Date: July 23, 2020

Response to Reviewers Questions Regarding Application for Funds for Migrant/Undocumented Mental Health and Substance Use Services. RFP 2020.1

1. What is the number of members in Tier I, II, and III support groups?

   Collectively, the number of individuals impacted by the 3-Tier support groups are thousands. In an effort to help understand how the numbers are broken down, I will quickly describe each Tier and how it impacts individuals on a larger scale to a smaller scale. Please keep in mind that the program puts a lot of emphasis on prevention as well as treatment. Ideally, when working with youth, focusing on prevention and education will reduce the chances a child, or later an adult, will need services for treatment and therapeutic intervention. We already see a trend within the school-based mental health program where children are advocating for themselves to get help and direction early on instead of holding on to the stress and later it expressing itself as a mental health condition (such as adopting negative coping mechanisms like self-medicating, etc.) This is key because a child who gets help early on will only need a few sessions, versus a child who has had no support over a long period of time, will most likely need several weeks or months of more intensive support.

   Tier I is school wide. Therefore, when one of our therapists or substance use counselors is addressing the whole student body, the entire school is receiving information. These discussions are prevention-based presentations and would be considered psychoeducational providing social and emotional techniques and learning to the student body. As a program, we try to speak to as many children as possible in many different settings. This is done by school-wide assemblies, grade level programs (wherein the therapist will work with the individual(s) providing the platform to talk to the entire grade in a school), or by classroom based presentations (this is the most common form we find that we use in the schools.) For parents and caregivers, we provide support and teaching through an interactive discussion-based group by holding parent workshops on campus. These workshops are done before school, during school and in the evening. The number of individuals impacted by a Tier I approach is at least a few hundred, and depending on the enrollment number at each school, could be up to 1,000 or more (highest enrolled school is about 2,600 students). There are 21 schools in the district and each school has a therapist assigned to provide therapeutic support and prevention.

   Tier II is where treatment type counseling approaches begin and this is done through group counseling. Students are identified, screened, and put into groups according to the need and what will be addressed in the group. In group counseling, it is both psychoeducational as well as processing. The more common types of groups we hold are groups for grief, anger, self-esteem, social skills, positive coping skills, and most all of our substance use counselors conduct at least 75% of their counseling of students in a

group setting. Groups are a powerful format because it allows for peer-to-peer interaction and provides a space to normalize and validate a person's experience.

The last Tier, Tier III is individual counseling. Therapists spend at least 80% of their time conducting Tier III as this is direct counseling/treatment. Child psychotherapy not only works with the child, but also the family and therefore, when working with a child, often times, parents/caregivers are also being connected to counseling/therapy to receive their own support. When necessary, family counseling will be provided. Therefore, it is not uncommon that a family unit may be receiving family counseling as well as some of the individuals within the family unit are receiving their own individual counseling. The program tries to provide a whole-health approach and will provide the type of counseling necessary for the need.

The approximate number of units (individual, family, group) in Tier II and Tier III that were provided from August, 2019 to June, 2020 for mental health was 1,383. The approximate number of units provided for substance use counseling was 310.

2. What is the process for the tier groups and how are children/adults identified and referred for individual and family assessments?

   A child is identified either by their teacher or administrator (a small percentage of referrals are self-referred.) The child is exhibiting a behavior such as defiance, withdrawn or change in mood. The child is connected to the therapist, and the therapist will assess the child to see if they would benefit from mental health support. They will also determine if the child would be a better fit for group counseling or individual. Additionally, the assessment will determine if family counseling is needed. At all times, we work with the families as much as possible, incorporating the family into the child's treatment. And when there are instances, the assessment process may also determine that the family member would be the best recipient of services and not the child since the stress is being transferred down from parent to the child. Therefore, providing the adult with support will also address the child's need.

3. What are the steps that you will take to select the people who will be referred to receive services?

   Since the money will be used to expand services already being provided to the community through the school-based mental health program, the additional money will allow for the program to put a concentration on providing services directly to the migrant/undocumented community. The selection process will follow the same process described in No. 2. and the same services will be provided which include, but are not limited to, prevention, education and intervention/treatment for both mental health and substance use.

4. What is the step-by-step process? how will this happen?

   I need more clarification as to what this question is asking.

5. Who will follow up after the children/adults have had a few sessions with a therapist?

   When an assessment is provided, it is determined if the client will need short-term (approximately six of less sessions) or long term (approximately 6-12 sessions). Both short and long-term sessions are handled at each site. At all times, the sessions are under a therapist's care and direction. When sessions are completed, as part of the client's discharge plan, RCLC provides information and resources for additional support in the future. Therefore, no one is left without the ability to reconnect with RCLC should they have a need in the future. Should the family need to have later afternoon or early evening sessions or sessions on Saturday, they will be referred to RCLC's main Center where they will be scheduled with a therapist that can accommodate those hours.

   Are they transferred to long term therapy if assessed as such?

   RCLC therapists provide both short and long-term care under the same therapist. To transfer care has the potential to be more harmful than beneficial so we provide services that meet the need of the client.

   Will Latino Commission be the provider for transfer to long term therapy?

   RCLC will provide long-term care if that is warranted. That will be determined in the assessment process and how the client responds to treatment.

   Will you bill, for example, MediCal, for long term therapy?

   We will not bill any other provider for services. The success of the program, is in large part, because we do not depend on funding from third-party insurance. If RCLC was to bill, a large percentage of individuals would not qualify or would not consent to treatment for fear of the implications it could have on them such as how it would impact their immigration status, etc.

6. Provide a flow chart that reflects the process starting from referrals to Latino Commission then the next steps. Could the whole process be included in your timeline that runs from August 1, 2020, to April 30, 2020?

   Due to the fact that funding will only be for about 7 months (I believe funding ceases in March and not April, 2020) the money would be best used to expand services already being provided, therefore, when the funding stops, services can continue up through June, 2020 and ongoing. Flow chart attached separately.

7. If the classes are now going to be distance learning, how will you reach the target population?

   As part of CVUSD's distance learning plan, the school district will be providing all households with electronic devices (one electronic device per child enrolled in school) and the ability to connect remotely either through Verizon Hot Spots, routers that are place strategically throughout the community, or a household will already have internet connection. This will increase the ability for RCLC to also remotely connect with children and families. Currently, during the summer, we have used any means possible that the family has (telephone, Zoom, FaceTime, etc.) however, now that households will be given the means to increase connectivity, RCLC will be able to use what CVUSD provides.

   Also, RCLC will be able to continue to provide prevention classes by remotely joining children in their classrooms to bring social emotional learning approaches. The social/emotional prevention classes we will be delivering electronically and will look similar to how the children will be receiving academic instruction. In other words, we will be able to utilize all the same things we could as if we were in a classroom presenting such as power points, white board, etc. We would simply be moving from a standard traditional platform of face-to-face, to a virtual platform of delivering services through the screen.

   The number of individuals who will not be able to connect will be greatly reduced, and for those individuals wherein they cannot connect, despite the options provided, we will use telephone, and if they can arrange transportation, be seen at our Center for person-to-person sessions.

8. If there are going to be different providers, what are those reimbursement rates going to be?

   The therapists and substance use counselors that will be providing services will be those already working within the school-based mental health program. Again, funds will be used to enhance the program. Therefore, any and all money received will be used to bill for direct client services. We will charge the same rate that the school district pays and that is $55/hr. Clients will be identified as either receiving services under the contract with CVUSD and CVUSD will be billed for those services, or receiving services under the RAP grant, and those will be billed to RAP. Because billing will be by the hour, RCLC will be able to allocate the hours to the funding that will support the work being done. When there is no longer funding from RAP, the work will be able to continue under the contract with the school district. By receiving money from RAP that is designated to be providing services for migrant/undocumented population, RCLC will be able to allocate funds directly to the population identified through already working with services within the school district such as the migrant department within CVUSD.

Will each client be assigned to a specific therapist for building trust and consistency or will therapist change?

Each client will be assigned to a specific therapist. The only time a client might be reassigned after the assessment phase is to connect a client to a therapist who may have a more specialized skill set that meets the client's need. For example, someone who may need more attention to address trauma, sexual assault, or abuse will be assigned to one of our therapists who are trauma trained. Should a child with ADHD benefit from services from one of our therapists who also has a behavioral background the child would be referred to a therapist with a behavioral background so that treatment incorporates behavioral approaches.

9. Who will be collecting data and reporting back?

   Data is collected by each therapist on the Data Port and then reports are ran monthly (please see Attachment A on the Application previously submitted.) The monthly reports can provide information for each of the column headings on the Data Port. For example, a report can be ran to determine how many females between 5 and 12 years old are being seen for depression. How many have engaged in self-harming behavior? What are the outcome of services?... and more. Should there be additional data that needs to be collected that RAP finds important to capture, we can add that to the Data Port for therapists to collect.

10. Please define the CVUSD role for this proposal in detail?

    RCLC can make available, the RFP for the services provided through CVUSD. It is a 70 page document and has been posted for public review. The RFP provides a detailed outline of the services provided under the contract. However, the RFP is quite large and would take some time to review. It is my hope that answering these questions within this responsive email will provide enough details for the Reviewers to feel like they understand the role CVUSD plays in the proposal. However, should the Reviewers want a copy of the RFP, I can forward a copy electronically.

    In an effort to try to answer the question without confusing anyone, CVUSD's role would be more simply stated in that the money received from RAP will be designated to service children and families who identify as migrant and/or undocumented. Children and families throughout the community are already accessing services through CVUSD; however, there has not been an opportunity to provide direct funding that focuses efforts on the migrant/undocumented communities. Although services for the migrant/undocumented community are already provided within CVUSD, the money received from RAP will afford RCLC the opportunity to set aside resources that specifically address needs in the migrant/undocumented community. RCLC can work with programs already in CVUSD to identify the target population. That is one of the

reasons why RCLC feels it is best to use this money to enhance the work that is already being done with the school-based mental health project.

Secondly, by using the services provided in the school-based mental health program, those receiving services are more open to the services because of the stigma that tends to be attached to mental health. Providing services from campus helps to remove the stigma of shame, concern, and feelings that they are 'crazy/loco.' We have noticed that people are more willing to connect with the therapist at the school versus going to a clinic. CVUSD has established itself as an entity that supports and welcomes the community and therefore providing services through the mental health program already on campus helps RCLC to utilize CVUSD's precious relationship within the community to usher in services to a part of the community that would otherwise be reluctant. Additionally, providing services through the schools allows for there to be 21 sites that people can access versus just one at our main Center. One of the issues many people face in the migrant/undocumented population is not having reliable transportation nor the time it requires to travel the distance to the clinic.

Lastly, by utilizing the program that is already established within the community, the funding from RAP can be put to use to bill for direct client services. There will not be a need to set aside funding for administrative costs, costs to operate, cost for materials, advertising, etc. These costs are already being covered and work is already in progress and therefore, money from RAP will be able to be designated specifically to direct services. And when funding ceases, the work can continue.

11. If awarded less than the amount will you still be able to provide services?

    If awarded less than the amount, we will be able to provide services. As stated in No. 10, the program within CVUSD already services the migrant/undocumented population. RCLC welcomes this additional funding because we would like to put a more concentrated effort within the identified population. Also, tracking data specific to the identified population will only help RCLC progress and enrich the program more. Therefore, we see whatever amount of funding as an opportunity to grow and reach more individuals.

12. Is there a more up-to-date measurement tool that can be used? Reviewers were questioning a tool mentioned that they indicate in not currently used. Here are some other tools: https://www.actforyouth.net/resources/pd/trauma-assess-tools.pdf

    This question is more difficult to answer in that it has been our experience that utilizing tools that are standardized and evidenced-based, they tend to not be culturally sensitive to this population. When working with children, RCLC finds that the way a tool needs to be administered (such as the language used on the tool or concept within the tool) does not relate to our population. Secondly, we have also found that to use a tool, it is subjective because it is self-report, and we have noticed that the community we work

with under reports. Therefore, the information that the tool is intended to extrapolate is not sufficient enough. It takes time to build rapport and trust, and so, we find that our assessment process is ongoing and wrapped into treatment. We have to revisit, over the course of treatment, those areas that a tool would initially measure. It is not that RCLC is opposed to them, we have found that it just limits our scope of work. Second to that, our youth work is prevention-based, and it is difficult to find measurement tools that are both culturally sensitive and examine type of prevention that needs to be addressed. RCLC's experience has shown that the work on the eastern-end of the Coachella Valley has to be a holistic, grassroots, and relational approach. Utilizing standard instruments of measurements tend to move the approach into a more clinical, sterile, and less personalized approach that can turn the community away. In general, we have found that our assessment process needs to be broader so that we can take a whole health approach. Should the Reviewers want to see a copy of our Assessment/Screening tool as well as our treatment plan and discharge, I have attached a copy. We have created our screening/assessment, treatment plan and discharge plan into one document with four parts. We have done this, in part, because assessing and gathering of information happens throughout the duration of therapy. However, should there be a need to utilize a standard tool, RCLC is open to discussing tools that meet the requirements of RAP and the Reviewers.

13. If a family gets a tablet but have no internet access, how will you meet with them?

    RCLC therapists can meet with children and families over the phone (this is what has been more commonly used this Summer.) For those who have reliable transportation, and local and county ordinances permit, we can also meet with them in person, maintaining CDC's guidelines either at the school or at our clinic.

14. Is all of the work going to be done by a licensed Clinician or will you also have an ASW? How many ASW per licensed supervisor and for how many hours will they be supervised for the number of ASW practicum hours?

    We have three types of clinicians working within the schools. Some are licensed and some are registered associates. All positions meet the requirements of the California BBS. Those positions are: (1) clinical social workers; (2) marriage and family therapists; and (3) professional clinical counselors. Each of these disciplines are recognized by the BBS and are able to provide therapy under their license. Those who are registered associates receive supervision, per the guidelines of the BBS, by either a licensed clinical social worker or licensed marriage and family therapist. RCLC's supervisors meet the supervisor requirements.

    The ratio for supervision is as follows: The first 10 hours of clinical services provided, 1 hour of supervision must be received. For the remaining 11-40 hours of clinical hours, a second hour of supervision must be provided.

An hour of supervision is defined as either: One hour of individual or triadic (supervisor and one supervisee or triadic is supervisor and 2 supervisees) or 2 hours of group supervision equals one supervisory hour.

15. There was frequent mention in the application about substance abuse, however, how does Latino Commission plan to address other areas that children for example have/are experienced/ing such as child abuse, self-harm, suicidal ideation/attempts, domestic violence, anxiety, depression, trauma from detained or deported parents?

    These issues and others are addressed under the mental health counseling a child or family member receives. The majority of the examples that are provided above are what mental health would look at as stressors or factors that are contributing to the person's need for mental health support. They are not exclusive but are considered as part of the treatment plan. For example, a child may be treated for anxiety that stems from witnessing domestic violence. The DV is a stressor but treatment would address the anxiety. One is not exclusive from the other. They were not directly mentioned in the Application because it falls under the larger umbrella of the scope of mental health counseling.

    I also want to comment on one thing that the Application does address and that is the training therapists receive. We provide annual trainings on mandates of child, elderly and dependent adult abuse, trafficking, LQBTQ community, and trauma. In addition to these yearly trainings, RCLC also provides monthly trainings that address topics specific to our community. Therefore, some trainings may have guest speakers that talk about the programs and supports offered to community members, child and adolescent programs, support groups through churches, other nonprofit organizations and AA groups. RCLC attempts to bring and expose all agency personnel to trainings and informational meetings so that they can provide a comprehensive treatment approach that addresses areas such as trauma, abuse, societal stigma as well as social and emotional stressors (and other topics) that contribute to a mental health diagnosis.

    In summary, it is my hope that answering these questions brings some clarity and understanding to the questions the Reviewers have. When RCLC was presented with this opportunity, there are many factors that we have had to consider on how best to use the funds. Never before have we faced a pandemic like we are currently facing. We know that the COVID-19 crisis is negatively impacting people's mental well-being. We also know that when the pandemic subsides, and the infection rates go down, and people return to the new normal, there will be some who struggle to navigate the changes. The residual effects will be felt long after the pandemic has passed, and it will be then, and not just now, that mental health and substance use recovery will be needed. Therefore, the services will not stop but will continue. And through the money RCLC will receive from RAP, if awarded, it affords RCLC the opportunity to focus on the undocumented/migrant community to not only provide needed services, but to gain a better understanding of what exactly are the needs (which we hope to understand from

the data tracked through the Data Port) and what is preventing the community from accessing the help and support. Thus, RCLC sees that this is only the beginning of a great opportunity.