RIVERSIDE COUNTY BEHAVIORAL HEALTH COMMISSION
SITE REVIEW

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

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

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

After completing the form, please return to Behavioral Health Commission Liaison, Sylvia Bishop either by e-mail (SBishop@ruhealth.org) or interoffice (MS #3810).

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

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

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

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

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

BEHAVIORAL HEALTH COMMISSIONER

☐

REGIONAL BOARD MEMBER

☐ Desert ☐ Mid-County ☐ Western

NAME OF FACILITY/ PROGRAM:

☐

ADDRESS: ☐ **PHONE NUMBER:** ☐

TYPE OF PROGRAM: *(Check what applies)*

☐ Mental Health ☐ Substance Abuse ☐ County Facility ☐ Contract Provider

REGION SERVED:

☐ Desert ☐ Mid-County ☐ Western

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

ACCESSIBILITY & SECURITY

Is the Program/ Clinic Easily Located:
☐ YES ☐ NO

Is there ample parking:
☐ YES ☐ NO

Is the entrance easily located:
☐ YES ☐ NO

Handicap Parking Spaces:
☐ YES ☐ NO

Wheelchair Ramps:
☐ YES ☐ NO

Automatic Doors for handicap access:
☐ YES ☐ NO

Low clearance counters:
☐ YES ☐ NO

In case of emergency, are exits clearly marked:
☐ YES ☐ NO

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

☐ Lobby/ waiting room ☐ Indoor area ☐ Outdoor area
☐ Childcare or kid space ☐ Recreational areas ☐ Cafeteria or vending machine

Security: *(Check all that apply)*

☐ Security fence around clinic ☐ Security cameras in facility ☐ Cameras in parking lot
☐ Emergency exits ☐ Security guard

PROGRAM/ CLINIC INFORMATION

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

☐ Outpatient ☐ Inpatient ☐ Day Treatment ☐ Residential

Does this program require a referral:

☐ YES ☐ NO

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

☐ Children/ Youth (0-16) ☐ Transition Age Youth (16-25) ☐ Adult (19-59)
☐ Older Adult (60+)

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

☐ Assessment/ Intake ☐ Physical Health Screenings ☐ Medication Assisted Treatment
☐ Individual Therapy ☐ Group Therapy ☐ Detoxification
☐ Classes or Education Groups ☐ Peer Supports ☐ Crisis Intervention
☐ Case Management ☐ Integrated Care

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

Does this facility provide medication:

- [ ] YES
- [ ] NO

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

- [ ] YES
- [ ] NO
- [ ] Not Applicable

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MISCELLANEOUS SERVICES OFFERED

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

☐ YES ☐ NO

Benefits Assistance:
(SSI, healthcare, etc.)

☐ YES ☐ NO

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

☐ YES ☐ NO

Meals/ snacks available:
(Provided or for purchase)

☐ YES ☐ NO

Home Visits:

☐ YES ☐ NO

Follow-up Care:

☐ YES ☐ NO

STAFF ADDITIONAL COMMENTS: *(if any)*

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

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