Riverside University Health System Behavioral Health

Mental Health Services Act (MHSA)

MHSA 3-Year Program & Expenditure Plan FY17/18 through FY19/20 Feedback Survey – Planning Process

Please submit your comments by 5:00 pm, Friday, May 16, 2017.

Forms can be mailed to: Riverside University Health System – Behavioral Health, MHSA Administration, 2085 Rustin Avenue, MS #3810, Riverside, CA 92507; or sent via e-mail to: MHSA@rcmhd.org; or by fax to 951-955-7205.

1. **Do the programs described in the MHSA Plan meet the needs of the priority populations as identified in the Plan?**

2. **What do you think are the strengths and weaknesses of the MHSA Programs?**

3. **Please provide feedback on the existing MHSA Programs. Are there any gaps in services (and if so, where)? Are new services needed (and if so, what)? Should some programs be eliminated (and if so, which ones)?**

4. **Do you have any other recommendations or comments about the programs or services?**

5. **Is your community getting information about mental health services available through the County?**

6. Are there any problems with getting information about what mental health services are available from the County?

7. Are members of your community able to access the County mental health services?

	Very Satisfied	*Somewhat Satisfied*	*Satisfied*	*Unsatisfied*	*Very Unsatisfied*
Overall, how do you feel about the Plan?	☐	☐	☐	☐	☐

Please Tell Us About Yourself

The information you provide will remain confidential and anonymous.

What is the Primary Language you speak at home?

- ☐ English
- ☐ Spanish
- ☐ Other? ________________________

Age Group:

- ☐ Under 18
- ☐ 18 – 25
- ☐ 26 – 59
- ☐ 60 or Older

Gender:

- ☐ Male
- ☐ Female
- ☐ Transgender/Other :______________________

What is your Race/Ethnicity?

- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Latino/Hispanic
- ☐ Tribal/Native American

  (Tribe:____________________________)
- ☐ White/Caucasian
- ☐ Mixed Race: ________________________
- ☐ Other: _____________________________

Which of the following groups/categories apply to you?

- ☐ Mental Health Client/Consumer
- ☐ Family Member of a Mental Health Consumer
- ☐ County Mental Health Department Staff
- ☐ Substance Abuse Service Provider
- ☐ Community-Based/Non-Profit Mental Health Service Provider
- ☐ Community-Based Organization (**Not** Mental Health Service Provider)
- ☐ Children and Family Services Organization
- ☐ K-12 Education Provider
- ☐ Law Enforcement
- ☐ Veteran Services
- ☐ Senior Services
- ☐ Hospital/Health Care Provider
- ☐ Advocate
- ☐ Other County Agency
- ☐ Tribal Agency: _____________________________
- ☐ Other: ____________________________________

If you represent an agency or organization, please tell us which one and provide your role or position:

Agency:____ Role/Position: ____________________________________

Please indicate the Region of the County in which you are most involved:

- ☐ **Mid-County Region** (Hemet, San Jacinto, Perris, Lake Elsinore, Temecula, etc.)
- ☐ **Western Region** (Riverside, Norco/Corona, Moreno Valley, etc.)
- ☐ **Desert Region** (Banning, Blythe, Indio, Cathedral City, etc.)
- ☐ **Other** (specify): ____