity.

- Disparities between White and Hispanic adults are evident in the Western and Mid-County region. However gradual improvements have occurred over time.

- The Desert region has shown an increase in the number of Hispanics served and a reduction in the disparity between the White and Hispanic group.

45% White
41% Hispanic
7% Black
5% Asian/PI
.6% Native American
1% Multirace

- The number of Black adults served has increased in each region. Given the proportion of Black adults in the population this group is overrepresented at 7% of the County population and 13% of the adult consumers served in FY08/09.

- The Asian American/PI group has shown slight decreases in the number served. Disparities have continued for this group with 5% of the population and only 2% of the adult consumers served in FY0809.

Adult Western Region
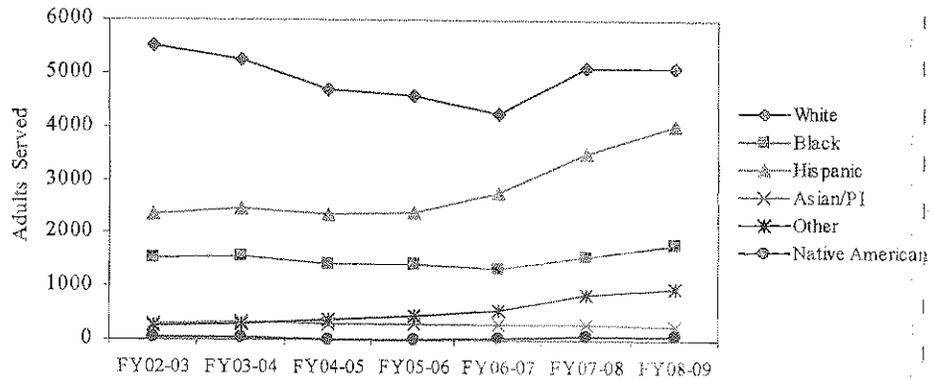
Adult Mid-County Region

Adult Desert Region

Research and Evaluation
Riverside County Department of Mental Health | 06.02.2010
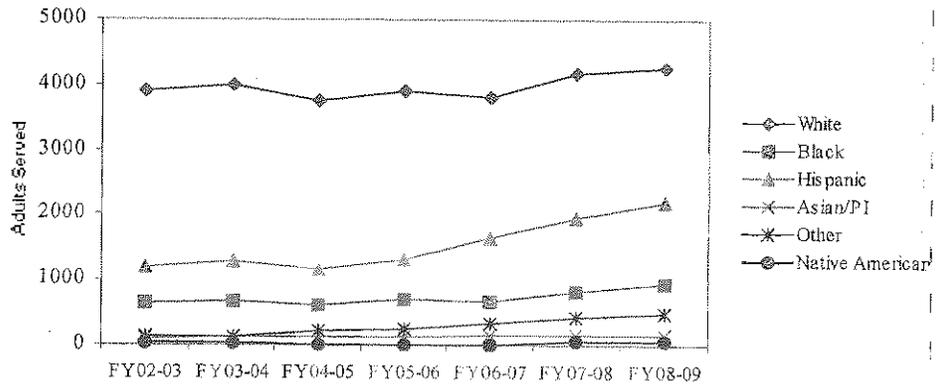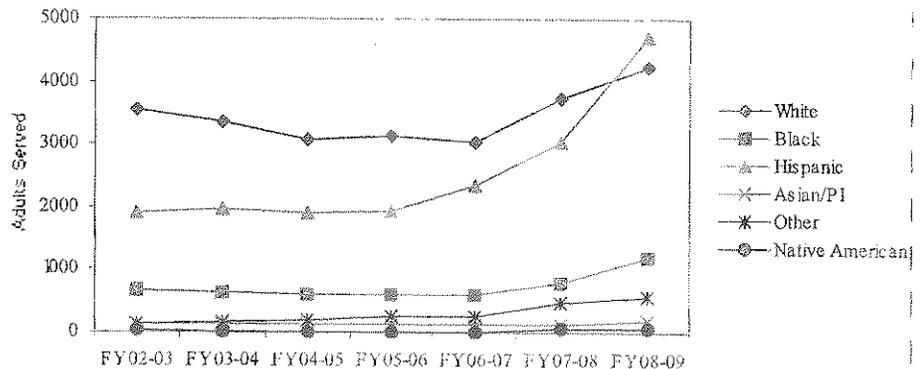
SERVICE TRENDS

The following graphs show the trends for the number of older adults served in each region by ethnicity.

- Disparities between White and Hispanic older adults are not as evident. Given that a large proportion of the older adult population is White it is expected that smaller proportions of older adults would be served in the other ethnic groups.

- The number of Asian/PI older adults served in the Western region (6.2%) is a slightly higher proportion than is present in the population(4%).
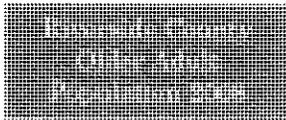
70% White
19% Hispanic
5% Black
4% Asian/PI
.6% Native American
1% Multirace

- The number of Hispanic older adults served is closely reflective of the County population(19%): 22.9% served in the Desert, 17.5% served in the Western region and somewhat less in Mid-County at 15.9% served.

- The number of Black older adults served has increased. This group is overrepresented at 5% of the population and 12% of the consumers served.

Older Adult Western Region
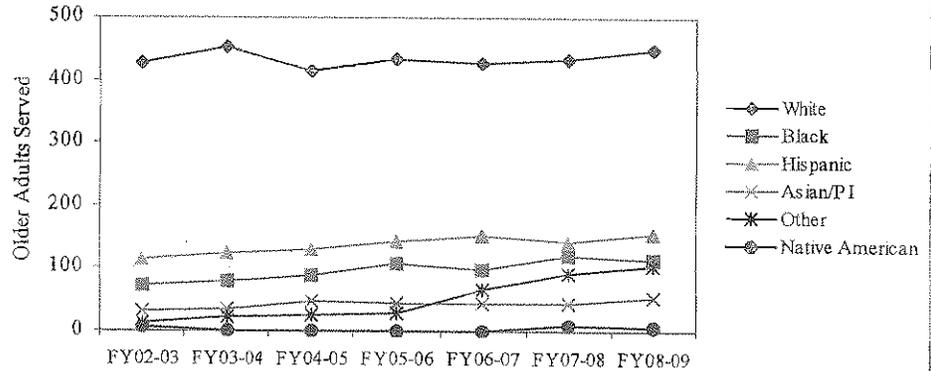
Older Adult Mid-County Region
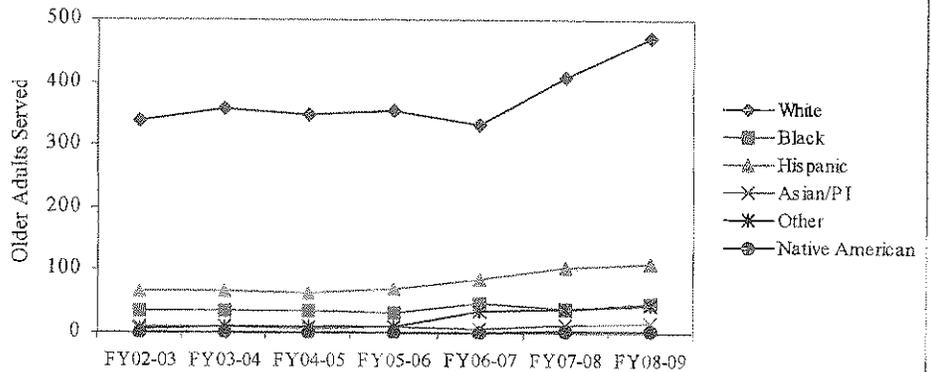
Older Adult Desert Region
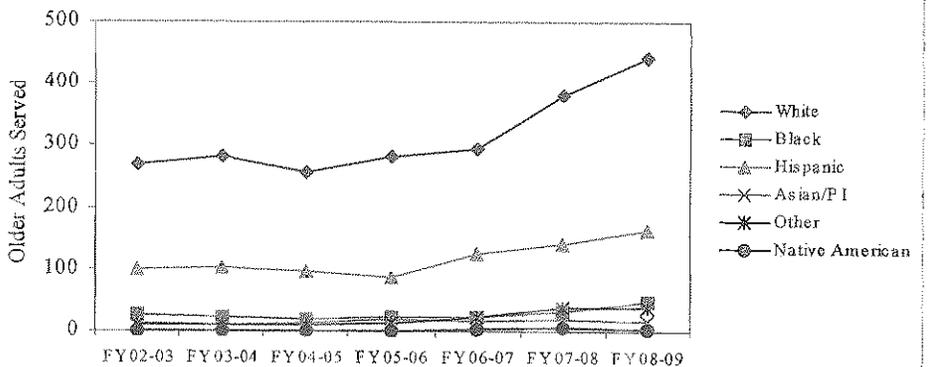
ATTACHMENT #47

Problem Resolution Report:
Grievances, Appeals and State Fair Hearings
FY2008-2009, 2nd Half
January 1 through June 30, 2009
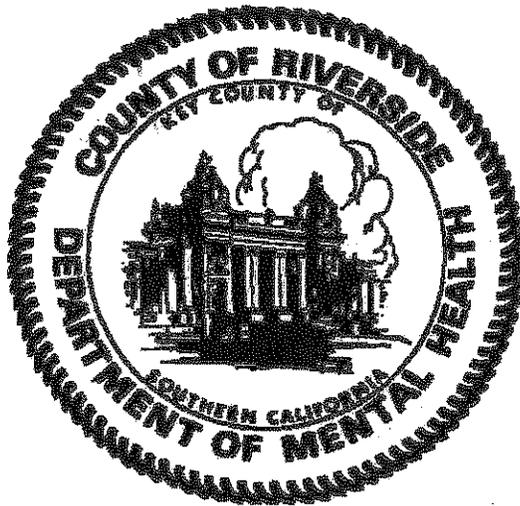
Riverside County Department of Mental Health
Outpatient Quality Improvement

The term **Problem Resolution** includes:
- The grievance process (available to all consumers of mental health services).
- The appeal process and expedited appeal process (available to Medi-Cal beneficiaries).
- The State Fair Hearing (available to Medi-Cal beneficiaries).

Section I of this report describes the results of 6 Grievances and 15 Complaints filed with Outpatient Quality Improvement (QI) from January 1 through June 30, 2009.

The timeliness of QI's response in resolving the grievances was within guidelines in 5 of the 6 grievances. There was one case with delayed resolution for which an explanation is provided.

Grievance filings decreased in the current reporting period compared to the previous Jul-Dec08 period, continuing a trend of a decrease in grievances filed during the last three years. The number of grievance subjects reported in the filed grievances followed a similar pattern. The number of complaints decreased in the current reporting period to 15 (from 24 in the previous Jul-Dec08 reporting period) and the number of complaint subjects reported decreased. These data trends are presented in Figures 1-4.

The most frequently listed grievance/complaint categories (see Table 2) were:
- Quality of services (26.9%)
- Interaction/Conduct by doctor with client (13.5%)
- Type/Frequency/Location of services (11.5%)
- Interaction/Conduct by staff with client (11.5%)
- Interaction/Conduct by staff with family/guardian (11.5%)

Section II of this report describes the results of the 26 Appeals filed with QI from January 1 through June 30, 2009 and also the five filings for State Fair Hearings during the same time period.

The timeliness of QI's response to the formal appeals was within guidelines in 19 of the 26 appeals and explanations for delayed appeal resolutions are provided.

Finally, the State Fair Hearing process is covered and the results of the five State Fair Hearings are summarized.

Summary of Problem Resolution for January 1 through June 30, 2009			
	Total Filed	**Resolved**	**QI Response within Guidelines**
Number of Grievances	6	6	5
Number of Complaints	15	15	n/a
Number of Appeals	26	26	19
Number of State Fair Hearings	5	4	n/a

Introduction

The term "Problem Resolution" includes the grievance process (available to all consumers of mental health services) as well as the appeal process, the expedited appeal process and the State Fair Hearing (available to Medi-Cal beneficiaries). Problem Resolution is directed and coordinated by Outpatient Quality Improvement (QI) of the Riverside County Department of Mental Health according to standards and procedures established by the State.

A Grievance is an expression of dissatisfaction by any consumer/beneficiary of mental health services about any matter. The majority of the concerns that mental health service consumers have can be resolved using the grievance process, which was designed to encourage rapid identification and resolution of mental health concerns.

However, some actions by mental health service providers are not covered by the grievance process and instead use the appeal process. The appeal process covers actions by mental health service providers to deny requests for specialty mental health coverage to Medi-Cal beneficiaries.

An expedited appeal (with more rapid resolution) can be filed when the standard appeal resolution process could jeopardize the beneficiary's health or ability to maintain maximum function. There were no expedited appeals filed in Riverside County from January 1 through June 30, 2009.

If an appeal is denied, the mental health service beneficiary has the right to a State Fair Hearing by filing their request for a State Fair Hearing with the Administrative Adjudications Office in Sacramento. A State Fair Hearing is an independent review conducted by the State as the final arbitration for appeals when services have been denied, terminated, or reduced.

Section I. Grievances & Complaints filed from January 1 through June 30, 2009

A grievance is a formal expression of dissatisfaction by any consumer/beneficiary of mental health services arising in the course of utilizing his/her Mental Health Plan. Examples of common grievance subjects are: rude conduct of provider staff with the consumer, dissatisfaction with the type/frequency/location of services offered, and problems with medications.

A grievance may be filed by a consumer/beneficiary (or that person's representative) with his/her health service provider, CARES, or with Quality Improvement (QI). A grievance may be filed orally or in writing. The provider or CARES then faxes the grievance to QI, which directs and coordinates the grievance process. The grievance must be entered into the electronic Grievance Log within one day.

A complaint is filed when the consumer has an issue and requests follow-up but does not want to "file" a grievance. The issue is still logged and the "complaint only" box is checked. The beneficiary may later file a grievance if the resolution of the complaint is not satisfactory.

State Requirements:

The State requires that Quality Improvement's Grievance Log documents: a) the name of the beneficiary/consumer, b) the date of the receipt of the grievance, c) the nature of the problem, and d) the final disposition of the grievance.

There are also State requirements for the timeliness of Quality Improvement's response during the Grievance Process. Complaints do not have a State requirement for timeliness.

These State requirements are:
1) A letter acknowledging the receipt of the grievance must be sent by QI to the beneficiary within ten (10) working days.

2) A written decision/resolution letter must be sent by QI to the beneficiary within 60 calendar days of QI's receipt of the grievance.

A total of 21 grievances and complaints were logged between January 1 and June 30, 2009:
- 6 (28.6%) were grievances
- 15 (71.4%) were complaints

Table 1. Timeliness and Resolution of Six Grievances Logged by Type of Case

	Closed Cases	Open Cases	Total
Number of Grievances Filed	6	0	6
Acknowledgment Letter Sent within 10 Working Days	6	0	6
Resolution Letter Sent within 60 Days	5	0	5
Resolution Letter Not Sent within 60 Days	1	0	1

Table 1 summarizes the timeliness and resolution of the 6 grievances logged between January 1 and June 30, 2009. There were 6 grievances filed in total and all of these grievances were closed cases.

Acknowledgement Letters
All acknowledgement letters (100%) were sent within ten working days for all six of the cases. These acknowledgement letters took an average of two days to be sent and the longest took eight calendar days.

Resolution Letters
Five (83%) of the six mailed resolution letters were sent within 60 days. These resolution letters took an average of 45 days to be sent and the longest took 59 days.

● There was one resolution letter (row 4) which was not sent until 77 days after the grievance filing as QI Staff waited for the therapist to respond to the grievance before resolving it.

Table 2. Summary of the Nature or Subject of the Grievances and Complaints Logged

	FY08-09, 1st Half (1/01/2009 – 6/30/2009)		
	Grievance (N = 6) (28.6%)	Complaint (N = 15) (71.4%)	Total (N = 21)
Physical Plant	0	0	0
Patients' Rights	6.3% (1)	8.3% (3)	7.7% (4)
Type/Frequency/Location of Services	18.7% (3)	8.3% (3)	11.5% (6)
Medication Issues	6.3% (1)	8.3% (3)	7.7% (4)
Seclusion/Restraint	0	2.8% (1)	1.9% (1)
Financial/Personal Property	0	0	0
Language or Cultural	0	2.8% (1)	1.9% (1)
Quality of Services	31.2% (5)	25.0% (9)	26.9% (14)
Physical/Sexual Abuse	0	5.5% (2)	3.8% (2)
Interaction/Conduct by Doctor with Client	12.5% (2)	13.9% (5)	13.5% (7)
Interaction/Conduct by Doctor with Family/Guardian	6.3% (1)	0	1.9% (1)
Interaction/Conduct by Doctor with Other	0	0	0
Interaction/Conduct by Staff with Client	6.3% (1)	13.9% (5)	11.5% (6)
Interaction/Conduct by Staff with Family/Guardian	12.5% (2)	11.1% (4)	11.5% (6)
Interaction/Conduct by Staff with Network Provider	0	0	0
Interaction/Conduct by Staff with Other	0	0	0
Total Subject Items Checked	16	36	52

Table 2 summarizes the nature or subject of the 6 grievances and 15 complaints logged between January 1 and June 30, 2009.

Grievance Subjects It should be noted that with each grievance filed a consumer may indicate more than one subject category. For example, a consumer may indicate in their grievance an issue with both quality of services and medications. Multiple categories were indicated in 83% of the grievances filed.

In total, for six grievances from January 1 through June 30, 2009, there were 16 subject items listed. The most frequently reported categories were:

Quality of Services	31.2% (n=5)
Type/Frequency/Location of Services	18.7% (n=3)
Interaction/Conduct by Staff with Family/Guardian	12.5% (n=2)
Interaction/Conduct by Doctor with Client	12.5% (n=2)

Complaint Subjects More than one complaint subject category could be indicated by the consumer with each unique complaint. This was true in 87% of the complaints filed. For instance, both "Type/Frequency/Location of Services" and "Quality of Services" tended to be checked in one complaint.

In total, for 15 complaints from January 1 through June 30, 2009, there were 36 subject items listed. The most frequently encountered categories were:

Quality of Services	25.0% (n=9)
Interaction/Conduct by Staff with Client	13.9% (n=5)
Interaction/Conduct by Doctor with Client	13.9% (n=5)
Interaction/Conduct by Staff with Family/Guardian	11.1% (n=4)

Grievance and Complaint Totals Summarized Over the Last Three Years.

Figure 1 on the following page shows that the number of filed grievances has decreased in each six-month reporting period since July 2006. Grievances from consumers who filed multiple grievances in each six-month period have also decreased.

Filed GrievanceTotals: 2006-2009
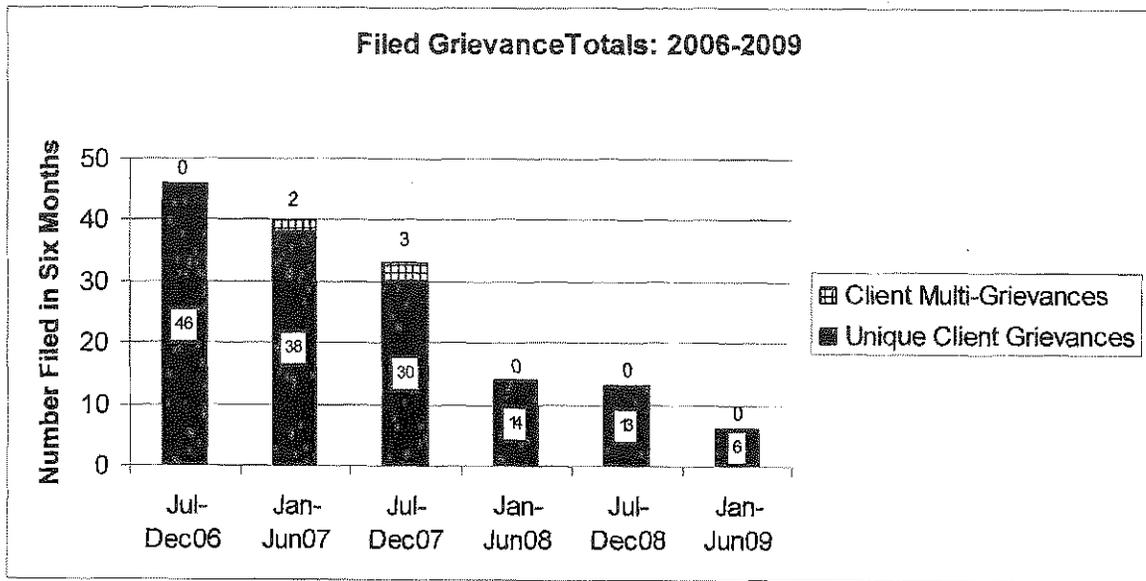
Figure 1.

Figure 1 shows that the total number of filed grievances has decreased in the five six-month reporting periods since July 2006. The solid blue bars are the totals for unique individual grievance filers, while the hatched portion of the bars are the totals of the multiple grievances filed by consumers during the same six-month period.

Filed Complaint Totals: 2006-2009
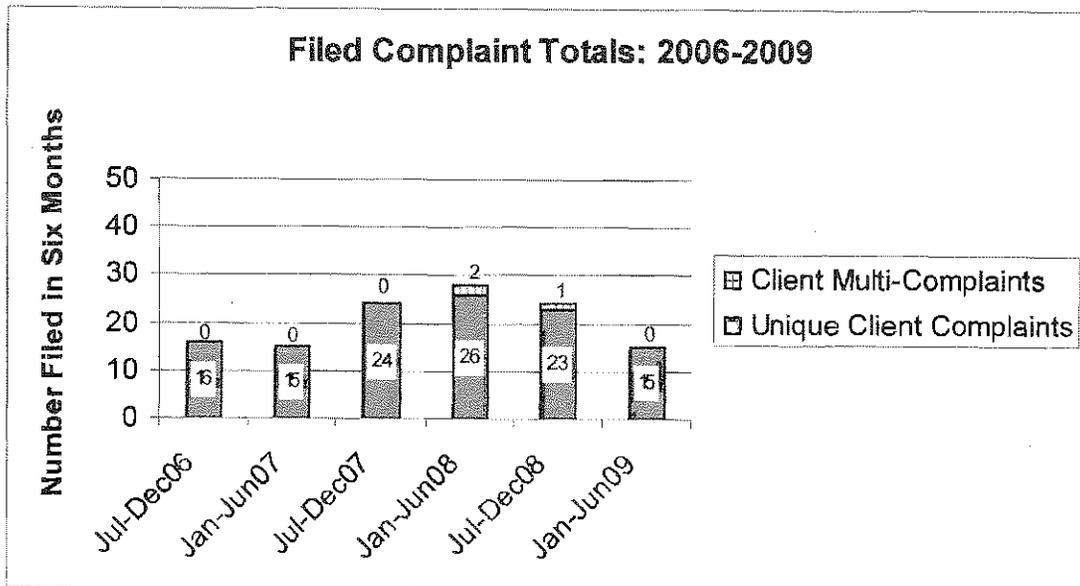
Figure 2.

Figure 2 shows the total number of filed complaints during the last three years. The solid yellow bars are the totals for unique individual complaint filers, while the hatched portion of the bars are the totals of the multiple complaints filed by consumers during the same six-month period.

Grievance Subject Items Checked: 2006-2009
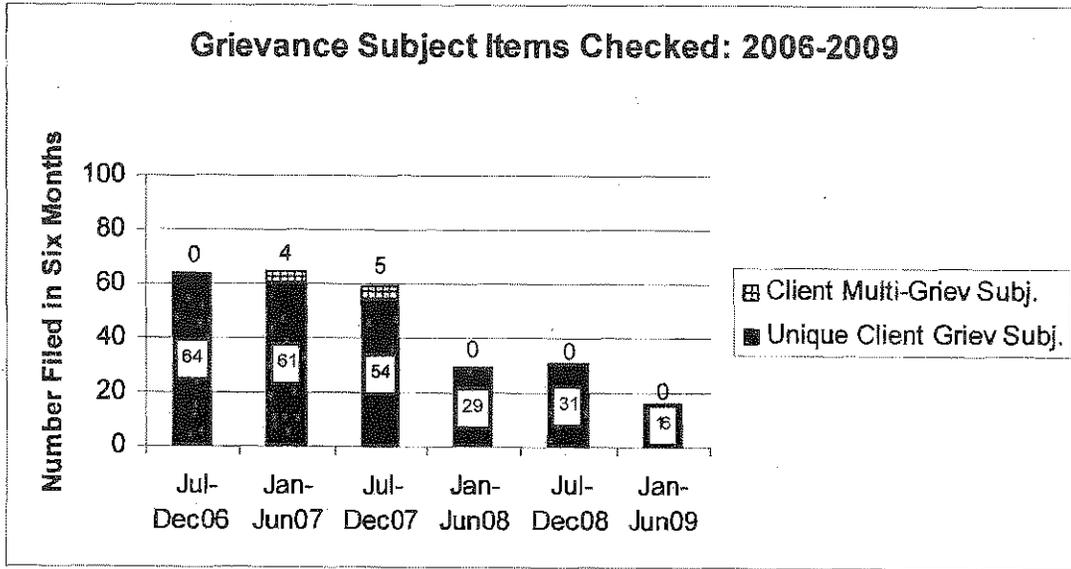
Figure 3.

Figure 3 shows the number of grievance subject items checked by consumers during the latest six-month period decreased compared to the previous six-month period (Jul-Dec08). The solid blue bars are the number of subject items checked by unique individual grievance filers, while the hatched portion of the bars are the checked subject item totals for the multiple grievances filed by consumers during the same six-month period.

Complaint Subject Items Checked: 2006-2009
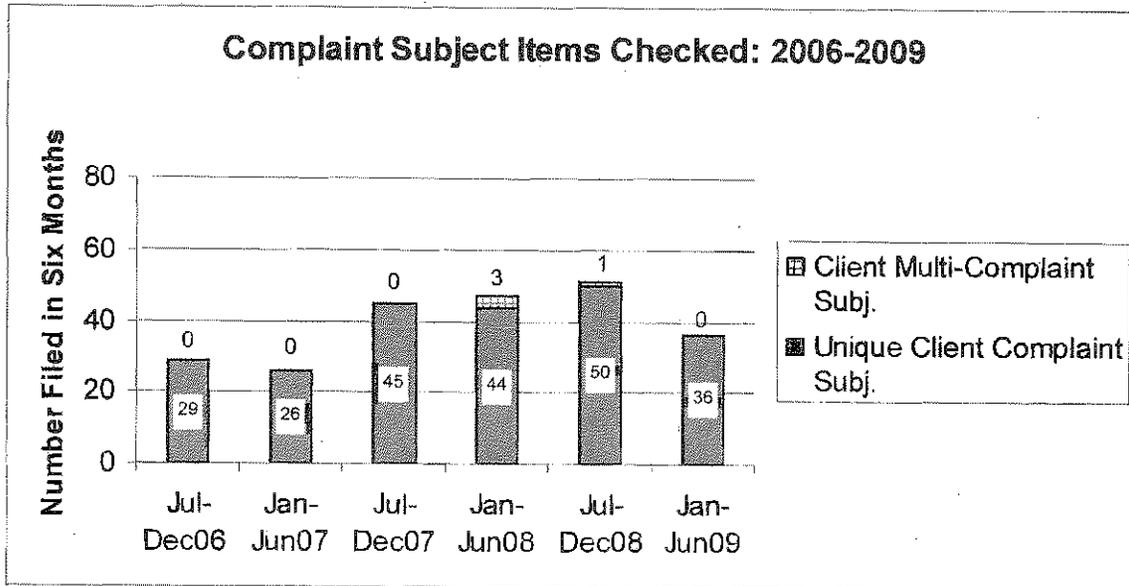
Figure 4.

Figure 4 shows that the number of complaint subject items checked by consumers during the latest six-month period decreased slightly compared to the previous six-month period (Jul-Dec08). The yellow bars are the number of subject items checked by unique individual complaint filers, while the

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hatched portion of the bars are the checked subject totals for the multiple complaints filed by consumers during the same six-month period.

Section II. Appeals and State Fair Hearings from January 1 through June 30, 2009

The Appeals procedure allows mental health service beneficiaries (i.e. persons eligible under the Medi-Cal Program) the opportunity to have their individual circumstances formally considered when actions are taken by county or contract service providers to terminate or reduce authorizations for mental health services.

An expedited appeal (with more rapid resolution) can be filed when the standard appeal resolution process could jeopardize the beneficiary's health or ability to maintain maximum function. There was one expedited appeals filed in Riverside County in the current reporting period.

An appeal may be filed by the beneficiary/beneficiary's representative (either orally or in writing) with the contract provider, Riverside County Department of Mental Health clinician, RCDMH supervisor, the Central Access Team (now known as CARES), or with Outpatient Quality Improvement. However, an oral appeal must be followed up with a written and signed appeal.

The Outpatient Quality Improvement (QI) unit of Riverside County Department of Mental Health receives the Appeal (either directly or forwarded by provider) and then the QI Problem Resolution Specialist directs and coordinates the appeal process. The appeal must be entered into the Appeal Log within one working day of receipt.

The State requires that the Quality Improvement's Appeal Log documents: a) the name of the beneficiary, b) the date of the receipt of the appeal, c) the nature of the problem, and d) the final disposition of the appeal, including the date when the written decision is sent to the beneficiary.

There are also State requirements for the timeliness of Quality Improvement's response during the Appeal Process. These are:

1) A letter acknowledging the receipt of the appeal must be sent by QI to the beneficiary within ten (10) working days.

2) A written decision/resolution letter must be sent by QI to the beneficiary within 45 calendar days of QI's receipt of the appeal.

The Appeals Log documents the timeliness of QI's response and resolution of the appeals and also whether the appeal was denied or approved (or approved with modifications).

In the Appeals Log, there were 26 appeals filed in the second half of fiscal year 2008-2009 (between January 1, 2009 and June 30, 2009). There were delays in the timeliness of QI's initial response to four of the 26 appeals and there were delays in the timeliness of their resolution. These data are shown in Table 3.

Table 3. Timeliness and Resolution of 26 Appeals Logged by Type of Case

	Closed Cases	Open Cases	Total
Number of Appeals Filed	26	0	26
Acknowledgment Letter Sent within 10 Working Days	22	0	22
Acknowledgment Letter Not Sent within 10 Working Days	2	0	2
Acknowledgment Letter Not Sent [No Contact Information or Already Approved]	2	0	2
Resolution Letter Sent within 45 Days	22	0	22
Resolution Letter Not Sent within 45 Days	2*	0	2*
Resolution Letter Not Sent [No Contact Information or Already Approved]	2	0	2

Table 3 summarizes the timeliness and resolution of 26 regular appeals logged between July 1 and June 30, 2009. As shown in Table 3, there were 26 appeals in total and all of these cases were closed cases.

Acknowledgement Letters

Twenty-two (84.6%) of the 26 acknowledgement letters were sent (row 2) within ten working days (taking an average of the same day and a maximum of 14 calendar days).

[Row 3] Two acknowledgement letters were not sent within 10 working days. One acknowledgement letter was sent in 16 calendar days along with the resolution letter as the QI specialist was notifying the social worker in concert with the client. In a second appeal the acknowledgment letter was sent in 46 days. The client had been unreachable by telephone and had changed his/her address thus causing a delay.

[Row 4] One acknowledgement letter was not sent because there was no address and the denied services were already approved as QI staff arranged for continued services. The approval decision was handled by telephone in 24 days. There was also no address for a second appeal in which a contract provider was calling on behalf of child who had been a client. This appeal was denied as the medical necessity requirement was not met. The QI decision was handled by telephone in 35 days.

Resolution Letters

[Row 5] Twenty-two (84.6%) of the resolution letters that were sent were completed within the 45-day timeliness requirement. These resolution letters took an average of 15 days to be mailed.

*See next page.

* [Row 6] There were two appeals which had resolution letters but these were not completed within 45 calendar days. Extension requests for additional time to provide resolution were not filed by QI Staff for these appeals. Conditions associated with these appeals were as follows:

- In one appeal of denied services to a consumer, the QI specialist was able to obtain approval for services with modifications. The additional psychiatric referral was slightly delayed and the resolution letter was sent after 47 days.

- A second appeal of denied services was a request for psychiatric services. While QI Staff were not able to arrange authorization for services as requested, choices of alternate services were provided. The resolution of this appeal took 66 days.

[Row 7] There were two appeals in which resolution letters were not sent. One resolution letter was not sent because there was no address and the denied services were already approved as QI staff arranged for continued services. The approval decision was handled by telephone in 24 days. There was also no address for a second appeal in which a contract provider was calling on behalf of child who had been a client. This appeal was denied as the medical necessity requirement was not met. The QI resolution decision was handled by telephone in 35 days.

The <u>appeal decisions</u> that were made for the 26 appeals in the second half of fiscal year 2008-2009 were as follows:

- 8 (30.8%) were approved
- 4 (15.4%) were approved with changes
- 9 (34.6%) were denied
- 3 (11.5%) were referred
- 1 (3.8%) was both denied (for some services) and affirmed (for other services)
- 1 (3.8%) was withdrawn by the beneficiary

Overall, 12 (46.2%) of the appeals were approved or approved with compromise modifications and nine (34.6%) were denied.

The <u>appeal subject</u> or nature of the problem that resulted in the 26 appeals in the second half of fiscal year 2008-2009 fell into two categories:

1) "Denial of Access" to mental health services – 15 cases (57.7%)
   In this category, beneficiaries who filed an appeal had been denied mental health services or denied therapy with the requested provider.

2) "Denial of Continuation" of mental health services – 11 cases (42.3%).
   In this category, beneficiaries who filed an appeal had been denied authorizations of continued services with their provider -- usually continued visits to their therapist.

A State Fair Hearing is an independent review conducted by the State as the final arbitration for appeals when services have been denied, terminated, suspended, or reduced. In managing the appeal process (described above) for Medi-Cal recipients, Outpatient QI is able to work out compromises acceptable to the consumer in most of the filed cases. However, if their appeal is denied by QI, the mental health service beneficiary has the right to file a request for a State Fair Hearing with the Administrative Adjudications Office in Sacramento.

As a general rule, the State Fair Hearings are intended for beneficiary problems (e.g., actions by providers to not continue mental health services or to deny mental health services) that cannot be resolved at the appeal level. The required procedure for beneficiaries of mental health services to follow is to file an appeal with Outpatient QI first, and then file for a State Fair Hearing only if a satisfactory resolution cannot be reached. Until the end of 2006, beneficiaries could file for a State Fair Hearing without first going through the formal appeals process. As of December 2006, the State began requiring that the consumer go through the appeals process as a prerequisite to any State Fair Hearing. There were two exceptions in the current reporting period as this requirement was not adhered to in State Fair Hearing #94 and State Fair Hearing #97. In both cases the claimant filed the request for the Hearing without going through the appeals process.

To request a State Fair Hearing, the specialty mental health services beneficiary (Medi-Cal recipient) or the beneficiary's representative files a statement in writing with the Administrative Adjudications Office in Sacramento. Normally this may only be done after exhausting the appeal process with Outpatient QI.

An Administrative Law Judge presides over each State Fair Hearing and carefully considers the merits of both sides of each case. A representative of Outpatient Quality Improvement attends each hearing and represents Riverside County Department of Mental Health. A State Fair Hearing may also be conducted by telephone.

Table 4. Summary Table of State Fair Hearings from January 1 through June 30, 2009

Case Number	QI Date	Hearing	Outcome
#94	3/23/09	Hearing scheduled for April 21, 2009	Claimant not in Riverside County and does not respond. Considered Abandoned.
#95	4/06/09	Hearing held April 21, 2009	Conditional withdrawal by claimant not filed prior to Hearing and no appearance by claimant. Considered abandoned.
#96	3/24/09	Hearing scheduled for June 16, 2009	No response from claimant prior to scheduled hearing. Considered abandoned.
#97	5/18/09	Hearing date not set.	Hearing postponed until the claimant goes through the appeals process for possible resolution.
#98	6/02/09	Telephone Hearing held July 16, 2009	Pending written decision by Judge.

There were five filings for State Fair Hearings from Riverside County in the second half of fiscal year 2008-2009 and these are summarized in Table 4.

● In State Fair Hearing Case #94 the claimant filed for a hearing without going through the appeals process. Outpatient QI determined that the claimant's Medi-Cal was not in Riverside County and the hearing was postponed. Attempts to reach the claimant were unsuccessful and the claimant did not respond to the certified letter nor attend the Hearing.

• In State Fair Hearing Case #95 the claimant's provider requested an increased frequency of therapy sessions for the claimant and an initial psychiatric session. QI was able to arrange the initial psychiatric session for the claimant but the claimant did not respond and did not attend the Hearing.

• State Fair Hearing Case #96 was determined to be abandoned as the claimant did not attend the hearing. Outpatient QI had arranged for an initial session with a psychiatrist as requested by the claimant but the claimant did not respond.

• The claimant in State Fair Hearing Case #97 had not filed an appeal prior to filing for a State Fair Hearing. The information given to Outpatient QI by the claimant's social worker did not indicate a need for mental health services and the Fair Hearing was postponed to allow possible resolution during the appeal process.

• State Fair Hearing Case #98 was a telephone hearing on 7/16/09 and was a re-opening of SFH #87 dated 8/14/08 which was discontinued by the Judge. The Judge requested supportive paperwork from the claimant's provider as well as list of County Clinics which was sent by Outpatient QI. The outcome of this State Fair Hearing will be determined by the Judge's written decision.

Problem Resolution Report:
Grievances, Appeals and State Fair Hearings
FY2008-2009, 1st Half
July 1 through December 31, 2008

Riverside County Department of Mental Health
Outpatient Quality Improvement

April 2009

The term **Problem Resolution** includes:

- The grievance process (available to all consumers of mental health services).
- The appeal process and expedited appeal process (available to Medi-Cal beneficiaries).
- The State Fair Hearing (available to Medi-Cal beneficiaries).

Section I of this report describes the results of 13 Grievances and 24 Complaints filed with Outpatient Quality Improvement (QI) from July 1 through December 31, 2008.

The timeliness of QI's response in resolving the grievances was within guidelines in 9 of the 13 grievances. There was one case with delayed resolution for which an explanation is provided. In another case QI did not send a resolution letter because the consumer did not return the grievance form. A third grievance was referred to Patients' Rights. Finally, one Inpatient grievance was not resolved.

Grievance filings decreased slightly in the current reporting period compared to the previous Jan-Jun08 period, continuing a trend of a decrease in grievances filed during the last two and one-half years. The number of grievance subjects checked in the filed grievances followed a similar pattern. The number of complaints decreased in the current reporting period to 24 (from 28 in the previous Jan-Jun08 reporting period) but the number of complaint subjects checked increased. These data trends are presented in Figures 1-4.

The most frequently listed grievance/complaint categories (see Table 2) were:
- Quality of services (28%)
- Type/Frequency/Location of services (18%)
- Interaction/Conduct by staff with client (11%)

Section II of this report describes the results of the 31 Appeals filed with QI from July 1 through December 31, 2008 and also the six filings for State Fair Hearings during the same time period.

The timeliness of QI's response to the formal appeals was within guidelines in 19 of the 31 appeals and explanations for delayed appeal resolutions (and lack of resolutions) are provided.

Finally, the State Fair Hearing process is covered and the results of the six State Fair Hearings are summarized.

Summary of Problem Resolution for July 1 through December 31, 2008			
	Total Filed	**Resolved**	**QI Response within Guidelines**
Number of Grievances	13	12	9
Number of Complaints	24	15	n/a
Number of Appeals	31	25	19
Number of State Fair Hearings	6	5	n/a

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The term "Problem Resolution" includes the grievance process (available to all consumers of mental health services) as well as the appeal process, the expedited appeal process and the State Fair Hearing (available to Medi-Cal beneficiaries). Problem Resolution is directed and coordinated by Outpatient Quality Improvement (QI) of the Riverside County Department of Mental Health according to standards and procedures established by the State.

A Grievance is an expression of dissatisfaction by any consumer/beneficiary of mental health services about any matter. The majority of the concerns that mental health service consumers have can be resolved using the grievance process, which was designed to encourage rapid identification and resolution of mental health concerns.

However, some actions by mental health service providers are not covered by the grievance process and instead use the appeal process. The appeal process covers actions by mental health service providers to deny requests for specialty mental health coverage to Medi-Cal beneficiaries.

An expedited appeal (with more rapid resolution) can be filed when the standard appeal resolution process could jeopardize the beneficiary's health or ability to maintain maximum function. One expedited appeal was filed in Riverside County from July 1 through December 31, 2008.

If an appeal is denied, the mental health service beneficiary has the right to a State Fair Hearing by filing their request for a State Fair Hearing with the Administrative Adjudications Office in Sacramento. A State Fair Hearing is an independent review conducted by the State as the final arbitration for appeals when services have been denied, terminated, or reduced.

Section I. Grievances & Complaints filed from July 1 through December 31, 2008

A grievance is a formal expression of dissatisfaction by any consumer/beneficiary of mental health services arising in the course of utilizing his/her Mental Health Plan. Examples of common grievance subjects are: rude conduct of provider staff with the consumer, dissatisfaction with the type/frequency/location of services offered, and problems with medications.

A grievance may be filed by a consumer/beneficiary (or that person's representative) with his/her health service provider, the Central Access Team (now known as CARES), or with Quality Improvement (QI). A grievance may be filed orally or in writing. The provider or CAT(now known as CARES) then faxes the grievance to QI, which directs and coordinates the grievance process. The grievance must be entered into the electronic Grievance Log within one day.

A complaint is filed when the consumer has an issue and requests follow-up but does not want to "file" a grievance. The issue is still logged and the "complaint only" box is checked. The beneficiary may later file a grievance if the resolution of the complaint is not satisfactory.

State Requirements:

The State requires that Quality Improvement's Grievance Log documents: a) the name of the beneficiary/consumer, b) the date of the receipt of the grievance, c) the nature of the problem, and d) the final disposition of the grievance.

There are also State requirements for the timeliness of Quality Improvement's response during the Grievance Process. Complaints do not have a State requirement for timeliness.

These State requirements are:
1) A letter acknowledging the receipt of the grievance must be sent by QI to the beneficiary within ten (10) working days.

2) A written decision/resolution letter must be sent by QI to the beneficiary within 60 calendar days of QI's receipt of the grievance.

A total of 37 grievances and complaints were logged between July 1 and December 31, 2008:
- 13 (35.1%) were grievances
- 24 (64.9%) were complaints

Table 1. Timeliness and Resolution of 13 Grievances Logged by Type of Case

	Closed Cases	Open Cases	Total
Number of Grievances Filed	12	1	13
Acknowledgment Letter Sent within 10 Working Days	12	1	13
Resolution Letter Sent within 60 Days	9	0	9
Resolution Letter Not Sent within 60 Days	1	0	1
Resolution Letter Not Sent [Grievance form not returned to QI]	1	0	1
Resolution Letter Not Sent [Grievance referred to Patients' Rights]	1	0	1
Resolution Letter Not Sent [Inpatient Grievance]	0	1	1

Table 1 summarizes the timeliness and resolution of the 13 grievances logged between July 1 and December 31, 2008. There were 13 grievances filed in total and 12 of these grievances were closed cases.

Acknowledgement Letters
All acknowledgement letters (100%) were sent within ten working days for all 13 of the cases in columns one and three. These acknowledgement letters took an average of three days to be sent and the longest took 8 days.

Resolution Letters
Nine (90%) of the ten mailed resolution letters were sent within 60 days. These resolution letters took an average of 19 days to be sent and the longest took 50 days.

- One resolution letter (row 3) was not sent until 62 days after the grievance filing while QI Staff were confirming the availability of an alternate clinic for the consumer.

- In a second grievance case (row 4), the consumer did not return the grievance form and QI Staff did not send a resolution letter. The case was closed after 56 days.

- A third grievance case (row 5) was referred to Patients' Rights and closed in two days but a resolution letter was not sent.

- A fourth grievance (row 6) entered into the Grievance Log was an Inpatient Grievance and no action was taken after the acknowledgement letter was sent (one day).

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Table 2. Summary of the Nature or Subject of the Grievances and Complaints Logged

	FY08-09, 1st Half (7/01/2008 - 12/31/2008)		
	Grievance (N = 13) (35.1%)	Complaint (N = 24) (64.9%)	Total (N = 37)
Physical Plant	0	0	0
Patients' Rights	3.2% (1)	3.9% (2)	3.7% (3)
Type/Frequency/Location of Services	12.9% (4)	21.6% (11)	18.3% (15)
Medication Issues	6.5% (2)	9.8% (5)	8.5% (7)
Seclusion/Restraint	0	0	0
Financial/Personal Property	0	3.9% (2)	2.4% (2)
Language or Cultural	0	0	0
Quality of Services	29.0% (9)	27.5% (14)	28.0% (23)
Physical/Sexual Abuse	0	0	0
Interaction/Conduct by Doctor with Client	9.7% (3)	7.8% (4)	8.5% (7)
Interaction/Conduct by Doctor with Family/Guardian	6.5% (2)	3.9% (2)	4.9% (4)
Interaction/Conduct by Doctor with Other	0	0	0
Interaction/Conduct by Staff with Client	9.7% (3)	11.8% (6)	11.0% (9)
Interaction/Conduct by Staff with Family/Guardian	12.9% (4)	7.8% (4)	9.8% (8)
Interaction/Conduct by Staff with Network Provider	6.5% (2)	0	2.4% (2)
Interaction/Conduct by Staff with Other	3.2% (1)	2.0% (1)	2.4% (2)
Total Subject Items Checked	31	51	82

Table 2 summarizes the nature or subject of the 13 grievances and 24 complaints logged between July 1 and December 31, 2008.

Grievance Subjects It should be noted that more than one grievance subject category may be checked by the consumer/beneficiary in the grievance log associated with each unique grievance entry. This was true in 85% of the grievances filed.

In total, for 13 grievances from July 1 through December 31, 2008, there were 31 subject items listed. The most frequently encountered categories were:

Quality of Services	69.2% (n=9)
Type/Frequency/Location of Services	30.8% (n=4)
Interaction/Conduct by Staff with Family/Guardian	30.8% (n=4)
Interaction/Conduct by Doctor with Client	23.1% (n=3)
Interaction/Conduct by Staff with Client	23.1% (n=3)

Complaint Subjects More than one complaint subject category could be checked by the consumer/beneficiary in the grievance log associated with each unique complaint entry. This was true in 67% of the complaints filed. For instance, both "Type/Frequency/Location of Services" and "Quality of Services" tended to be checked in one complaint.

In total, for 24 complaints from July 1 through December 31, 2008, there were 51 subject items listed. The most frequently encountered categories were:

Quality of Services	58.3% (n=14)
Type/Frequency/Location of Services	45.8% (n=11)
Interaction/Conduct by Staff with Client	25.0% (n=6)
Medication Issues	20.8% (n=5)
Interaction/Conduct by Doctor with Client	16.7% (n=4)
Interaction/Conduct by Staff with Family/Guardian	16.7% (n=4)

Grievance and Complaint Totals Summarized Over the Last Two and One-Half Years.

Figure 1 on the following page shows that the number of filed grievances has decreased in each six-month reporting period since July 2006. Grievances from consumers who filed multiple grievances in each six-month period have also decreased.

Filed GrievanceTotals: 2006-2008
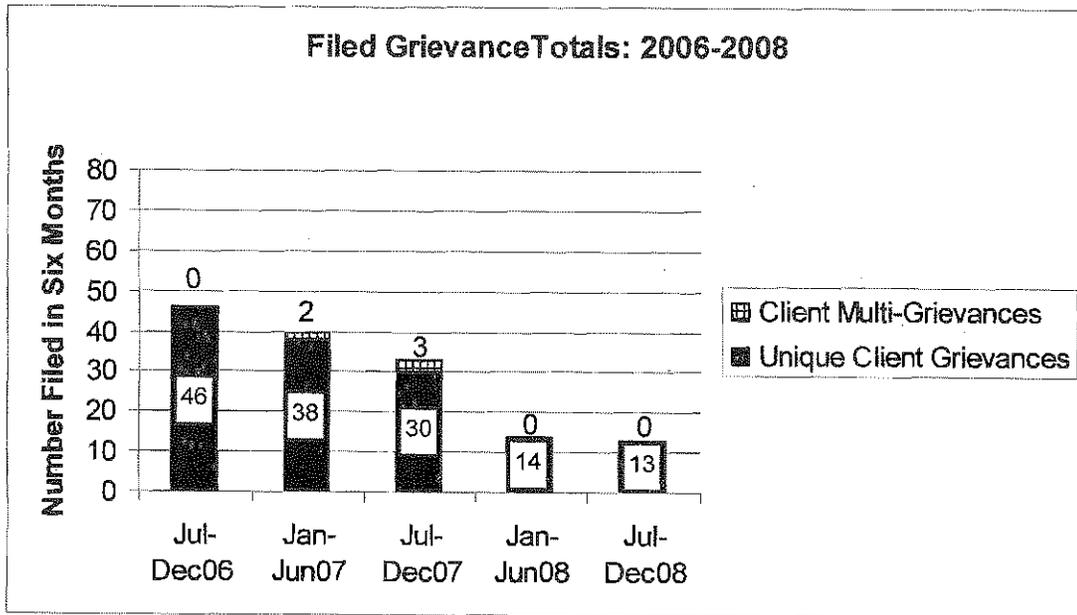
Figure 1.

Figure 1 shows that the total number of filed grievances has decreased in the four six-month reporting periods since July 2006. The solid blue bars are the totals for unique individual grievance filers, while the hatched portion of the bars are the totals of the multiple grievances filed by consumers during the same six-month period.
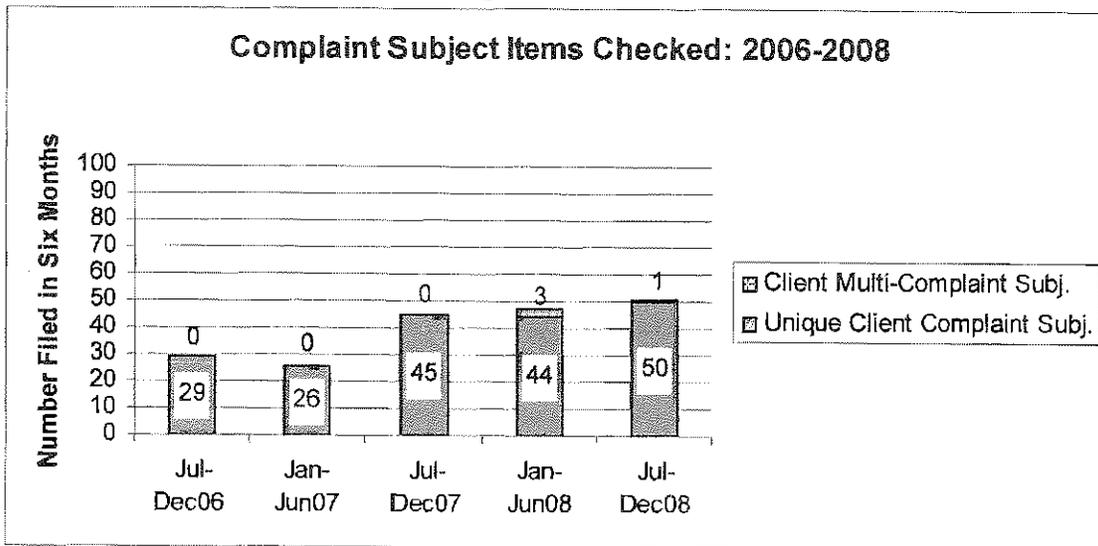
Filed Complaint Totals: 2006-2008
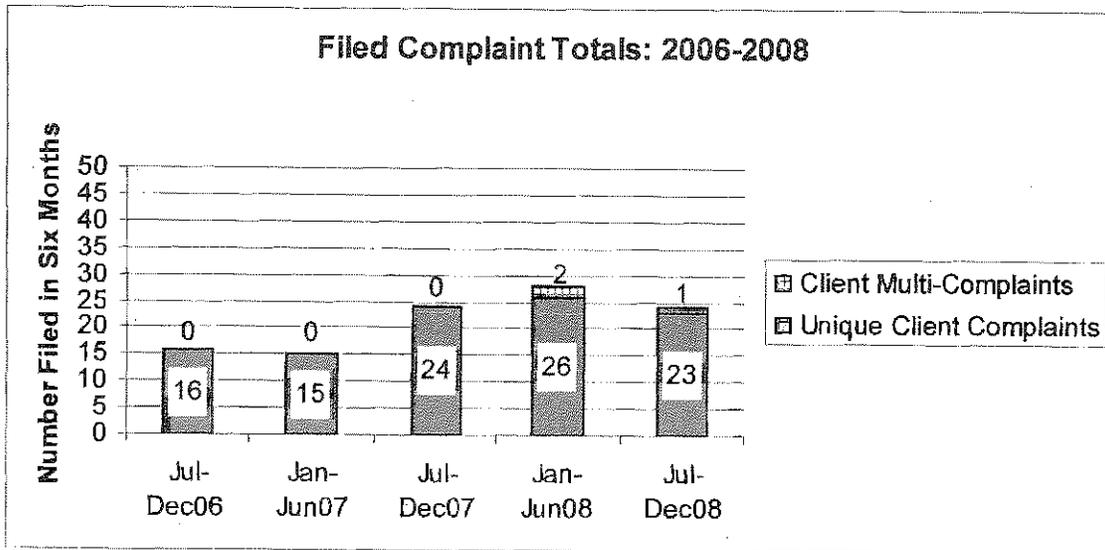
Figure 2.

Figure 2 shows the total number of filed complaints during the last two years. The number of complaints filed in the latest six-month period is slightly less than the previous six-month period (Jan-Jun08). The solid yellow bars are the totals for unique individual complaint filers, while the hatched portion of the bars are the totals of the multiple complaints filed by consumers during the same six-month period.

Grievance Subject Items Checked: 2006-2008

Figure 3.

Figure 3 shows the number of grievance subject items checked by consumers during the latest six-month period increased slightly compared to the previous six-month period (Jan-Jun08). The solid blue bars are the number of subject items checked by unique individual grievance filers, while the hatched portion of the bars are the checked subject item totals for the multiple grievances filed by consumers during the same six-month period.

Complaint Subject Items Checked: 2006-2008

Figure 4.

Figure 4 shows that the number of complaint subject items checked by consumers during the latest six-month period increased slightly compared to the previous six-month period (Jan-Jun08). The yellow bars are the number of subject items checked by unique individual complaint filers, while the hatched portion of the bars are the checked subject totals for the multiple complaints filed by consumers during the same six-month period.

The Appeals procedure allows mental health service beneficiaries (i.e. persons eligible under the Medi-Cal Program) the opportunity to have their individual circumstances formally considered when actions are taken by county or contract service providers to terminate or reduce authorizations for mental health services.

An expedited appeal (with more rapid resolution) can be filed when the standard appeal resolution process could jeopardize the beneficiary's health or ability to maintain maximum function. There was one expedited appeals filed in Riverside County in the current reporting period.

An appeal may be filed by the beneficiary/beneficiary's representative (either orally or in writing) with the contract provider, Riverside County Department of Mental Health clinician, RCDMH supervisor, the Central Access Team (now known as CARES), or with Outpatient Quality Improvement. However, an oral appeal must be followed up with a written and signed appeal.

The Outpatient Quality Improvement (QI) unit of Riverside County Department of Mental Health receives the Appeal (either directly or forwarded by provider) and then the QI Problem Resolution Specialist directs and coordinates the appeal process. The appeal must be entered into the Appeal Log within one working day of receipt.

The State requires that the Quality Improvement's Appeal Log documents: a) the name of the beneficiary, b) the date of the receipt of the appeal, c) the nature of the problem, and d) the final disposition of the appeal, including the date when the written decision is sent to the beneficiary.

There are also State requirements for the timeliness of Quality Improvement's response during the Appeal Process. These are:

1) A letter acknowledging the receipt of the appeal must be sent by QI to the beneficiary within ten (10) working days.

2) A written decision/resolution letter must be sent by QI to the beneficiary within 45 calendar days of QI's receipt of the appeal.

The Appeals Log documents the timeliness of QI's response and resolution of the appeals and also whether the appeal was denied or approved (or approved with modifications).

In the Appeals Log, there were 31 appeals filed in the first half of fiscal year 2008-2009 (between July 1, 2008 and December 31, 2008). There were difficulties in the timeliness of QI's initial response to the 31 appeals and there were difficulties in the timeliness of their resolution. These data are shown in Table 3.

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Table 3. Timeliness and Resolution of 31 Appeals Logged by Type of Case

	Closed Cases	Open Cases	Total
Number of Appeals Filed	31	0	31
Acknowledgment Letter Sent within 10 Working Days	25	0	25
Acknowledgment Letter Not Sent within 10 Working Days (QI Staff misunderstanding)	3	0	3
Acknowledgment Letter Not Sent [No Contact Information or Already Approved]	3	0	3
Resolution Letter Sent within 45 Days	16	0	16
Resolution Letter Not Sent within 45 Days	7*	0	7*
Resolution Letter Not Sent [Appeal paperwork not returned to QI]	4	0	4
Resolution Letter Not Sent [No Contact Information or Already Approved]	3	0	3
Resolution Letter Not Sent [Resolution in State Fair Hearing]	1	0	1

Table 3 summarizes the timeliness and resolution of 31 regular appeals and one expedited appeal logged between July 1 and December 31, 2008. As shown in Table 3, there were 31 appeals in total and all of these cases were closed cases.

Acknowledgement Letters

Twenty-five (89%) of the 28 acknowledgement letters were sent (rows 2 and 3) within ten working days (taking an average of two days and a maximum of nine calendar days). The acknowledgement letter for the expedited appeal was sent the same day.

[Row 3] Three acknowledgement letters were not sent within 10 working days. One acknowledgement letter was sent in 18 calendar days and two took 33 days. There was a misunderstanding by a QI Staff member that the acknowledgement letter could wait until the appeal paperwork was filed. This misunderstanding has been corrected.

[Row 4] Three acknowledgement letters were not sent because there was no contact information (two appeals) or the denied services were already approved (one appeal).

Resolution Letters

[Row 5] Sixteen (70%) of the 23 resolution letters that were sent were completed within the 45-day timeliness requirement. These resolution letters took an average of 15 days to be mailed. The expedited appeal was resolved in two days with approval of services and consumer satisfaction.

*See next page.

* There were seven appeals which had resolution letters but these were not completed within 45 calendar days. Extension requests for additional time to provide resolution were filed by QI Staff for two of these appeals. Conditions associated with the remaining five appeals were as follows:

- In one appeal of denied services to a provider, QI Staff were able to obtain approval for the reinstatement of the services and telephoned the consumer of this approval after 42 days. The resolution letter, however, was not mailed for another five days.

- A second appeal of denied services was due to lack of medical necessity. While QI Staff were not able to arrange authorization for services as requested, choices of alternate services were provided. The resolution of this appeal took 78 days.

- A third appeal was initiated by the consumer by telephone but the appeal paperwork did not arrive for 34 days. After receiving the appeal paperwork the QI appeal specialist was then able to obtain a referral to alternative services and the consumer was satisfied with this resolution. Resolution of the appeal required 48 days.

- In a fourth appeal of denied services to a provider QI Staff were able to obtain approval for the consumer to obtain the services but the submission of the revised treatment authorization request took slightly longer than expected. This appeal was resolved with approval in 49 days.

- A fifth appeal was initiated by the consumer's provider by telephone but the appeal paperwork did not arrive for 33 days. Resolution of the appeal required an additional 23 days to obtain test scores. The resolution of this appeal took a total of 56 days.

There were eight appeals (rows 7, 8 and 9) in which resolution letters were not sent.

- [Row 7] There were four appeals (initiated by telephone) where QI sent the appeal paperwork to the consumers. The appeal forms were never received by QI and the cases were closed after 27 days.

- [Row 8] There were three appeals for which QI had no consumer contact information (two appeals) or the appeal had already been approved (one appeal).

- [Row 9] One appeal was filed in conjunction with State Fair Hearing #90. The resolution for this beneficiary was the acceptance of a conditional withdrawal agreement (provided in Spanish) as a result of the authorization for the requested mental health services.

The appeal decisions that were made for the 31 appeals in the first half of fiscal year 2008-2009 were as follows:

- 13 (41.9%) were approved (including the expedited appeal)
- 2 (6.5%) were approved with changes
- 6 (19.4%) were denied
- 3 (9.7%) were referred
- 6 (19.4%) were without a decision
- 1 (3.2%) was in conjunction with a State Fair Hearing filing.

Overall, 15 (48.4%) of the appeals were approved or approved with compromise modifications and six (19.4%) were denied.

The appeal subject or nature of the problem that resulted in the 31 appeals in the first half of fiscal year 2008-2009 fell into three categories:

1) "Denial of Access" to mental health services – 27 cases (87.1%)
   In this category, beneficiaries who filed an appeal had been denied mental health services or denied therapy with the requested provider.

2) "Satisfaction" difficulties in mental health services – one case (3.2%)
   Consumers in this category expressed dissatisfaction with the quantity or quality of therapy services.

3) "Denial of Continuation" of mental health services – three cases (9.7%).
   In this category, beneficiaries who filed an appeal had been denied authorizations of continued services with their provider -- usually continued visits to their therapist.

State Fair Hearings from July 1, 2008 through December 31, 2008

A State Fair Hearing is an independent review conducted by the State as the final arbitration for appeals when services have been denied, terminated, suspended, or reduced. In managing the appeal process (described above) for Medi-Cal recipients, Outpatient QI is able to work out compromises acceptable to the consumer in most of the filed cases. However, if their appeal is denied by QI, the mental health service beneficiary has the right to file a request for a State Fair Hearing with the Administrative Adjudications Office in Sacramento.

As a general rule, the State Fair Hearings are intended for beneficiary problems (e.g., actions by providers to not continue mental health services or to deny mental health services) that cannot be resolved at the appeal level. The required procedure for beneficiaries of mental health services to follow is to file an appeal with Outpatient QI first, and then file for a State Fair Hearing only if a satisfactory resolution cannot be reached. Until two years ago, beneficiaries could file for a State Fair Hearing without first going through the formal appeals process. As of December 2006, the State began requiring that the consumer go through the appeals process as a prerequisite to any State Fair

Hearing. There was an exception in the current reporting period as this requirement was not adhered to in State Fair Hearing #90: the claimant filed the appeal after the request for the Hearing.

To request a State Fair Hearing, the specialty mental health services beneficiary (Medi-Cal recipient) or the beneficiary's representative files a statement in writing with the Administrative Adjudications Office in Sacramento. Normally this may only be done after exhausting the appeal process with Outpatient QI.

An Administrative Law Judge presides over each State Fair Hearing and carefully considers the merits of both sides of each case. A representative of Outpatient Quality Improvement attends each hearing and represents Riverside County Department of Mental Health. A State Fair Hearing may also be conducted by telephone.

Table 4. Summary Table of State Fair Hearings from July 1 through December 31, 2008

Case Number	QI Date	Hearing	Outcome
#87	7/28/08	Hearing held August 14, 2008	Judge orders hearing discontinued.
#88	8/04/08	Hearing scheduled for September 10, 2008	Conditional withdrawal by claimant not filed prior to Hearing and no appearance by claimant. Considered abandoned.
#89	8/18/08	Hearing held October 9, 2008	Claimant did not attend hearing. Considered abandoned.
#90	9/19/08	Hearing scheduled for November 5, 2008	Conditional withdrawal request by claimant.
#91	11/05/08	Telephone Hearing held January 27, 2009	Pending written decision by Judge.
#92	11/10/08	Hearing scheduled for January 6, 2009	Conditional withdrawal by claimant prior to Hearing.

There were six filings for State Fair Hearings from Riverside County in the first half of fiscal year 2008-2009 and these are summarized in Table 4.

● In State Fair Hearing Case #87 the Judge ruled a discontinuance as claimant was unable to rationally participate in the hearing.

● The claimant in State Fair Hearing Case #88 accepted a conditional withdrawal as a result of authorization for mental health services arranged by Outpatient QI. The claimant did not file the conditional withdrawal paperwork and did not appear at the Hearing.

● State Fair Hearing Case #89 was determined to be abandoned as the claimant did not attend the hearing and did not respond to offers for assistance by Outpatient QI.

● The claimant in State Fair Hearing Case #90 accepted a conditional withdrawal (provided in Spanish) as a result of authorization for the requested mental health services arranged by Outpatient QI.

● When State Fair Hearing Case #91 was held, the Judge ordered the claimant's mental health services provider to submit a letter of support within ten days documenting the need for the claimant to return to previous frequency of services. The claimant agreed. The outcome of this State Fair Hearing will be determined by the Judge's written decision.

● In State Fair Hearing Case #92 the QI specialist was able to obtain six more months of the requested mental health services for the claimant and the claimant submitted a conditional withdrawal.

ATTACHMENT #48

Initial Implementation of Prevention and Early Intervention Programs

Program Name	Description	Target Pop.	Status
Community Education & Stigma Reduction			
Media & Mental Health Promotion	Establish Community Education reduction committee to identify needs and develop strategic plan; Develop educational materials for community events and media efforts; Outreach will occur to engage hard to reach populations.	Community-at-large	Committee to be established
Dare to be Aware Youth Conference	Full day conference for 1000 middle and high schools students; Goals are to increase awareness and reduce stigma related to mental illness.	Middle & High School students	Conference scheduled for 11/30/10
Volunteer Center/Helpline/211	24/7 crisis/suicide prevention hotline; Provides referrals and resource information.	Community-at-large	Ongoing
Network of Care	Interactive website available to consumers, family & community members; community-based organizations and providers; Easy access to a wide variety of behavioral health resources.	Community-at-large	Ongoing
Call to Care	Provides training for lay persons to initiate and maintain understanding, caring relationships with people from their communities; Trained individuals also participate in outreach events.	Adults	Ongoing
Outreach Activities	RCDMH staff provide community outreach and engagement activities targeting underserved populations.	Community-at-large	Ongoing
Active Minds	Local colleges and universities will develop and support chapters of this student run mental health awareness, education, and advocacy group; The student run chapters will organize campus wide events to remove the stigma that surrounds mental health issues and create an environment for open conversations about mental health issues.	TAY & their families	Application is complete, Melanie to send out announcement via email
Promotores de Salud Mental	Promotores will provide health and mental health education and support to members of their respective communities.	Hispanic Pop; all ages	Contract approved by BOS 6/29; Myriam working w/ contractor to develop workgroup
NAMI Initiatives:			
- Parents & Teachers as Allies	Families and school professionals learn the warning signs of early-onset mental illnesses in children and adolescents.		
- In Our Own Voice	A public education program in which two trained consumer speakers share their personal stories about living with mental illness and achieving recovery.	Community-at-large	RFP to be released 8/11/10
- Breaking the Silence	Teaches students in upper elementary school, middle school, and high school about serious mental illness.		

	Description	Target Pop.	Status
Parent & Family Support & Training			
Triple P	Multi-level system of parent education and support for families with children from birth to age 12; Will include an 8 week group model.	Parents of children 0-12	RFP to be released 8/11/10
Caregiver Support Groups	Psychoeducation curriculum and supportive interventions and provide support groups for caregivers of seniors with mental illness, dementia, or receiving PEI services.	Adults and older adults	MOU in development with Office on Aging; RFP for Desert is in development
School Based Early Intervention			
Families & Schools Together (FAST)	An outreach and multi family group process in schools; 10 week program for up to 14 families.	Elementary school children & their families	Working with developer to provide presentation to interested districts; RFP in development
Specialized Early Intervention Strategies			
Parent-Child Interaction Therapy (PCIT) Mobile Units	For families w/ children who exhibit chronic disruptive behaviors at home, in school, preschool or daycare. Services will be provided in a mobile vehicle.	Parent & child (aged 2-6)	Currently filling positions; working on purchase of mobile units
Outreach and Reunification Services to Runaway TAY	Crisis intervention and counseling strategies will be used to facilitate re-unification of the youth with an identified family member.	TAY (16-25)	Ongoing
TAY Initiatives:			
- Depression Treatment Quality Improvement (DTQI)	Based on the concepts of Cognitive-Behavioral Therapy (CBT). Typically a group model but can be individual.		
- Peer-to-Peer Services	Will utilize youth speaker's bureaus to outreach and educate at-risk youth and the community-at-large of the unique issues each group of identified at-risk youth experience as they relate to mental health and interpersonal issues.	TAY (16-25), LGBTQ, Foster Youth, Youth transitioning into college, runaway youth	Providers selected; contracts in development
- Digital Storytelling	Provides three day workshop for individuals during which they produce a 3 to 5 minute digital video to tell their story. Gives the individual a unique way to communicate something about their life experiences. Participants are then asked to invite whomever they would like to a viewing party.		Implementation Plan developed
Cognitive-Behavioral Therapy (CBT) for Late-Life Depression	Reduces suicidal risk and depression; Individual intervention.	Older Adults 60 years +	Providers selected; contracts in development
Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	Targets older adults who have minor depression and are receiving home-based social services from community services agencies; Individual early intervention.	Older Adults 60 years +	Supervisor to be hired

Description	Target Pop.	Status
Trauma Reduction		
Cognitive-Behavioral Interventions for Trauma in Schools (CBITS)	Children ages 10-14	Evaluation in progress; Need clarification from potential providers
Cognitive Behavioral Therapy group intervention at schools to reduce children's symptoms of Post Traumatic Stress Disorder (PTSD) and depression caused by exposure to violence.		
Seeking Safety	TAY and Adults	Providers selected; contracts in development
Coping skills program designed for people with a history of trauma and substance abuse; Group or individual format; Female, male or mixed gender groups; Found effective with people with PTSD and for those with a trauma history that do not meet criteria for PTSD.		
Prolonged Exposure Therapy for Post-Traumatic Stress Disorder (PTSD)	Older Adults	Supervisor to be hired
Cognitive-Behavioral Therapy program for older adult men and women with PTSD who have experienced single or multiple/continuous traumas; Individual treatment.		
Specialized Ethnic Community Initiatives		
Ethnic & Cultural Community Leaders in a Collaborative Effort	Community-at-large	Ongoing
Community leaders from ethnic and cultural populations work within local communities to build a network of individuals from these communities to promote mental health information and the use of PEI services.		
Hispanic/Latino		
Mamás y Bebés (Mothers & Babies)	TAY and Adult women	Developing RFP
Manualized 12 week mood management perinatal group intervention for women.		
African American Initiatives:		
- Africentric Youth and Family Rites of Passage Program	African American Youth ages 11-15 years	
After school program, held for two hours, three days per week for the 9-month academic year. Serves 15 youth.		
- Cognitive-Behavioral Interventions for Trauma in Schools (CBITS)	Children ages 10-14	Contracts in development
Cognitive-Behavioral Therapy group intervention at schools to reduce children's symptoms of Post Traumatic Stress Disorder (PTSD) and depression caused by exposure to violence.		
- Effective Black Parenting	Parents/guardians of African American children aged 2-12	
Group parent education program for small groups of parents; Also available are one-day seminar version which is taught with large numbers of parents.		

Native American

	Description	Target Pop.	Status
Guiding Good Choices	Prevention program that provides parents of children 9-14 years old with the knowledge and skills needed to guide their children through early adolescence; Group model.	Native American parents of children aged 9-14	Contractor selected and notified; Contract negotiation to be scheduled
Incredible Years (IY) - SPIRIT	Group parent intervention to strengthen parenting competencies and foster parents' involvement in children's school experiences; SPIRIT is a culturally-tailored adaptation.	Native American parents of children aged 0-11	

Prepared by MOORE_J 8/12/2010

ATTACHMENT #49

Action	Description	Developmental Highlights	Future Direction
#4 * Comprehensive New Employee Welcoming	New employee orientation that instructs on RCDMH mission, values, structure and service delivery	• Held preliminary meetings to brainstorm content • Identified pertinent policy and created related summaries	• Slow growth due to Dept. downsizing and few new employees
#5 Evidence Based Practices (EBP), Advanced Treatment (ATS), and Recovery Skills Development (RSD) Program	Provides primary support for training staff in clinical, recovery, and service delivery skills	• EBP: Recovery Management; Multi-dimensional Family Tx; Parent-Child Interaction Tx; Aggression Replacement Tx; Depression Tx Quality Improvement; Non-violent Crisis Intervention; COD Manual Series • ATS: Self-mutilation; Eating Disorders; Seeking Safety (trauma focused) • RSD: Recovery Practices for Supervisors; Evolution of Consumer Movement (both staff and consumers); Recovery Model (Mark Ragins) • Developed and conducted Paraprofesssional Training Series: Mental Health Risk; Law, Ethics, and Boundaries	• Continue supports for EBP • Training on Working with People across the age spectrum who have neuro-cognitive challenges • Next Paraprofessional courses: Advanced Recovery training; Communication and Counseling Skills; Orientation to the DSM • Improve and standardize fidelity across trainings offered
#6 Cultural Competency and Diversity Education Development Program	Provides primary support for training regarding diversity and cultural competency	• Calif. Brief Multicultural Competency Scale; Interpreters' Training; Bridges Out of Poverty; Deaf and Hard of Hearing Sensitivity; Spirituality and Mental Health	• Military Culture and MH needs of Veterans and their Families

# / Program	Description	Accomplishments	Next Steps
#7 Professional Development for Clinical and Administrative Supervisors	Comprehensive Public Mental Health Services leadership program	• Held initial collaborative meeting with Central HR/Center for Government Excellence	• Identify and clarify competencies • Determine/develop structure/format and implement
#8 Law Enforcement Collaborative Education Enhancement	Expand RPD training on responding to consumers in mental health crisis to rest of Riverside law enforcement	• Expanded to correctional deputies • Scheduled collaborative meeting to plan expansion to patrol deputies • Developed Stakeholder Advisory committee	• Hire a Department trainer • Expand to Sheriff patrol Deputies • Outreach, smaller independent law enforcement agencies • Develop program to educate staff/consumers/families on law enforcement
#9 Integrated Services Resource Education	Creates central point of coordination to optimize utility of Department and community resource data banks: Network of Care; 211; CARES Website; RCDMH Website; Guides to Services	• Hired full-time Community Resource Educator • Developed central information gathering tool • Developed and proposed infrastructure to report and update data • Design CARES website	• Standardize reporting of Dept. programs to ensure accuracy of service descriptions • Update data banks to reflect new information • Finalize CARES website • Provide in-service education for our employees, contractors, and partner agencies
#10 Consumer and Family Member Mental Health Workforce Development Program	Progressive workforce development of consumer and family member employees within Riverside's Public Mental Health Service System	• Hired 3 Senior Peer Support Specialists (under Consumer Affairs) • Supported peer volunteer program • Developed infrastructure for Peer intern program • Maintained pre-employment training/Advanced training	• Implement Peer Intern Program • Develop and implement workforce development program for family members

# / Program	Description	Status / Accomplishments	Next Steps
#11 Mental Health Recovery Certificate Exploration and Planning	Expansion of post-secondary education to meet the needs of mental health occupational shortages or shortfall of critical skills	• Currently not activated due to Dept. downsizing	
#12 Professional Licensure Support Program	Development of pre-licensed, professional staff to become licensed Provides BBS required courses to maintain clinical licensure	• WET proposal accepted by EDA to invest $50,000 of American Research and Recovery Act funds to support our pre-licensed staff to become licensed • Developing survey tool to gather necessary data from pre-licensed staff for EDA to process funding	• Survey pre-licensed staff • Develop MOU with EDA; develop contract for employee participation • Identify training curriculum, training format and instructor • Implement • Maintain training necessary to meet requirements for BBS licensure
#13 Public Mental Health Graduate School Internship Program	Field Site and academic support for developing community mental health practitioners	• Hired full time University and School Liaison • Hired 3 part-time Department field instructors • Standardized university affiliation agreements • 2009-10 Academic year: placed 55 students in Dept. Field Sites • Formalized and conducted 4 annual, centralized student trainings • Guest lecture or academic support on community MH practice at RCC, LLU, CSUSB, and La Sierra University	• Further structure student field instruction to enhance learning environment • Support Dept. Field instructors to optimize instruction and increase Dept. field sites • Develop Dept. practice competencies that create standards for field excellence • Develop relationship with cultural specific social service agencies to provide immersion/shadowing for Dept. students • Explore expansion of student workforce into non-clinical and non-professional job classifications

#14 Financial Incentives for Workforce Development	Financial incentives for the recruitment or retention of public mental health workforce; focus on meeting disparity needs and hard-to-fill positions	• Actively collaborated with LLU MFT program to develop their stipend program and assisted with student selection process • Graduated four 20/20 participants: Bilingual/Spanish • Promoted State MHSA Loan Assumption Program (MHLAP) and assisted Riverside applicants with submissions • MHLAP 2009-10 cycle: 13 Riverside applicants were awarded • Researched and applied for 2 HPSA designations (allows for employee scholarship and loan assumption programs)	• Slow growth due to Dept. downsizing • Maintain support for university stipend program • Maintain support for MHLAP • Provide liaison role for Health Resources and Services Administration and continue HPSA process
State Administered: Regional Partnership	Southern Regional WET collaboration among: Riverside, San Luis Obispo, Kern, Santa Barbara, Ventura, Orange; San Diego, San Bernardino, San Diego, Imperial, and Tri-Cities	• Established mission, direction, and develop a Regional WET Plan • Hired a Southern Regional WET Coordinator (now resigned)	• Hire new Southern Regional WET Coordinator • Develop Regional recruiting materials for entry into public mental health careers
* First 3 WET Action address staffing the unit:	WET Coordinator Staff Development Officer Assistants (2) and Analyst	Health Education Assistant I University & School Liaison Community Resource Educator	MSW intern (academic year only) PT Field instructors (3)