

Training & Continuing Education Bulletin

Orange County Health Care Agency Behavioral Health Services

August 2007

E-Learning Tips:

How to Log into Essential Learning:

Name of Company: HCA

Company Password: orange

Enter your First & Last Name

If you are a County Employee enter your employee number. If you work for one of our contract programs enter the password assigned to you.

If you are a new employee of the County of Orange or contract agency please have your service chief/program director send an E-mail to cysqrttraining@ochca.com to request new access for staff.

To access online courses click on "Other Courses Offered by HCA" to find a course. When you get to HCA, you can see the list of all available online courses by just clicking on *GO*, or you can narrow the selection to those approved by one or another accrediting body (e.g. APA, CBBS-California Board of Behavioral Sciences) or to a specific topic area.

Please E-mail or call with any questions or concerns. All registrations are done via essential learning or e-mail. **No phone registrations.**

cysqrttraining@ochca.com or call
Zanetta Nowden-Moloi

(714) 796-0179

Website:

http://essentiallearning.net

ORTIPS

This section provides monthly critical reminders in relation to documentation standards. Please review the following two tips:

The first tip is brought to your attention as it has been identified by the State and QRT staff as an area that requires your attention. Please make sure that your charting practices are consistent with the following tips.

- 1) One of the reasons for Recoupment in an EPSDT audit is when the documentation in the chart does not establish that the focus of the proposed intervention is to address the mental health condition. The following progress note was recouped by the State due to the intervention not being tied to the mental health condition.
- S 17 yr old Hispanic male with Major Depressive Disorder. Clt presents with depressed mood, anxiety, self-injury, unresolved grief and having abandonment issues. (*I*) Engaged clt in activity to find job possibilities in area around his house. Informed him of steps in regards to completing applications and presentation of self.

The following are some ideas of how the intervention would actually address the mental health condition (in this case depression):

- a) confronted clt's cognitive distortions that result in a depressed mood and interfere with his ability to find a job.
- b) explored clt's anxiety about obtaining job applications, and helped clt. develop a plan to cope with his anxious feelings.

2) Hours worked vs. time billed

In no case will the units (minutes) of time reported or claimed for any person exceed the amount of actual time worked.

The County of Orange Health Care Agency is an approved provider of continuing education credits for the California Board of Behavioral Sciences (provider no. PCE389), and is approved by the American Psychological Association to sponsor continuing education for psychologists. The Orange County Health Care Agency maintains responsibility for this program and its content.

GAY & GRAY

August 2007

Presenter: Nikki Yocham, MFT

DateTime

Location

Aug. 14, 2007 9 a.m. – 12 p.m. or 1 p.m. – 4 p.m.

744 N. Eckhoff, Orange (Auditorium)

Aug. 16, 2007 9 a.m. – 12 p.m. or 1 p.m. – 4 p.m.

405 W. 5th Street Ste. 433A

Course Description: Increase knowledge of mental health professionals on working with Older Adults (OA) who are Lesbian, Gay, Bisexual, or Transgender (LGBT) individuals who may also have a serious mental illness.

Objective:

- 1. Participants will understand the special issues that LGBT Older adults face
- Participants will understand the special needs that LGBT older adults who also have a mental illness face
- 3. Participants will develop a clear understanding of the demographics of OA who are LGBT in Orange County via discussion of an annual OA LGBT survey done locally

You may register for this course online via Essential Learning

3 CE credits have been applied for: psychologists, social workers and MFTs

Critical Incident Disaster Response and Substance Abuse Issues

Presenter: Joshua Taylor, MA, BHS/HCA MHSA Training Program Date/Time: August 29, 2007 9 a.m. – 12 p.m. or 1 p.m. – 4 p.m. Location: 405 W. 5th Street, Ste. 433A Santa Ana, 92701

This course is designed to familiarize the participants with Critical Incident Disaster response. Discussion will include: the types of disasters that can affect our local community, the impact they might have on our services, and clinician self care and building resilience during times of crisis response.

Objectives:

- 1. Identify the different types of disasters that affect our community
- 2. Learn how to minimize the impact of PTSD, Relapse and Depression from a critical incident on the AOD clients
- 3. Learn how to build resilience and proper self care for the clinician

3 CE credits have been applied for: psychologists, social workers, MFTs, and AOD Counselors

August 2007

ANNOUNCEMENTS

Joshua Taylor is the new Assistant Training Coordinator for BHS MHSA Training Program. Prior to his current position, he led the Alcohol and Drug Abuse (ADAS) training program for Alcohol and Drug Abuse Services. He is part of the faculty at California Pacific College of the Arts and Riverside Community College where he teaches a variety of psychological courses. He holds a Bachelors degree in Management, a Masters in Clinical Psychology and is receiving a Doctorate in Clinical Psychology. In his new role he will assist the BHS Training Coordinator in the development and implementation of Mental Health Services Act (Prop 63) training programs across the county. Please join us in welcoming Joshua to the training program.

Guadalupe Montoya is the new Office Assistant for BHS MHSA Training Program. Guadalupe worked for New Century Mortgage for two years as a payroll administrator where she processed payroll and maintained/updated files for approximately 850 employees. Please join us in welcoming Guadalupe to the training program.

August 2007

Our training bulletin does not usually advertise job openings, but the following announcement relates to a teaching position in a program funded by our MHSA training money to train consumers to work in the mental health system.

ANNOUNCEMENT OF VACANCY (CERTIFIED)

The Santa Ana College School of Continuing Education wishes to develop a group of qualified candidates for instruction opportunities. The assignments may be daytime or evening.

POSITION: Mental Health Worker Training Instructor

(NON-CREDIT PROGRAM)

STARTING SALARY: Based on experience

(*12 hours per week)

STARTING DATE: Fall 2007 Semester (September 10, 2007)

CLOSING DATE: Wednesday, August 15, 2007

MINIMUM QUALIFICATIONS:

For a non-credit course in Vocational Education (Mental Health Worker Training Program):

A Bachelors degree (Master's Preferred) in sociology, psychology, social work or in the field of mental health. OR a California College Instructor Credential.

Minimum of two years of occupational experience in the field.

Ability to work in a multiethnic environment with consumers and students who have a variety of learning styles and abilities.

Minimum two years teaching experience in the field.

If candidates are selected for an interview they will be required to present a 20 minute "teaching demonstration" on a subject chosen by the committee.

Please send Rancho Santiago Community College District Application for Certified personnel (available at www.rsccd.org), cover letter, copies of transcripts, and CV by Wednesday, August 15, 2007 to:

Vinicio J. López, MAEd Associate Dean, Instruction and Student Services Santa Ana College Marketplace Education Center 201 East 4th Street, 2nd Floor Santa Ana, CA 92701

Phone: 714.564.5770 Fax: 714.973.1240

August 2007

Show me the Evidence!

Are evidence-based practices really practical in a public mental health system?

There are several considerations that apply to the question of whether a public mental health system can or should adopt evidence-based practices. Among these are questions about whether such practices extend beyond narrow symptom relief and address broader issues of quality of life (i.e. are they applicable to a recovery-based system?), whether they have ever been validated on populations that include ethnic and linguistic minorities or poor people, whether they have been validated on persons with serious mental illness, and how they relate to the issue of providing consumer-run mental health services. The reason for raising these considerations is that the public mental health system is in danger of dismissing evidence-based practices as either not relevant to its clients or not sufficiently recovery-based to fit into a transformed system.

With regard to the breadth of focus of evidence-based practices, there are several practices that include broad quality of life goals. These include supportive employment, supportive education, family psychoeducation, Assertive Community Treatment and social skill training. Parent training and social skill training for children and youth reduce child abuse, teach positive social skills, and improve school functioning. Functional Family Therapy and Multisystemic Therapy reduce drug abuse and juvenile crime recidivism. Wraparound helps families find homes, and keeps children in school.

Family psychoeducation, Multisystemic Therapy, Brief Strategic Therapy, Behavioral Parent Training were all either developed for primarily ethnic or linguistic minority group members or were extensively validated on persons from such groups, as has been stimulant medication for ADHD children. The above interventions, plus supportive employment, Assertive Community Treatment and social skill training have been used extensively and successfully with persons with serious mental illness.

Most of the evidence-based practices that are available have not been validated using consumers or family members as service providers. Some consumer-run services, such as NAMI's Peer-to-Peer program and their Family-to-Family program have limited data supporting their usefulness. Probably the most studied consumer-run program is Wellness Recovery Action Planning (WRAP). This program is typically evaluated using pre-post surveys of participants to address questions of attitude change and self-reported behavior change. Results have been positive, though there have been no random-assignment, controlled studies, nor have results been reported for other than self-report data.

BHS/MHSA Training Team

Casey Dorman, Ph. D. Training Coordinator

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For further information

E-mail:
cysqrttraining@ochca.com
or
mtrainingprogram@ochca.com

Or call: Main Line (714) 796-0179 FAX: (714) 568-5781

Your Culture and Mine By Minh-Ha Pham, Psy.D., Cultural Competency Department

Evidence to Resolve the Myth of Immigrant Criminality

The post-9/11 climate of fear of terrorism and the recent post-incident reports related to the Virginia Tech killer in Blacksburg have somehow linked immigrants with crime, both among the media and among the general population. In fact, data from the census indicate that for every ethnic group without exception, young male incarceration rates are lowest for immigrants, even among the least educated (Rumbaut & Ewing, 2007). This fact particularly holds true for the Mexicans, Salvadorans, and Guatemalans who make up the bulk of the undocumented population. In addition, data of the last three censuses spanning the current era of mass immigration have displayed the same consistent pattern of low incarceration rates among young male immigrants. This same finding was also reported by three major government commissions over the first three decades of the 20th century.

Regardless of their legal status, immigrants are not the cause of the crime problem in the U.S. Although the undocumented population has increased two fold to 12 million since 1994, the Uniform Crime Reports released from the FBI indicated that U.S. violent crime rates have declined 34.2%, and property crime rate decreased 26.4% between 1994 and 2005. Cities where large populations of immigrants inhabited such as New York, Los Angeles, Chicago, and Miami have also reported reduced crime rates from 1994 to 2005. These data confirmed that crime rates have declined while immigration has increased.

Data analysis from the year 2000 U.S. Census indicated that the incarceration rate is five fold higher among native-born men (3.5%) in the age range (comprising the majority of the prison population) of 18 to 39 than the incarceration rate of foreign-born (0.7%). This study also revealed that foreignborn incarceration rate was 2.5 times less than that of the 1.7% rate of nativeborn non-Hispanic white men and approximately 17 times less than the 11.6% rate for native-born black men. In year 2000, the incarceration rate of foreignborn Hispanic men was 7 times lower than that of native-born Hispanic men while the incarceration rate of foreign-born white men was 3 fold less than that of native-born non-Hispanic white men. For foreign-born Mexicans, the rate of incarceration in year 2000 was 8 times lower than the 5.9% rate of native-born males of Mexican descent. A similar pattern was also observed with foreign-born Salvadoran and Guatemalan men's incarceration rate of 0.5% versus the 3% rate among native-born males of Salvadoran and Guatemalan descent. Although the year 2000 incarceration rate of foreign-born Laotian and Cambodian men of 0.9% was the highest among Asian immigrant groups, it was more than 8 times lower than the 7.3% incarceration rate of native-born Laotian and Cambodian descent. Among Asians, in year 2000 foreign-born Chinese/Taiwanese men had an extremely low incarceration rate of 0.2% that was 3.5 fold lower than the 0.7% rate of native-born men of Chinese/Taiwanese descent. These data have clearly confirmed just the opposite from the conventional theories of crime and immigration.