Mental Health Services Act - Innovation Stakeholder Community Feedback Form

As an alternative to this online Google survey a PDF version of the survey is available at the following website <u>https://www.rcdmh.org/MHSA/Innovation</u>, and can be emailed to <u>BHCullturalComp@ruhealth.org</u>, faxed to 951-955-7205 or mailed to Riverside University Health System – Behavioral Health, MHSA Administration (Innovation), 2085 Rustin Ave., MS #3810, Riverside, CA 92507.

Additionally, you can leave your feedback on the MHSA

Innovation Feedback Voicemail at (951) 358-3014.

Purpose of this Survey:

The following Google survey was developed to gather stakeholder and community input on the RUHS-BH Innovation Eating Disorder Project Proposal. MHSA Innovative projects are unique as they are intended to test the implementation of novel, creative methods of mental health practices that produce successful outcomes and contribute to learning for integration into the mental health system. An Innovative Project is a project that Riverside University Health Systems (RUHS-BH) designs and implements for a de ned time period (up to ve years). By statute, 5% of local MHSA funding must be used for Innovative Projects. RUHS-BH has developed an Innovation plan focusing on best practices for an Intensive Outpatient Eating Disorder Program (ED-IOP). Thank you for taking the time to review the Innovation plan and provide any feedback or comments you may have about this plan.

Section 1 (Innovation Survey), Section 2 (Tell Us more about you)

* Indicates required question

1. The purpose of the Eating Disorder Innovation project is clear to me. *

Mark only one oval.

Strongly Disagree

🔵 Disagree

Neutral

O Agree

Strongly agree

2. Are you satisfied with the Innovation project activities described? *

Mark only one oval.

Very Satisfied

Satisfied

O Neutral

Unsatisfied

- Very Unsatisfied
- 3. Do you support RUHS-BH using funds to implement this Eating Disorder Innovation project? *

Mark only one oval.

- Strongly Support
- Support
- Neutral

Opposed

- Strongly Opposed
- 4. Do you have any concerns about the innovation project described? *

Mark only one oval.

No concerns

Some Concerns

- Unsure
- Concerns
- Many Concerns

5.	lf you	have	any Co	oncerns	what	are	they?
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6. Do you have any ideas to add to the Eating Disorder Innovation project?

7. Do you have any other recommendations or comments about the proposed Innovation project?

Tell Us about yourself (All answers are optional)

8. Age:

Mark only one oval.

0-15
16-25
26-59
60+

9. Race/Ethnicity (Select all that Apply):

Check all that apply.

 Hispanic or Latino/x

 Asian

 Native Hawaiian or Pacific Islander

 Black or African American

 White or Caucasian

 Middle Eastern or North African

 American Indian or Alaska Native

 Other:

10. Are you a person with a disability? If yes, please specify.

11. Sex:

Mark only one oval.

Female

🔵 Male

Prefer not to say

12. Gender Identity:

Mark only one oval.



🔵 Boy/Man

_____ Trans

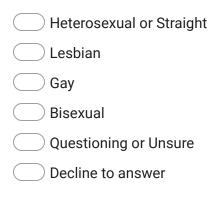
Non-Binary

Gender Fluid

Questioning or Unsure

13. Do you identify as:

Mark only one oval.



14. Are you responsible for caring for a child or young adult age 25 or younger?

Mark only one oval.

Yes No

15. Are you a veteran?

Mark only one oval.



16. Name:

17. Which stakeholder group do you currently identify with?

Check all that apply.

Consumer/Person with lived experience/have mental health challenges
Family member/caregiver of person with mental illness/mental health challenges
Mental Health/Physical Health/Substance Use Professional/service provider
Faith-based Organization
Law Enforcement
Community Member
RUHS-BH employee
Community Based Mental Health Provider
Other:

18. If you indicated "other" above, please help us understand your Stakeholder group?

19. If you would like us to contact you regarding this Innovation project please provide your name and contact information.

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