Riverside University HEALTH SYSTEM Behavioral Health

Riverside University Health System – Behavioral Health

Cultural Competency Program

Cultural Competency Plan
Annual Update
2022 -2023

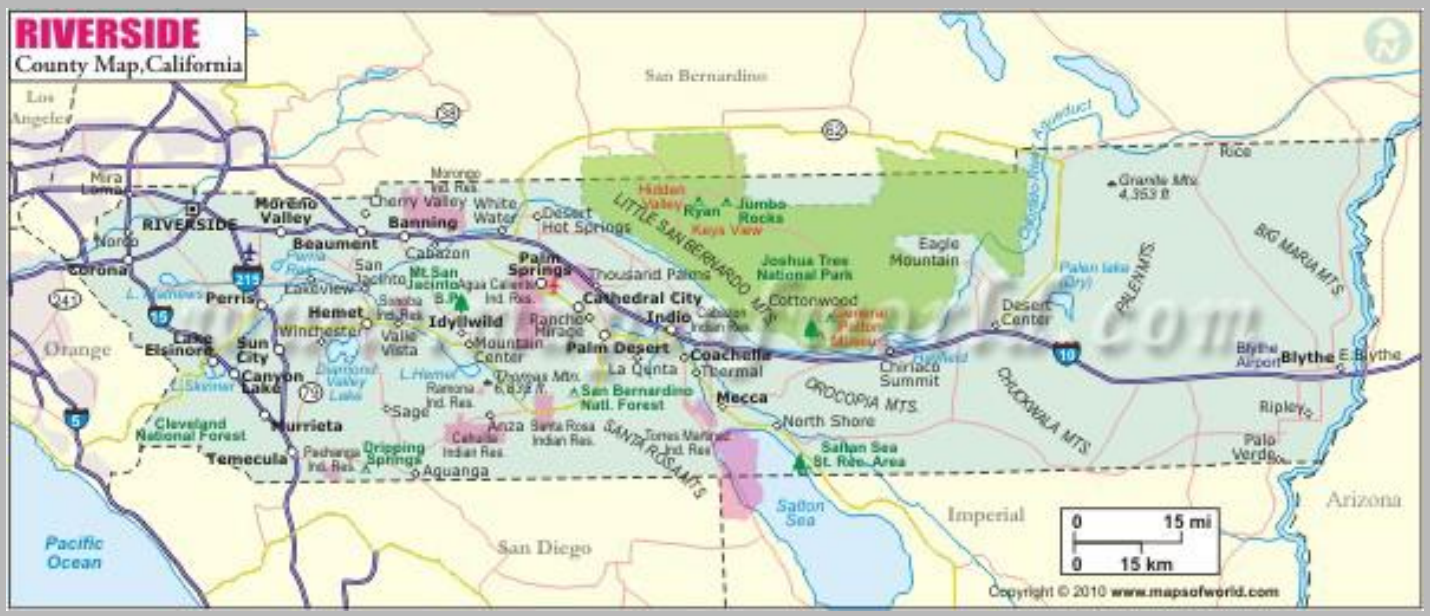
A report on FY 2021-2022
and
An outlook for FY 2022-2023

Land Acknowledgment

The Cultural Competency program acknowledges the traditional, ancestral, and contemporary homelands of the Indigenous Peoples of Southern California whose land it occupies. The Cahuilla (Iviatem), Cupeño (Kúpangaxwichem), Luiseño (Payómkowichum), Serrano (Marra'yam), and Chemehuevi (Nuwuvi) Peoples, and their ancestors have been here since time immemorial. They have cared for the land and all peoples with great integrity.

The Cahuilla, Cupeño, Luiseño, Serrano, and Chemehuevi Peoples honored the earth, animal and plant beings, the water, and all peoples that lived here. The Cultural Competency program acknowledges the reciprocal relationship and wants to continue and extend this value of caring, wellness, and behavioral health to all Indigenous Peoples, Native Americans, and all residents of Riverside County. The Cultural Competency program wants to create relationships built on trust and accountability with its community members.

With this land acknowledgment, the Cultural Competency program will be respectful and mindful to tribal sovereignty, culture, and beliefs of the Indigenous Peoples of this land.

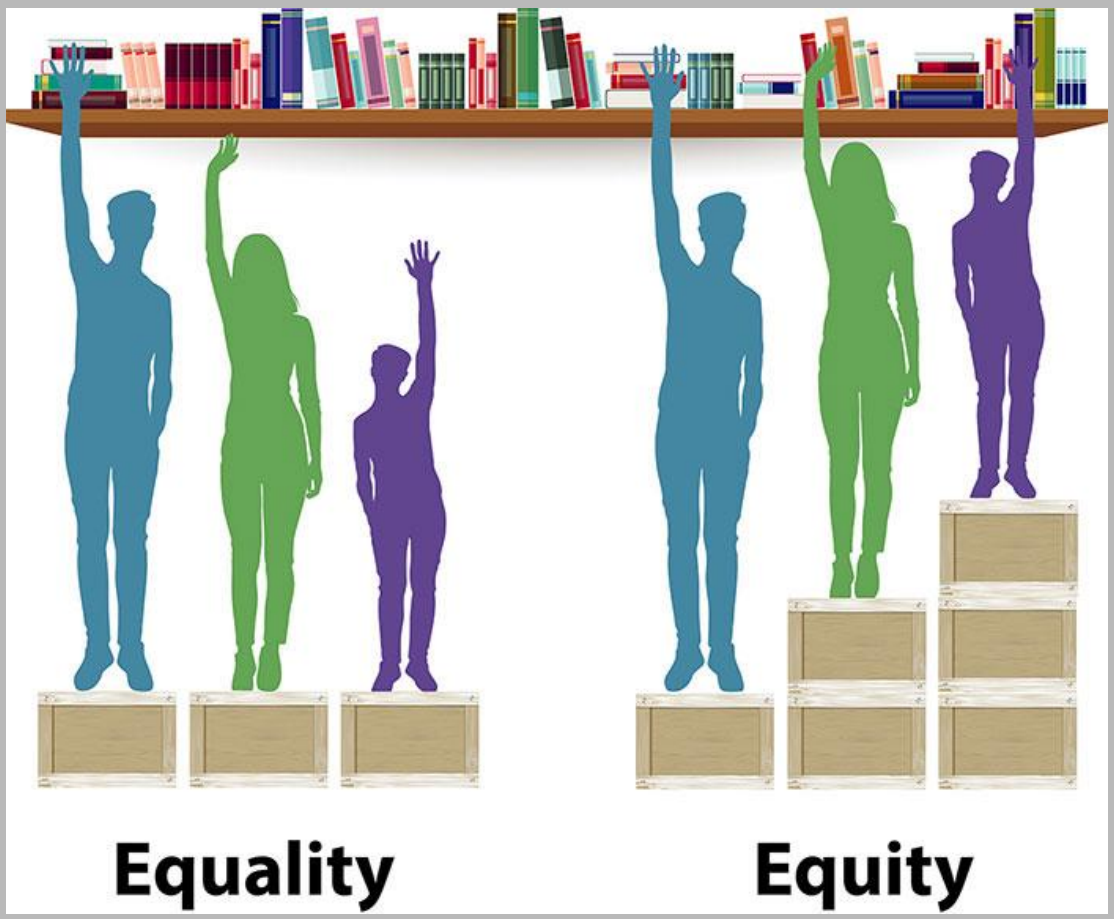


Purpose

The Cultural Competency program (CCP) works to continuosly develop and improve the cultural and linguistic service delivery of RUHS-BH. Its goal is to make certain the departmet is providing equitable behavioral healthcare for all individual within the diverse community of Riverside County. CCP strives to meet this goal by working with the department's entire system of care. While we all know healthcare inequites have existed in the past, CCP is in the business of linking our underserved, underrepresented, and innappropriately served populations to services by removing barrriers to access. The work is guided by the national Culturally and Linguistically Appropriate Services (CLAS) Standards.

Equity Statement

The RUHS-BH Cultural Competency program is committed to equity, diversity, inclusion, justice, and belonging. The program aims to serve all community members throughout their journey towards wellness and recovery. An additional goal is to increase access to services for populations who were historically inapproriately served by healthcare systems. The CCP understands the value in employing staff who possess life experiences and expertise to make certain the workforce is culturally responsive and uses diversity to promote innovation and quality outcomes for the people we serve.



2021 – 2022 Accomplishments

The Cultural Competency Program (CCP) made several changes during FY 2021-2022. With some level of in-person contact resurging in the county, post COVID-19 restrictions, the CCP was able to outreach and engage the community in a way that was different from the prior year. Through a commitment to reduce barriers and create access points for traditionally underserved and inappropriately served populations, the CCP was able to accomplish the following goals that were outlined in the FY 2020-2021 Annual Update:

- **Actively engage community representation which includes transitional age youth.**
  - The CCP has joined forces with the Rainbow Youth Collaborative to provide technical assistance and administrative guidance for this TAY focused community group.

- **Promote and recruit a workforce and leadership that is culturally and linguistically diverse.**
  - Through resources and referral the CCP highlighted job openings to individuals from population that were identified as underrepresented in the behavioral health field.

- **Establish and promote culturally appropriate policies and infuse them throughout RUHS- BH.**
  - The CCP created and implement a cultural sensitivity customer service training for the clinic staff. This included a listening session and input from community members.

- **Coordinate departmental activities which promote quality improvement.**
  - The CCP now works with the Quality team to ensure that department contract organizations have cultural competency plans in place. Extending the dedication to equity outside of department walls.

- **Provide RUHS-BH workforce trainings related to at least three underserved populations.**
  - The CCP has worked with the Workforce Education and Training to outline new trainings for employees. These trainings include cultural awareness on the Disabilities and Middle Eastern North African populations.

- **Actively recruit ethnically diverse members for all program committees.**
  - The CCP increased the level of community involvement from traditionally underserved or inappropriately served populations. In addition, to reorganizing the fulltime Clinician that services the Veterans population under the CCP umbrella. This position also liaises Veterans needs.

- **Create new Cultural Consultant contracts to have a greater reach throughout the community.**
  - New cultural populations were identified and added; Cultural Community Liaisons (CCLs) were hired, as independent contractors, to act as cultural advisors between the department and the community. In addition to hiring new CCLs for the preexisting populations of African American, Asian American Pacific Islander, LGBTQIA+, and Native American, the CCP also added new CCLs positions for the following populations:
    - Deaf and Hard of Hearing
    - Latino/Latina
    - Middle Eastern North African
    - People with Disabilities
    - Spirituality

    All of these groups, less have active community advisory groups. These groups have the dual

role of providing culturally informed feedback to the department, while assisting with getting the word out about access to services.

- **Prepare list of community-based, culturally and linguistically appropriate, nontraditional behavioral health and substance use providers.**
    - The cultural advisory groups have created a list of community-based organizations that provide resources to the community.

- **Create a resource list of consumer operated programs that are cultural, ethnic and linguistically specific for distribution in the community. Cultural Competency will work with Consumer Affairs, Family Advocate and Parent Partner programs to list their programs/activities available for cultural and linguistic specific populations.**
    - The CCP has added two fulltime Peer positions under its umbrella. A Senior Parent Partner and Senior Family Advocate act as team leads and work with the CCLs to make sure the lived-experience voice is included in all the planning of the CCP.

- **Report the CCRD recommendations to the QI committee.**
    - The CCP is now a standing agenda item at the monthly Quality Improvement Committee meeting.

- **Actively participates in PEI Steering Committee.**
    - The CCLs are all members of the PEI Steering Committee.

- **Build newly identified Cultural Subcommittees (e.g., Latinx, Middle Eastern North African, Deaf and Hard of Hearing, People with Disabilities).**
    - The CCLs have created cultural advisory committees that include community-based organizations, mental health advocates, social influencers, and department employees.
    - The cultural advisory committees include:
        - African American Family Wellness Advisory Group
        - Asian American Task Force
        - Community Advocating for Gender& Sexuality Issues
        - Deaf and Hard of Hearing
        - HISLA
        - MECCA
        - Native American
        - Wellness and Disability Equity Alliance

- **Hire Cultural Community Liaisons and provide training and technical assistance.**
    - New CCLs were hired and they have been actively conducting community outreach to build trust and relationships.

- **Review Client Satisfaction Survey Results and Client Grievance Summary.**
    - The CCP is now included in the grievance summary process and is an active member of the Quality Improvement Committee.

The following goal outlined in the FY 2020-2021 Annual Update has not been met:

- **Meet on a quarterly basis with RUHS-BH Research and Evaluation program to determine outcomes and progress.**

2021 – 2022 Highlights from Cultural Groups

All of the new Cultural Community Liaisons (CCLs) spent a great deal of time familiarizing themselves with the department, as well as establishing themselves in the community and gaining trust through the process of relationship building. This resulted in attending various department members and support of countless community events, both virtually and in-person. The CCLs created culturally informative trainings for department contractors and outside healthcare agencies.

The 2021-2022 Cultural Community Liaisons are:
Dakota Brown – People with Disabilities
Riba Eshanzada – Middle Eastern North African
Shirley Guzman – Latino/Latina
Hazel Lambert – African American
Dr. Sean Milanovich – Native American
Dr. Ernelyn Navarro – Asian American Pacific Islander
Kevin Phalavisay – LGBTQIA+
Rachel Postovoit – Deaf and Hard of Hearing
Benita Ramsey – Spiritualilty
Aurelio Sanchez – Veterans (on staff as a Clinical Therapist)

In an effort to decrease department hosted events and turn over the event planning and conceptulization to those who know the community best, the CCLs and their associated cultural advisory groups acted as sponsor and advisors to community-driven event planning. The department is now in a more active role of educating, providing resouces, and creatively increasing accessibility. Additonally, having the community host the event removes the stigma barrier that the department faces, while creating a space for behavioral health to be a topic at the table.

African American

Cultural Community Liaison, Hazel Lambert

The African American Family Wellness Advisory Group worked diligently to build meaingful community relationships. Some collaborators included: The Group, California Black Women Health Project, Riverside Historic Society, Black Lives Matter, Antiracist Riverside, National Coalition of Negro Women, NAACP, Kwanzaa groups, Barbarshop/Salon mental health, Operation SafeHouse, Healthy Heritage, African American Coalition, Black Doll project, the Dell Foundation, the IEWB/RCOE Caregivers and several other organizations.

One group highlight was the colloaboration and support of many Black male, therapists, counselors, peers, and professionals, working together for a virtual weeklong event during California's African American Mental Health week. Black Man Made Well was a successful event that has turned into a regional movement.

Asian American Pacific Islander

Cultural Community Liaison, Dr. Ernelyn Navarro


ANNOUNCEMENT The Mental Health Services Act (MHSA) was created to dedicate funding for California's public mental health service system. Riverside County would like feedback from stakeholders on its annual MHSA Plan for the FY 2021-2022 to prioritize programs and services needed. Please visit: www.rcdmh.org/MHSA/MHSA-Plan-Feedback-Survey

(For more information, visit: https://www.rcdmh.org/MHSA/MHSA-Plan-Update.)

CHECK OUT WHAT WE'VE BEEN UP TO!

RIVERSIDE LUNAR FESTIVAL 2022

January 29th & 30th: Our Team, along with community partners AATF, IEHP, FilAm Resource Center, Reach Out, and many more, celebrated the Lunar New Year in Downtown Riverside after a 2-year hiatus due to the pandemic. We were thankful to finally engage in person with the community, allowing us to provide resource to more than 350 people and collect over 300 Community Needs Assessment surveys.

EASTVALE LANTERN FESTIVAL 2022

February 19th & 20th: At the 1st Annual Lantern Festival celebration in Eastvale, we provided resources to more than 500 people and were able to collect 324 community needs assessment surveys. Despite the windy conditions, it was so much fun interacting with the community and we look forward to next year. Way to go, Team!

CULTURAL EXCHANGE

February 22nd: RUHS-BH provided all Community Mental Health Program Promoters with the opportunity to learn from one another so that it may be mutually beneficial as we all work together to raise awareness for mental health. For the 1st Cultural Exchange, our very own Frances Abalos and Nicole Dumaguindin were able to share about the Filipino culture through the lens of American society. Thank you to the both of you for an interactive and engaging presentation!

We would like to especially acknowledge our Staff Development Officer Michelle Downs, LMFT, for providing a space to grow in cultural competency and to collectively be more mindful as we approach different communities with cultural humility. We look forward to learning from our fellow Promoters during our next Cultural Exchange!

RUHS PRESENTS CULTURAL EXCHANGES

The Asian American Task Force worked to continue building upon estblished community connections and create an inviting environment for inclusion of all those who identify as Asian and/or Pacific Islander. Some collaborations included: Read Stepped Care program, AARP resrouces, ACEs Action, Riverside Overdose Data to Action, Young SAMOA, AntiRacist Riverside, Inland Chinese American Association, Palm Desert Autism Walk, Norco College, IE Together, Riverside Unified School District Board, Island Grad and many other organizations.

Some group highlights were the collaboration and support to the Riverside Lunar Festival and the Eastvale Latern Festival.

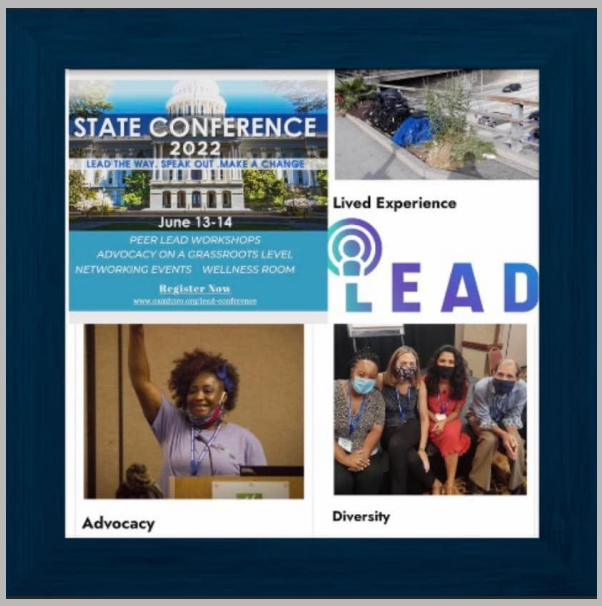
Deaf and Hard of Hearing

Cultural Community Liaison, Rachel Postovoit

It took some time and community input to find a CCL for the Deaf and Hard of Hearing population. However, the CCL was still able to make great strides in relationship building, resulting in collaborations with: Inland Empire Health Plan, IE Regional Capacity Big Collaborative, Temecula School District, Coming Out Youth Group, Deaf-Blind experts, Inland Resource Center and other organizaitons and individuals.

Latino/Latina

Cultural Community Liaison, Shirley Gomez



The Latino/Latina population is the largest cultural specified group in Riverside County. In the first year of having a CCL in this role, connections and collaborations were created with: Latino/Latina council members, the Latino Commission, Latinx Therapist Network, Mexican Consulate, Palm Springs Unified School District, Desert Sands Unified School District, Riverside County Office of Education Migrant Liaison, Peace From Chaos, and many additional community groups and organizations.

In addition to creating realationships, timely event dictated that special attention was paid to the commnity of Blythe. Also, additional focus was on gathering community feedback through the California Mental Health Peer Run Organizations's LEAD project. Therefore, the continuation of the montly KERU mental health awareness radio show was imparative, as well as a tremendous amout of work in Blythe and hosting multiple listening sessions for the LEAD project work, culminating in a state conference.

LGBTQIA+

Cultural Community Liaison, Kevin Phalavisay

The Community Advocating for Gender & Sexuality Issues was able to continue work throughout the community. Additionally, CAGSI extended it's reach and increased membership. Relationship building and collaboration was made with several community organizatons, including: Corona Fundamental Intermediate School, CAL LGBTQ+, Rainbow Youth Coalition, Borrego Health, The Center, IE Sexual Health Fair, San Bernardino Department of Behavioral Health, Trevor Project, California Baptist University, Temecula Sheriffs, City of Perris, Mount San Jacinto College and many other community groups.

One event that CAGSI was able to support in FY 2021-2022 was the Transgender Day of Rememberance.

Middle Eastern North African

Cultural Community Liaison, Riba Eshanzada

As a newly identified population, there was a lot of time spent creating relationships. These newly formed relationships include: the Riverside Sheriff Department, the UCR MENA Student Union, Middle Ground, Muslim Middle Group, Tayba Foundation, Sahaba Initiative, Community Health Association Inland Southern Region, Riverside Community Health Coaltion, Middle Eastern Student Center, Access California, the UCR Department of Social innovation, and several other commuity groups.

Native American

Cultural Community Liaison, Dr. Sean Milanovich

The Native American population was able to make some great strides in collaborating with the community. Those successful collaborations include: Riverside United School District, Coachella Valley Archaeological Society, Band of Desert Cahuilla Indians, California Indian Nations College, Indian Health, community elders, Agua Caliente Band of Cahuilla Indians, San Manuel Native American Resource Center, Saige Youth Group, KVCR-UCR Indian Times Radio, Idywild Art Center, Desert Sage, Thousand Palms Oasis Preserve, Low Riders & Literacy, Yurok Tribe Wellness Coalition, Association of Tribal Archives Libraries & Museums, and very other community members and groups.

People with Disabilities

Cultural Community Liaison, Dakota Brown

Being a new identified population, relationships needed to be created with members of the population and supporters. Newly formed community connections include: Community Action Committee, Student Disability Resource Center, Inland Empire Disabilities Collaborative, Operation Safehouse, Disability Rights CA, Invisible Disabilities Association, SoCal Adaptive Sports, Veterans Commission Outreach Team, California Department on Aging, DOnetwork IHSS Advocacy and Organizing Series, Community Connected Health Initiative, Department of Rehabilitation, RollingStart, Autism Walks, Autism Society I.E., National Advisory Committee on Seniors and Disasters, and National Advisory Committee on Individuals with Disabilities and Disasters.

Spirituality

Cultural Community Liaison, Rev. Benita Ramsey

As a reignigted population, work was centered around cultivating new relationship with previously established allies, including: Interfaith Task Force, Upstream Committee Meeting, Riverside Interfaith Council, along with other community organizations.

THE ENHANCED NATIONAL CLAS STANDARDS

The Enhanced National Culturally and Linguistically Appropriate Standards are organized as one Principal Standard and three themes:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS- related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

2021 – 2022 Update on 3-Year Plan Goals

Table 1: COMMITMENT TO CULTURAL COMPETENCE IN BEHAVIORAL HEALTH & SUBSTANCE USE PROGRAMS

Objective	Ensure that RUHS Behavioral Health and Substance Use service delivery system meets the cultural and linguistic needs of target population by developing Cultural Competence Plan Requirements that will be distributed to all department clinics and contractors on an annual basis.	
Strategies for implementation	• Post Cultural Competency Plan Requirements on website	*Complete*
	• Schedule presentations at directors' meetings	*Complete*
	• Schedule presentations with contract agencies	*Complete*
	• Develop a monitoring system of compliance with plan requirements	*Complete*
	• Prepare list of community-based, culturally and linguistically appropriate, nontraditional behavioral health and substance use providers. Cultural Competence Program and Cultural Competence Reducing Disparities Committee identifies programs in the community	*Complete*
	• Create a resource list of consumer operated programs that are cultural, ethnic and linguistically specific for distribution in the community. Cultural Competence Program Manager works with Consumer Affairs, Family Advocate and Parent Partner programs to list their programs/activities available for cultural and linguistic specific populations	*Complete*
CLAS Standards Met	1: Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. 9: Establishes culturally and linguistically appropriate goals, policies, and management accountability and infuses them throughout the organizations planning and operations. 10: Conducts ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. 12: Conducts regular assessments of community health assets and needs and uses the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. 15: Communicates the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	

Table 2: DATA COLLECTION AND ASSESSMENT OF BEHAVIORAL HEALTH & SUBSTANCE USE SERVICE NEEDS

Objective	Provide measurable, quantifiable analysis of disparities by race, ethnicity, language, age, gender, and other relevant areas of the target population to ensure that consumers and family members are receiving comprehensive and respectful care in a manner compatible with their cultural health beliefs, practices and preferred language on an annual basis.	
Strategies for implementation	• Penetration rates for unserved, underserved and inappropriately served populations increase 1.5 to 2% over prior year's rate	*Complete*
	• Develop a Data Collection Tool and Guidelines/Protocol - Summarize results and incorporate into program planning operations	*Not Met*
	• Meet on a quarterly basis with RUHS-BH Research and Evaluation program to determine outcomes and progress	*Not Met*
	• Presentation of Who We Serve and Unmet Needs reports to the Cultural Competency Reducing Disparities	*Complete*
	• Identify populations with higher levels of disparities/low penetration rates	*Complete*
	• Create list of activities targeting hard to reach populations	*Complete*
	• Cultural Competence Program Manager collaborates with Quality Management in developing a cultural competency contract monitoring tool	*Complete*

CLAS Standards Met	4: Educates and trains workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. 10: Conducts ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. 11: Collects and maintains accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. 12: Conducts regular assessments of community health assets and needs and uses the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. 14: Creates conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints. 15: Communicates the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Table 3: COMMUNITY ENGAGEMENT

Objective	Increase Community Outreach and Engagement activities in Behavioral Health and Substance Use by 5%, as recommended by the Cultural Competence Reducing Disparities Committee's ethnic and cultural community advisory groups and determine how they will be allocated to the program budget.
Strategies for implementation	• Latinx subcommittee *Complete* • Asian American Task Force (AATF) *Complete* • Community Advocacy for Gender and Sexuality Issues (CAGSI) *Complete* • Native American subcommittee *Complete* • Deaf and Hard of Hearing subcommittee *Complete* • Middle Eastern North African subcommittee *Complete* • People with Disabilities subcommittee *Complete* • Spirituality subcommittee *Ongoing* • African American Family Wellness Advisory Group (AAFWAG) *Complete* • Monthly meetings with Staff Analyst regarding allocation of funds/budget *Not Met* • Staff Analyst to develop Budget Expenditure Reports as needed *Complete*
CLAS Standards Met	1: Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. 9: Establishes culturally and linguistically appropriate goals, policies, and management accountability and infuses them throughout the organizations planning and operations. 13: Partners with the community to design, implement and evaluate policies, parties, and services to ensure cultural and linguistic appropriateness.

Table 4: INTEGRATION OF STAKEHOLDERS WITHIN BEHAVIORAL HEALTH AND SUBSTANCE USE SYSTEM

Objective	Develop and recruit members for the Cultural Competence Reducing Disparities Committee and the cultural subcommittees. Ensure committee members are representative of the diverse community and that they have active participation in the MHSA stakeholder process.
Strategies for implementation	• Cultural Competency Manager maintains a list of members of the advisory committees by organization/ agencies, their self-identified membership affiliation and language preference — *Complete* • Cultural Competence Manager participates in Quality Assurance/Quality Improvement (QI) Committee — *Complete* • CCRD committee participates in the review and provides feedback of MHSA planning and stakeholder process — *Complete* • CCRD committee participates in the review and implementation of programs, including the MHSA program components — *Complete* • Members of the cultural competency team actively participate in PEI Collaborative Meetings — *Complete*
CLAS Standards Met	5: Offers language assistance to individuals who have limited English proficiency, at no cost to them, to facilitate timely access to all healthcare and services. 6: Informs all individuals of the availability of language assistance services clearly and in their preferred language, verbally. 9: Establishes culturally and linguistically appropriate goals, policies, and management accountability and infuses them throughout the organizations planning and operations. 13: Partners with the community to design, implement and evaluate policies, parties, and services to ensure cultural and linguistic appropriateness.

Table 5: WORKFORCE DEVELOPMENT

Objective	Continuous recruitment and retention of ethnically, culturally, and linguistically diverse staff at all levels of the organization to better provide services to the identified unserved and underserved populations reported in the Workforce Education and Training component of the MHSA. Increase the direct service staff by 5% annually to reflect racial, cultural and linguistic composition of the community.
Strategies for implementation	• Presentation of workforce report to the CCRD and QI committees with recommendations on targeted recruitment and retention strategies *Complete* • Cultural Competency Manager tasked with assessment of current workforce and participates as member of WET Steering Committee *Not Met* • Improve Cultural Competency program staffing infrastructure to meet the needs of diverse community. *Complete* - Hire full time Secretary I - Hire full time Social Services Planner - Develop agreement for Senior Parent Partner position - Develop Senior Consumer Specialist position - Retain three FTE Regional Outreach and Engagement Coordinator positions - Deaf and Hard of Hearing, Spirituality, and Latinx Outreach and Engagement Cultural Brokers - Develop service agreements through CIBHS with Community Leaders to function as Community Liaison/ Consultants for African Americans, Native Americans, Asian Americans, LGBTQ, Deaf and Hard of Hearing, and Blindness Support and faith-based leaders.
CLAS Standards Met	2: Advances and sustains organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources. 3. Recruits, promotes, and supports a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area. 4: Educates and trains workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. 9: Establishes culturally and linguistically appropriate goals, policies, and management accountability and infuses them throughout the organizations planning and operations. 10: Conducts ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

Table 6: WORKFORCE NEEDS ASSESSMENT

Objective	Collaborate with Workforce Education and Training (WET) program to plan, organize, and implement an assessment that captures the diversity and cultural competence training needs.
Strategies for implementation	• Use CLAS Standards and other tools to design a survey that will gather feedback from RUHS-BH staff regarding training needs and providing culturally responsive services. *Complete* • Prepare a summary report of the focus group as well as results from the survey that will be presented to Directors and Managers. *Complete*
CLAS Standards Met	2: Advances and sustains organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources. 4: Educates and trains workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. 10: Conducts ongoing assessments of the organization's CLAS-related activities and integrates CLAS- related measures into measurement and continuous quality improvement activities. 11: Collects and maintains accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Table 7: WORKFORCE TRAINING

Objective	Provide annual Cultural Competence training for RUHS-BH staff and contract agencies including management, clinical and support staff. By the end of 2020, 50% of direct services staff and supervisors will have completed Cultural Competence Training.
Strategies for implementation	• Identify Cultural Competency Foundations training — *Complete* • Make workforce training recommendations to Executive Management and secure approval to develop cultural competence training policy. — *Complete* • Provide county department and contract agencies staff with training on how to provide services using interpreters. — *Not Met* • Provide RUHS-BH staff and contract agencies staff with Culturally Specific Trainings for at least 3 underserved communities. — *Complete*

CLAS Standards Met	1: Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. 2: Advances and sustains organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources. 3. Recruits, promotes, and supports a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area. 4: Educates and trains workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. 7: Ensures the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Table 8: LANGUAGE CAPACITY

Objective	Building the Department capacity to address language needs by reducing language access barriers and providing consumers and family members with services and written materials such as forms, brochures, and fliers, in their threshold language.
Strategies for implementation	• Review and update RUHS-BH translation policy and protocol forincoming Translation Requests to be distributed to all program managers *Complete* • Recruit and select members to fill Translation Committee vacancies *Complete* • Select Chair of Translation Committee to serve 2-year term *Complete*
CLAS Standards Met	1: Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. 4: Educates and trains workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. 5: Offers language assistance to individuals who have limited English proficiency, at no cost to them, to facilitate timely access to all healthcare and services. 6: Informs all individuals of the availability of language assistance services clearly and in their preferred language, verbally. 7: Ensures the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. 8: Provides easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. 13: Partners with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Goals for 2022-2023

In FY 2022-2023, the Cultural Competency program is working to:

- **Focus more on health equity which was more aligned with the direction as a county, rather than cultural celebratory events.** The roles of the CCLs are to actively work with the communities to look at health equity and see what is working and what is needed. Some strategic goals partnering with the communities were integrating substance use disorder and increasing community engagement by 15%.

- **Increase collected stakeholder feedback at CCRD (Cultural Competency Reducing Disparities Committee) and cultural advisory meetings by 10%.** Needs assessments would be conducted at other community events and shared with the research team to create specific focused projects identified with needs, such as suicides of African American men in Riverside County or substance use disorder for the Latinx teenage boy population. This opens the possibilities to work with the community for approaching the issues included training, education, and partnering with local associations and organizations.

- **Increase community support by tailoring community outreach and resources.** A current effort is in place with San Bernardino County Behavioral Health to increase capacity with community organizations in order to bid on PEI contracts. It would increase capacity and knowledge of community organizations and familiarize applying for contracts with government organizations.

- **Work with the Purchasing department to be more involved with the contracting process regarding the selection of language providers and interpreters.** Community feedback highlighted translation inadequacies, especially for the deaf and hard of hearing community. Work to have a representative from that community, the community liaison, and other members of the cultural competency team be part of the selection procedure for the next bidding process.

Riverside University HEALTH SYSTEM Behavioral Health

Who We Serve
Consumer Population Profile
Fiscal Year 2021-2022

WWS-Fiscal Year 2020-2021
Executive Summary

Summary ▸ In fiscal year 2021-2022, Riverside University Health Systems Behavioral Health (RUHS-BH) provided services to 52,710 consumers through mental health and/or substance abuse services. In mental health, 43,389 consumers were served through outpatient mental health, and inpatient psychiatric services. In substance abuse, 9,321 consumers were served through detoxification, residential services, outpatient substance abuse treatment services, and intensive half day treatment programs (e.g., Drug Court, MOMs). An additional 9,636 consumers were served by RUHS-BH in detention facilities, with 1,912 of those consumers also served by RUHS-BH outside of the detention facility. The grand total of RUHS-BH consumers served in FY20/21 was 60,434 including detention consumers. Statistics for RUHS-BH Detention consumers is provided separately beginning on pg.16.

County Comparison ▸ When RUHS-BH mental health consumer population was compared to 2021 Riverside County population data, there were higher proportions of children, transitional age youth, and adult consumers in the RUHS-BH consumer population compared to the general population. The proportion of older adult consumers was less than the general population of Riverside County. The RUHS-BH substance use consumer population served a higher proportion of adults than is present in the Riverside County population, but served a lower proportion of Children, transitional age youth, and Older Adults than are present in the Riverside County general population.

Region ▸ For both mental health and substance abuse, the Western region served the most consumers, followed the Mid-County region, with the Desert region serving the fewest.

Gender ▸ Overall, within mental health, roughly equal half of the consumers were male and female (49.7% to 50.3%, respectively). Within substance abuse, the majority of consumers served were male at 62% of the population. There were some variations by age. In mental health, there were more older adult females (57%) than males (43%) served; however, for substance abuse there were more male older adult (64%) than female older adult (36%) consumers served.

Race/Ethnicity ▸ Hispanic/Latinx made up the largest race/ethnic group served, while Caucasians made up the second largest group served for both mental health and substance abuse. Combined they represent 70% of all the consumers served in mental health and 86% of all those served in substance abuse.

History & Diagnosis ▸ Overall, in mental health, 36.4% of consumers had a history of drug/alcohol abuse and 74.4% of consumers had Medi-Cal. In substance abuse, 53% were reported to have a mental illness and 92.6% had drug Medi-Cal. In mental health, within each region the largest proportion of consumers served had been primarily diagnosed with Mood, Anxiety or Adjustment disorder or Major Depression. This trend changed when looking specifically at primary diagnoses by age groups. Children more often had a diagnosis in the AD/D grouping (which includes Oppositional Defiance, Conduct Disorders, and Attention Deficit) and Mood, Anxiety, or Adjustment disorders. Adults and Older Adults were more often diagnosed with Major Depression or Schizophrenia/Psychosis disorder. In substance abuse, overall 37% of consumers had an opiate diagnosis, while 24.9% of consumers had an Amphetamine diagnosis. Combined, these two diagnoses accounted for 62.% of the treatment population. In examining diagnosis by age, children had primarily a Marijuana diagnosis (84.0%). Over a third of adults (36.5%) had an Opiate diagnosis, followed by Amphetamines (27.2%). The majority of older adults (62.1%) had an Opiate diagnosis, with Alcohol (21.8%) being the next highest diagnosis.

WWS-Fiscal Year 2021-2022
Region and Age Group

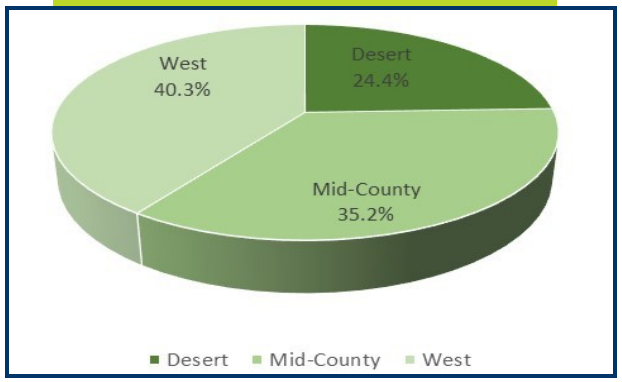
Riverside University HEALTH SYSTEM Behavioral Health

Regional Groups

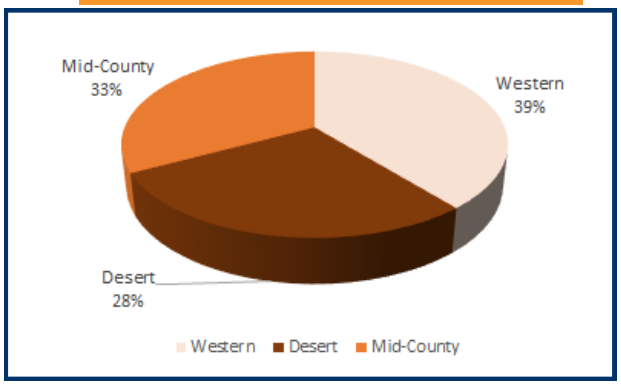
In Mental Health, the Western region served the highest proportion, followed by the Mid-County and Desert regions.

In Substance Use, the Western and Mid-County regions provided similar proportions of services, with Desert region servicing the fewest.

Mental Health



Substance Abuse



Age Groups of Consumers Served

	FY 20-21	%	FY 21-22	%	Change From Previous Yr	FY 20-21	%	FY 21-22	%	Change From Previous Yr
Children (<18 Years)	13,678	30%	13,501	31%	-1%	284	3%	362	4%	+1%
Adults (18-59 Years)	26,930	60%	25,466	59%	-3%	7,481	90%	8,312	89%	-1%
Older Adults (60+ Years)	4,487	10%	4,422	10%	-1%	561	7%	647	7%	0%
Total	**45,095**		**43,389**		**-2%**	**8,326**		**9,321**		**6%**
Transition Age Youth	9,448	21%	9,194	21%	-1%	1,026	12%	1,088	12%	0%

Age Groups

Overall, the total consumers served by mental health decreased (-3.7%) from FY20/21 to FY21/22. This decrease was observed across all age groups. The proportion served in each age group remained consistent. The largest age group served were adults (59%). Substance abuse primarily served adults, with a decrease in older adults (-1%) from FY 20/21. However, services for children increased by 1% and overall, the number of consumers served in substance abuse increased (+6%) from FY20/21 to FY21/22.

Rounding may provide numbers that are +/- 100% when summed.

WWS-Fiscal Year 2021-2022
Population Comparisons

	Mental Health					Substance Abuse				
	FY 21-22 Served	%	Riverside County Estimate	%	% Population Difference to Estimate	FY 21-22 Served	%	Riverside County Estimate	%	% Population Difference to Estimate
Children (<18 Years)	13,501	31.10%	586,874	23.42%	+7.7%	362	4%	586,874	23.42%	-19.5%
Adults (18-59 Years)	25,466	58.70%	1,343,974	53.62%	+5.1%	8,312	89%	1,343,974	53.62%	35.6%
Older Adults (60+ Years)	4,422	10.20%	575,503	22.96%	-12.8%	647	7%	575,503	22.96%	-16.0%
Total	**43,389**		**2,506,251**			**9,321**		**2,506,251**		
Transition Age Youth	9,194	21.20%	359,800	14.4%	+6.8%	1,088	12%	359,800	14.4%	-2.7%

Population Comparisons

The table above compares the mental health and substance abuse population with the general Riverside County population estimates for 2022. In mental health, the older adult population served is less proportionate relative to the county general population of older adults. This is also true in the substance abuse population where the proportion of older adults served is less than their representation in the overall county population. In both mental health and substance abuse the proportion served is greatest for adults. In mental health, the proportion of children served is more then their proportion represented in the overall youth population; whereas, for substance abuse the children population served is much lower relative to their proportion in the general population.

Rounding may provide numbers that are +/- 100% when summed.

**Source: State of California, Department of Finance, Projections-P3 State and County Projection Database , Complete P-3 File Database-Ready Format and Data Dictionary. Sacramento, California, December 2020. Retrieved from* http://www.dof.ca.gov/Forecasting/Demographics/Projections/

WWS-Fiscal Year 2021-2022
Gender

Riverside University HEALTH SYSTEM Behavioral Health

Mental Health

	West	%	Mid-County	%	Desert	%	Total
Male	8,977	51.3%	7,409	48.5%	5,201	49.0%	21,587
Female	8,523	48.7%	7,872	51.5%	5,407	51.0%	21,802
Total	**17,500**		**15,281**		**10,608**		**43,389**

Substance Abuse

	West	%	Mid-County	%	Desert	%	Total
Male	2,306	63%	1,743	57%	1,645	62%	5,594
Female	1,326	37%	1,308	43%	993	38%	3,627
Total	**3,632**		**3,051**		**2,638**		**9,321**

The tables above illustrate gender distributions in the consumer population by region. In mental health, slightly more females were served in the Mid-County and Desert regions than males, while the opposite was observed for West consumers. In mental health, countywide, RUHS-BH serves roughly an equal proportion of females and males in mental health. In substance use, across all regions, more males (62%) were served than females (38%) for FY21-22.

Mental Health

	Children (<18)	%	Adults (18-59)	%	Older Adults (60+)	%	Total	Transition Age (16-25)
Male	6,625	49%	13,075	51%	1,887	43%	21,587	4,174
Female	6,876	51%	12,391	49%	2,535	57%	21,802	5,020
Total	**13,501**		**25,466**		**4,422**		**43,389**	**9,194**

Substance Abuse

	Children (<18)	%	Adults (18-59)	%	Older Adults (60+)	%	Total	Transition Age (16-25)
Male	235	65%	5,046	61%	413	64%	5,694	680
Female	127	35%	3,266	39%	234	36%	3,627	408
Total	**362**		**8,312**		**647**		**9,321**	**1,088**

The tables above illustrate gender served by age group. In mental health, notably more older adults and slightly more transitional age youth served were female. Slightly more adult males were served than adult females. Additionally, the proportion of male and female children served were similar under mental health. For all age groups across the regions, more males were served than females by the County substance abuse providers.

Rounding may provide numbers that are +/- 100% when summed.

WWS-Fiscal Year 2021-2022
Race/Ethnicity

	Mental Health					Substance Abuse				
	FY 21-22	%	Riverside County Estimate	%	% Population Difference to Estimate	FY 21-22	%	Riverside County Estimate	%	% Population Difference to Estimate
Caucasian	11,187	25.78%	933,615	37.2%	-11.4%	3,750	40.2%	933,615	37.2%	+3.0%
Black/African American	4,759	10.48%	151,272	6.0%	+4.48%	711	7.6%	151,272	6.0%	+1.6%
Asian/PI	775	1.79%	159,279	6.4%	-4.6%	89	1.0%	159,279	6.4%	-5.4%
Hispanic/Latinx	19,366	44.63%	1,191,965	47.6%	-3%	4,255	45.6%	1,191,965	47.6%	-2.0%
Native American	146	0.34%	12,356	0.5%	-0.2%	88	0.9%	12,356	0.5%	+0.4%
Other	7156	16.49%	57,864	2.3%	+14.4%	428	4.6%	57,864	2.3%	+2.3%
Total	**43,389**		**2,506,351**			**9,321**		**2,506,351**		

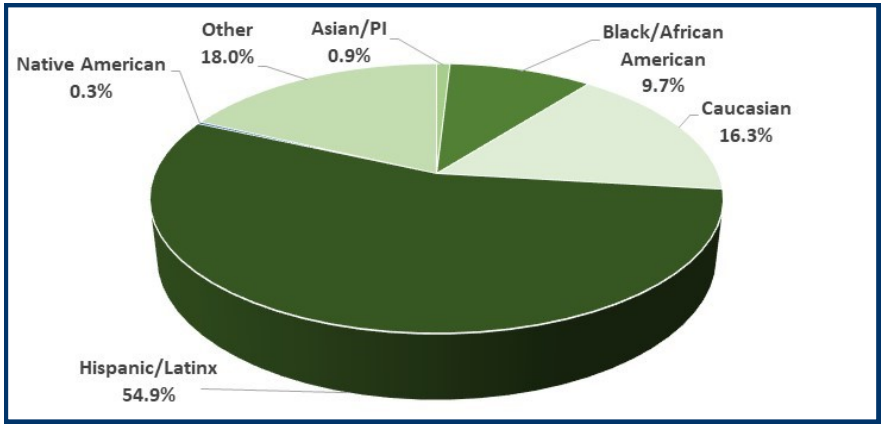
The table above provides a comparison of racial/ethnic groups served by County mental health and substance abuse providers in comparison to population estimates for the County overall. In the 2021-2022 fiscal year, Hispanic/Latinx consumers made up the largest proportion of the population served in mental health (44.6%). In substance abuse, Hispanic/Latinx consumers also made up the largest proportion of the population served (45.6%), followed closely by consumers identifying as Caucasian (40.2%). Compared to the Riverside County estimate for Hispanic/Latinx individuals, mental health served a proportion close to the reported population in Riverside County (47.6%). In addition, substance abuse served a proportion similar to the Riverside County population estimate of 47.6% for consumers identifying as Hispanic/Latinx. Although Native American consumers accounted for the smallest proportion of the consumer population in mental health and substance abuse, their representation in mental health is closely representative of the County population estimate of Native Americans; however, this group is overly represented in substance abuse compared to the County population estimate. In mental health, the proportion of Caucasian consumers served is less than their representation in the County population estimate, while the proportion of Black/African American consumers served is greater than the County population estimate. In both mental health and substance abuse, the proportion of Asian/PI consumers served is less than the County population estimate for this group. Lastly, for mental health and substance abuse, the proportion of consumers who were served and identified as Other (i.e., other race, multiracial, and unknown) was greater than the Riverside County population estimate.

Rounding may provide numbers that are +/- 100% when summed.

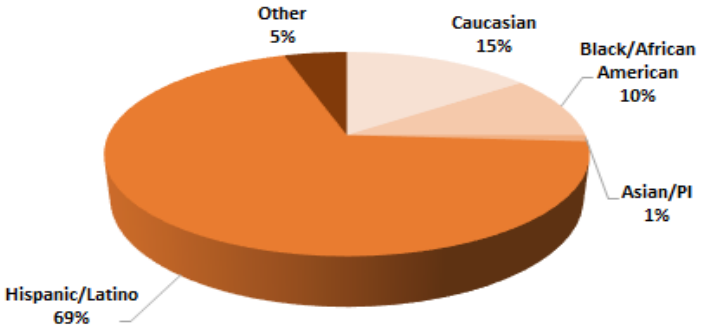
WWS-Fiscal Year 2020-2021
Race/Ethnicity by Age Group – Children

Riverside University HEALTH SYSTEM Behavioral Health

Mental Health



Substance Abuse



	West	Mid-County	Desert	Totals
Asian/PI	54	51	17	122
Black/African American	564	545	195	1,304
Caucasian	649	1077	478	2,204
Hispanic/ Latinx	2,867	2423	2	7,407
Native American	11	11	14	36
Other	1,130	882	416	2,428
Total	**5,275**	**4,989**	**3,237**	**13,501**

County Child Population 2022
5.2%
5.7%
28.1%
57.0%
0.5%
3.5%

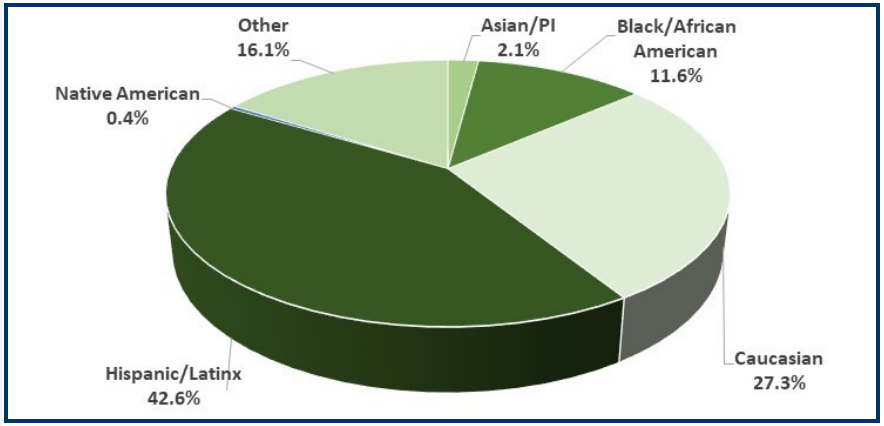
	West	Mid-County	Desert	Totals
Asian/PI	2	2	0	4
Black/African American	20	12	5	37
Caucasian	21	20	12	53
Hispanic/ Latinx	94	52	104	250
Native American	0	0	0	0
Other	5	6	7	18
Total	**142**	**92**	**128**	**362**

For children, Hispanic/Latinx were served more than any other race/ethnicity group in mental health for all regions. In addition, the proportion of Hispanic/Latinx children served in mental health was slightly lower than the proportion of Hispanic/Latinx children present in the County child population. In substance abuse, the proportion of Hispanic/Latinx children served was more than the general County child population. The proportion of Black / African American children served was higher than the general population percentage for both mental health and substance abuse services.

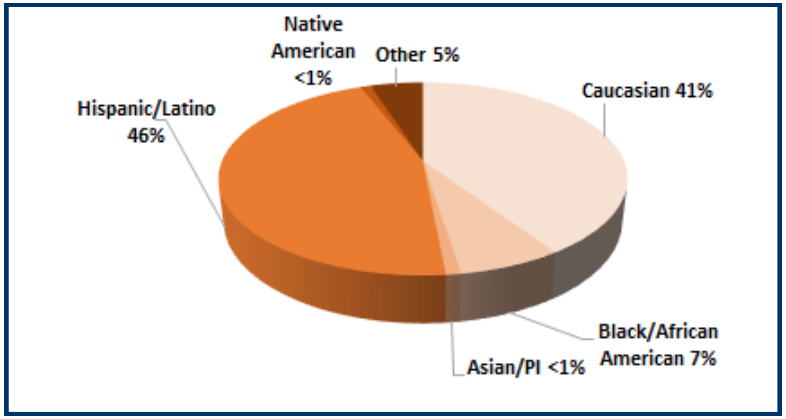
WWS-Fiscal Year 2021-2022
Race/Ethnicity by Age Group – Adults

Riverside University HEALTH SYSTEM Behavioral Health

Mental Health



Substance Abuse



	West	Mid-County	Desert	Totals
Asian/PI	275	182	75	532
Black/African American	1,517	924	520	2,961
Caucasian	2,615	2,535	1,802	6,952
Hispanic/ Latinx	4,357	3,187	3,292	10,836
Native American	41	26	27	94
Other	1,737	1,737	617	4,091
Total	**10,542**	**8,591**	**6,333**	**25,466**

County Adult Population 2022
6.5%
6.4%
31.9%
52.3%
0.5%
2.3%

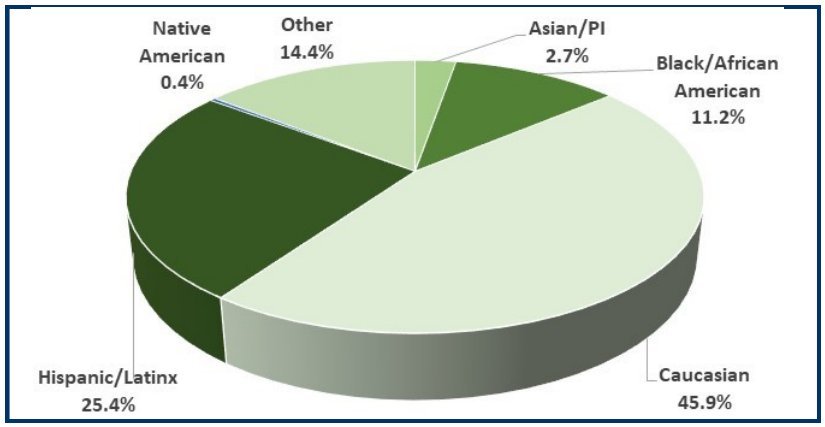
	West	Mid-County	Desert	Totals
Asian/PI	35	28	19	82
Black/African American	296	191	119	606
Caucasian	1,142	1,307	936	3,385
Hispanic/ Latinx	1,571	1,066	1,146	3,783
Native American	29	17	27	73
Other	192	122	69	383
Total	**3,265**	**2,731**	**2,316**	**8,312**

Among adults, Hispanic/Latinx were served more than any other race/ethnic group in mental health across all regions. In substance use, overall, Hispanic/Latinx were served slightly more than Caucasians with some regional differences. The proportion of Hispanic/Latinx adult consumers served by mental health (43%) and by substance abuse (46%) was lower than the proportion of Hispanic/Latinx adults present in the County Adult population (52.3%). Conversely, the proportion of Black / African Americans served with mental health was higher than the population percentage.

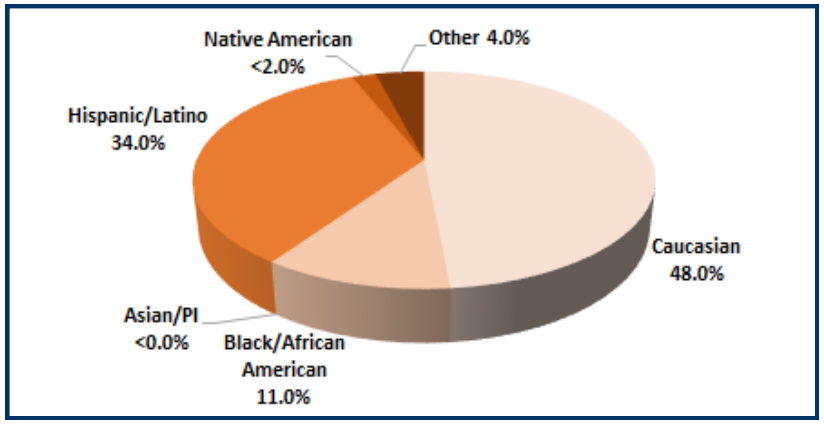
WWS-Fiscal Year 2021-2022
Race/Ethnicity by Age Group – Older

Riverside University HEALTH SYSTEM Behavioral Health

Mental Health



Substance Abuse



	West	Mid-County	Desert	Totals
Asian/PI	69	38	14	121
Black/African American	261	156	77	494
Caucasian	687	807	537	2,031
Hispanic/ Latinx	436	420	267	1,123
Native American	8	4	4	16
Other	222	276	139	637
Total	**1,683**	**1,701**	**1,038**	**4,442**

County OA Population 2022
7.1%
5.5%
59.0%
26.8%
0.6%
1.1%

	West	Mid-County	Desert	Totals
Asian/PI	2	1	0	3
Black/African American	28	25	15	68
Caucasian	99	113	100	312
Hispanic/ Latinx	83	72	67	222
Native American	4	5	6	15
Other	9	12	6	27
Total	**225**	**228**	**194**	**647**

Among older adults, Caucasian consumers were served more than any other race/ethnic group across both mental health and substance abuse, and across nearly all regions. For both mental health and substance abuse, Black / African Americans were served at higher rate than population percentages, whereas Asian / PI were served at a notably lower rate.

WWS-Fiscal Year 2021-2022
History-Medi-Cal

Mental Health

	West	%	Mid-County	%	Desert	%	Total	%
Medi-Cal	12,905	73.7%	11,197	73.3%	8,183	77.1	32,285	74.4%
No Medi-Cal	4,595	26.3%	4,084	26.7%	2,425	22.9%	11,104	25.6%
Total	**17,500**		**15,281**		**10,608**		**43,389**	

The table above provides the Medi-Cal status for consumers served by mental health. Overall, 74% of the mental health consumers served had Medi-Cal at some point in the 2021-2022 fiscal year. Regionally, there were some differences in mental health with the Desert region showing a slightly higher proportion of Medi-Cal consumers served at 77%, while the West region showed 74% and Mid-County region showed 73% enrolled in Medi-Cal.

Substance Abuse

	West	%	Mid-County	%	Desert	%	Total	%
DMC-ODS Medi-Cal	3,288	90.5%	2,849	93.4%	2,493	94.5%	8,630	92.6%
No DMC-ODS Medi-Cal	344	9.5%	202	6.6%	145	5.5%	691	7.4%
Total	**3,632**		**3,051**		**2,638**		**9,321**	

The table above provides the Medi-Cal status for consumers served by substance abuse. Overall, about 93% of the substance abuse consumers served had Medi-Cal at some point in the 2021-2022 fiscal year. In substance abuse, the Mid-County and Desert regions showed the highest proportion of consumers served with Medi-Cal at about 93% and 95%, respectively, while the Western region had served about 91% of consumers who were enrolled into Medi-Cal.

WWS-Fiscal Year 2021-2022
History- Co-Occurring

Riverside University HEALTH SYSTEM Behavioral Health

History Drug/Alcohol Abuse

A history of drug or alcohol abuse was reported for a little over a third of the mental health consumers served. There was some regional variation with the Mid-County region having the highest proportion of consumers with a drug or alcohol history; while, the Desert region reported the lowest proportion of consumers.

Mental Health

History Drg/Ach	West	%	Mid-County	%	Desert	%	Total	%
Yes	11,281	64.5%	5,097	66.6%	4,476	42.2%	15,792	36.4%
No	6,219	35.5%	10,184	33.4%	6,132	57.8%	27,597	63.6%
Total	**17,500**		**15,281**		**10,608**		**43,389**	

History Trauma

A history of trauma was derived from the mental health CSI Trauma indicator reported on the diagnosis data in the electronic health record. Overall, 53% had a history of trauma reported.

Mental Health

History Trauma	West	%	Mid-County	%	Desert	%	Total	%
Yes	8,860	50.6%	7,978	52.2%	6,430	60.6%	23,268	53.6%
No	8,640	49.4%	7,303	47.8%	4,178	39.4%	20,121	46.4%
Total	**17,500**		**15,281**		**10,608**		**43,389**	

History Mental Health

Data on mental illness is collected and recorded for substance abuse consumers from the California Outcomes Measurement System (Cal OHMS) data fields in the electronic health record. About 53% of consumers reported having a mental illness. Of those recorded as having a mental illness, 50.1% had a mental health service recorded in the 2021-2022 fiscal year.

Substance Abuse

History MH	West	%	Mid-County	%	Desert	%	Total	%
Yes	1,964	54.1%	1,594	52.2%	1,345	51.0%	4,903	52.6%
No	1,668	45.9%	1,457	47.8%	1,293	49.0%	4,418	47.4%
Total	**3,632**		**3,051**		**2,638**		**9,321**	

WWS-Fiscal Year 2021-2022
Diagnosis by Region

Riverside University HEALTH SYSTEM Behavioral Health

Mental Health

	West	%	Mid-County	%	Desert	%	Total	%
AD/D	1,313	7.5%	1,300	8.5%	774	7.4%	3,387	7.8%
Organic	87	0.5%	73	0.5%	18	0.2%	178	0.4%
Drug/Alcohol	230	1.3%	150	1.0%	63	0.6%	443	1.0%
Schiz/Psych	4,185	23.9%	2,702	17.7%	2,048	19.7%	8,935	20.6%
Mood/Anx/Adj	4,470	25.5%	4,200	27.5%	2,794	26.8%	11,464	26.4%
Major Depression	4,167	23.8%	3,688	24.1%	3,086	29.7%	10,941	25.2%
BiPolar	1,518	8.7%	1,604	10.5%	1,068	10.3%	4,190	9.7%
Other	1,530	8.7%	1,564	10.2%	7,57	5.3%	3,851	8.9%
Total	**17,500**		**15,281**		**10,608**		**43,389**	

When analyzing countywide FY 2021-2022 mental health consumer primary diagnoses, a large proportion of consumers were diagnosed with Mood, Anxiety, or Adjustment disorder (26.9%), Major Depression (25.6%), or Schizophrenia/Psychosis disorders (20.9%). Consumers showed less Organic (0.4%) or Drug/Alcohol (1.0%) disorders compared to other diagnoses. Within each region, these patterns were similarly prevalent. The Other diagnosis category comprised 8.9% of consumer diagnoses. Other diagnosis includes eating disorders, sleep disorders, somatic, pervasive developmental disorders, encounter for examination, impulse and missing diagnosis.

Rounding may provide numbers that are +/- 100% when summed.

WWS-Fiscal Year 2021-2022
Diagnosis by Age Group

Riverside University HEALTH SYSTEM Behavioral Health

Mental Health

	<18yrs	%	18-59yrs	%	60+	%	Total	%
AD/D	3,044	22.5%	335	1.3%	8	0.2%	3,387	7.8%
Organic	3	<1%	66	0.3%	109	2.5%	178	0.4%
Drug/Alcohol	15	0.1%	385	1.5%	43	1.0%	443	1.0%
Schiz/Psych	132	1.0%	7,469	29.3%	1,334	30.2%	8,935	20.6%
Mood/Anx/Adj	4,870	36.1%	5,854	23.0%	740	16.7%	11,464	26.4%
Major Depression	3,273	24.2%	6,367	25.0%	1,301	29.4%	10,941	25.2%
BiPolar	196	1.5%	3,381	13.3%	613	13.9%	4,190	9.7%
Other	1,968	14.6%	1,609	6.3%	274	6.2%	3,851	8.9%
Total	**13,501**		**25,466**		**4,422**		**43,389**	

A large proportion of consumers under the age of 18 were diagnosed with either a Mood, Anxiety, or Adjustment disorder (36.1%) or AD/D (22.5%), which includes oppositional defiance, conduct disorders, and attention deficit disorders, or Major Depression (24.2%).

Among adult consumers, Schiz/Psych (29.3%), Mood, Anxiety, or Adjustment disorders (23.0%), and Major Depression (25.0%) were more frequently diagnosed.

For older adults, Major Depression (29.4%) and Schiz/Psych (30.2%) were the most frequent diagnoses.

Variations in diagnosis were observed between age groups. For instance, the observed proportion of services for older adults with Mood, Anxiety, or Adjustment Disorders was lower than that observed for adults. At the same time, the observed proportion of older adults with a diagnosis of Major Depression or Schiz/Psych disorders was slightly higher than that observed in adults. In a related observation, while a Schiz/Psych disorder diagnosis was not uncommon among the adults and older adults served, the proportion observed for children was <1%. Similarly, the opposite occurrence was observed in the high proportion of children receiving services with an AD/D diagnosis, which was observed at a much lower proportion for adults (1.3%) and older adults (0.2%). Differences observed across age groups, particularly those occurring between populations over or under the age of 18 can possibly be attributed to age of first onset, or the primacy of diagnosis.

Rounding may provide numbers that are +/- 100% when summed.

WWS-Fiscal Year 2020-2021
Diagnosis by Region

Riverside University HEALTH SYSTEM Behavioral Health

Substance Abuse

	West	%	Mid-County	%	Desert	%	Total	%
Alcohol	753	20.7%	570	18.7%	539	20.4%	1,862	20.0%
Marijuana	347	9.6%	254	8.3%	243	9.2%	844	9.1%
Hallucinogen	4	0.1%	5	0.2%	1	0.0%	10	0.1%
Sedative/Hypnotic	18	0.5%	23	0.8%	14	0.5%	55	0.6%
Inhalants	2	0.1%	0	0.0%	0	0.0%	2	0.0%
Opiates	1,130	31.1%	1,314	43.1%	1,004	38.1%	3,448	37.0%
Cocaine	41	1.1%	16	0.5%	41	1.6%	98	1.1%
Amphetamines	942	25.9%	673	22.1%	709	26.9%	2,324	24.9%
Other substance	395	10.9%	196	6.4%	87	3.3%	678	7.3%
Total	**3,632**		**3,051**		**2,638**		**9,321**	

The table above provides data on primary substance diagnosis by region. Data on diagnosis was analyzed from ICD-10 most recent primary diagnosis recorded in the electronic health record for consumers served in substance abuse. Reporting does not differentiate between varying diagnostic categorization under the same substance, including differences between abuse or dependent diagnoses.

Across all regions, more than a third of substance use consumers (37.0%) had a primary diagnosis related to the usage of opiates. Additionally, a quarter of consumers (24.9%) had a primary diagnosis for amphetamines. Combined, these two diagnoses accounted for 61.9% of the treatment population. Among the total population served, a primary diagnosis related to alcohol (20.0%) was more common than a primary diagnosis related to marijuana (9.1%).

Diagnoses related to opiate use and amphetamines were the highest compared to other diagnoses across all regions and is reflective in each region individually where a primary diagnosis related to opiate use was the highest for its region.

Rounding may provide numbers that are +/- 100% when summed.

WWS-Fiscal Year 2020-2021
Diagnosis by Age Group

Riverside University HEALTH SYSTEM Behavioral Health

Substance Abuse

	<18yrs	%	18-59yrs	%	60+	%	Total	%
Alcohol	16	4.4%	1,705	20.5%	141	21.8%	1,862	20.0%
Marijuana	304	84.0%	534	6.4%	6	0.9%	844	9.1%
Hallucinogen	0	0.0%	10	0.1%	0	0.0%	10	0.1%
Sedative/Hypnotic	4	1.1%	49	0.6%	2	0.3%	55	0.6%
Inhalants	0	0.0%	2	0.0%	0	0.0%	2	0.0%
Opiates	15	4.1%	3,031	36.5%	402	62.1%	3,448	37.0%
Cocaine	1	0.3%	92	1.1%	5	0.8%	98	1.1%
Amphetamines	2	0.6%	2,264	27.2%	58	9.0%	2,324	24.9%
Other Substances	20	5.5%	625	7.5%	33	5.1%	678	7.3%
Total	**362**		**8,312**		**647**		**9,321**	

The table above provides data on primary substance diagnosis by age group. Data on diagnosis was analyzed from the ICD-10 most recent primary diagnosis recorded in the electronic health record for consumers served in substance abuse. Reporting does not differentiate between varying diagnostic categorization under the same substance, including differences between abuse or dependent diagnoses.

Overall, most substance abuse consumers (37.0%) had a primary diagnosis related to opiate usage. The second common primary diagnosis was related to amphetamine usage (24.9%).

Variations between primary substance and age group were observed. For consumers under the age of 18, a diagnosis related to marijuana usage was the most common (84.0%). Less common for this age group were diagnoses related to either opiate (4.1%) or amphetamine (0.6%) usage. Moreover, consumers under the age 18 were less observed to have a primary diagnosis related to alcohol usage (4.4%) than compared to the adult age group (20.5%) and older adult age group (20.0%). Lastly, although only 1.1% of consumers under the age of 18 were observed to have a primary diagnosis related to sedative or hypnotic usage, this diagnosis was even less commonly observed in the adult age group (0.6%) as well as the older adult age group (0.6%).

Rounding may provide numbers that are +/- 100% when summed.

Who We Serve
Detention
Consumer Population Profile
Fiscal Year 2021-2022

WWS-Fiscal Year 2021-2022

Executive Summary-Behavioral Health Detention Services

Summary ▸ In fiscal year 2021-2022, Riverside University Health Systems Behavioral Health (RUHS-BH) provided Behavioral Health Detention Services to 9,636 consumers.

Region ▸ The Western Region had the most consumers, followed by the Desert, and the Mid-County region, respectively.

Gender ▸ Overall, more male than female consumers were served (80% to 20%, respectively). Across all county regions and age groups, males consumers were served more than female consumers.

Race/Ethnicity ▸ Hispanic/Latinx made up the largest race/ethnic group served, while Caucasians made up the second largest group served. The Desert region served the most Hispanic/Latinx consumers, while Mid-County served the most Caucasian consumers.

Diagnosis ▸ Overall, the most frequent diagnoses were Drug/Alcohol disorders (16.9%), followed by Mood/Anxiety/ Adjustment disorders (13.2%), and Schizophrenia/Psychosis disorders (11.2%). Diagnoses varied by County region. Drug/Alcohol disorders were the most frequent diagnosis across all regions, in the Desert region (17.9%), Mid-County region (16.9%) and West he region (16.0%). Among adult consumers, Drug/Alcohol disorders (17.1%) were the most frequent diagnosis. For older adults Schizophrenia/Psychosis (16.1%) disorders were the most frequent diagnosis. Older adults were more likely to be diagnoses with Major Depression than were adult consumers.

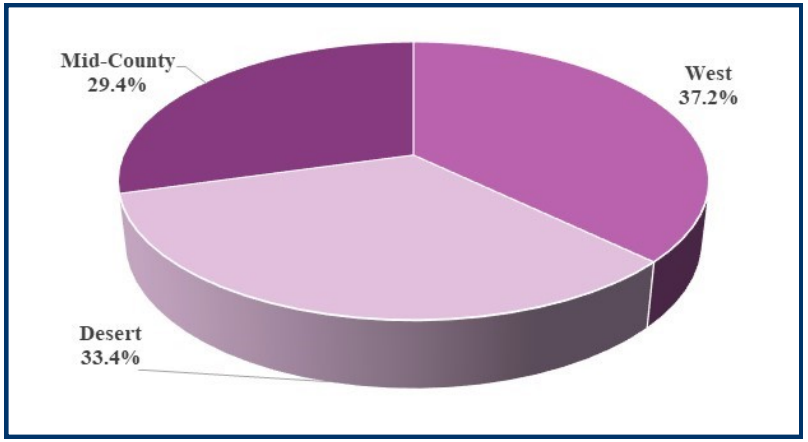
WWS-Fiscal Year 2021-2022
Detention Services - Region and Age

Riverside University HEALTH SYSTEM Behavioral Health

Regional Groups

More adults and older adults from the Western and Desert region received Behavioral Health services in Detention facilities.

Behavioral Health Detention Services



Age Groups of Consumers Served

	FY 20-21	%	FY 21-22	%	Change From Previous Yr
Adults (18-59 Years)	8,154	96%	9,221	95.7%	-0.3%
Older Adults (60+ Years)	312	4%	415	4.3%	+0.3%
Total	**8,466**		**9,636**		
Transition Age Youth	1,312	15.5%	1,278	13.3%	-2.2%

Age Groups

Overall, the total consumers served by behavioral health in detention increased (12.1%) from FY20/21 to FY21/22. This increase was observed for adults while older adults did not increase significantly. The largest age group served were adults (95.7%). At least 13.3% of the adults were transition age youth (TAY) age 18-25. Overall, the number of consumers was fairly consistent across fiscal years.

Rounding may provide numbers that are +/- 100% when summed.

WWS-Fiscal Year 2021-2022
Gender

Behavioral Health Detention Services

	West	%	Mid-County	%	Desert	%	Total
Female	731	20.4%	561	19.8%	619	19.3%	1,911
Male	2,850	79.6%	2,275	80.2%	2,592	80.7%	7,717
Total	**3,581**		**2,836**		**3,211**		***9,628**

The table above illustrate gender distributions for consumers served by behavioral health detention services by region. Countywide and among regions, RUHS-BH served a higher proportion of males than females (80.2%; 7,717/9,628).

Behavioral Health Detention Services

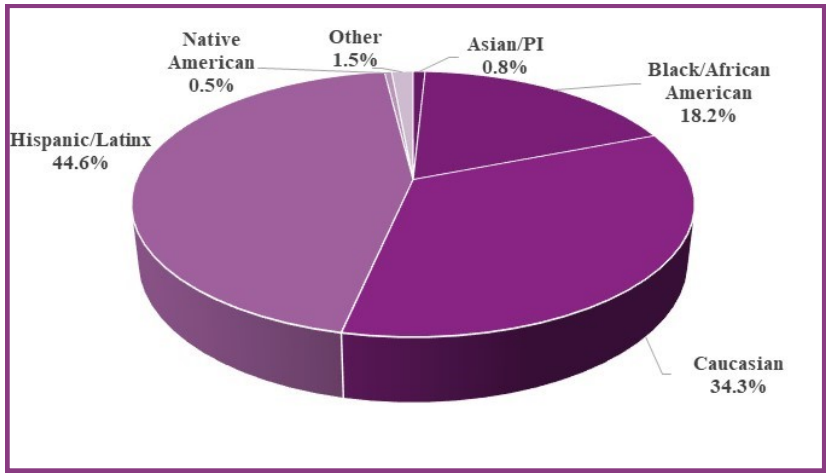
	Adults (18-59)	%	Older Adults (60+)	%	Total	Transition Age (16-25)
Female	1,845	20.0%	66	16.2%	1,911	238
Male	7,376	80.0%	341	83.8%	7,717	1,040
Total	**9,221**		**407**		***9,628**	**1,278**

The table above illustrate gender served by age group. More males than females were served in each age group.

Eight unknown gender statuses across consumers.

****Rounding may provide numbers that are +/- 100% when summed.***

WWS-Fiscal Year 2021-2022
Race/Ethnicity



Behavioral Health Detention Services

	West	Mid-County	Desert	Totals
Asian/PI	33	32	14	79
Black/African American	830	481	447	1,758
Caucasian	1,102	1,121	1,086	3,309
Hispanic/ Latinx	1,546	1,136	1,619	4,301
Native American	8	21	18	47
Other	66	45	31	142
Total	**3,585**	**2,836**	**3,215**	**9,636**

The table above provides a comparison of racial/ethnic groups served by Behavioral Health Detention Services. Hispanic/Latinx consumers were served the most (44.6%), followed by Caucasian consumers (34.3%) and Black/African American consumers (18.2%). The Other category includes other race, multiracial and unknown. Percentages may not sum to 100% due to rounding.

WWS-Fiscal Year 2021-2022
Diagnosis by Region

Riverside University HEALTH SYSTEM Behavioral Health

Behavioral Health Detention Services

	West	%	Mid-County	%	Desert	%	Total	%
AD/D	5	0.1%	10	0.4%	12	0.4%	27	0.3%
Drug/Alcohol	574	16.0%	478	16.9%	577	17.9%	1,629	16.9%
Schiz/Psych	480	13.4%	275	9.7%	322	10.0%	1,077	11.2%
Mood/Anx/Adj	497	13.9%	356	12.6%	423	13.2%	1,276	13.2%
Major Depression	208	5.8%	141	5.0%	157	4.9%	506	5.3%
BiPolar	142	4.0%	66	2.3%	84	2.6%	292	3.0%
Other	1,679	46.8%	1,510	53.2%	1,640	51.0%	4,829	50.1%
Total	**3,585**		**2,836**		**3,215**		**9,636**	

When analyzing FY 2021-2022 countywide consumer primary diagnoses, a large proportion of consumers were diagnosed with Drug/Alcohol disorders (16.9%), Mood, Anxiety, or Adjustment disorder (13.2%), or Schizophrenia/Psychosis disorders (11.2%). Consumers showed few AD/D (0.3%) disorders compared to other diagnoses. Diagnoses varied by region. In the Western region, Mood/Anxiety/Adjustment disorders were the most frequent diagnosis (13.9%), while Drug/Alcohol disorders were the most frequent diagnosis in the Mid-County (16.9%) and the Desert (17.9%) regions. The Other diagnosis category comprised 50.1% of consumer diagnoses. Other diagnosis includes eating disorders, sleep disorders, somatic, pervasive developmental disorders, encounter for examination, impulse and missing diagnosis. Missing diagnosis was relatively high.

Rounding may provide numbers that are +/- 100% when summed.

WWS-Fiscal Year 2021-2022
Diagnosis by Age Group

Behavioral Health Detention Services						
	18-59yrs	%	60+	%	Total	%
AD/D	27	0.3%	0	0.0%	27	0.3%
Drug/Alcohol	1,580	17.1%	49	11.8%	1,629	16.9%
Schiz/Psych	1,010	11.0%	67	16.1%	1,077	11.2%
Mood/Anx/Adj	1,243	13.5%	33	8.0%	1,276	13.2%
Major Depression	466	5.1%	40	9.6%	506	5.3%
BiPolar	282	3.1%	10	2.4%	292	3.0%
Other	4,613	50.0%	216	52.0%	4,829	50.1%
Total	**9,221**		**415**		**9,636**	

Among adult consumers, Drug/Alcohol disorders (17.1%), Mood, Anxiety, or Adjustment disorders (13.5%), and Schizophrenia/Psychosis disorders (11.0%) were more frequently diagnosed. For older adults, Schizophrenia/Psychosis disorders (16.1%), Drug/Alcohol disorders (11.8%), and Mood, Anxiety, or Adjustment disorders (8.0%) were the most frequent diagnoses. Older adults were more likely to be diagnoses with Major Depression than were adult consumers.