



Training & Continuing Education Bulletin

Orange County Health Care Agency Behavioral Health Services

April 2008

Upcoming Trainings

May

LGBT

MHSA Training Website

BHS Training Website:
<http://www.ochealthinfo.com/Behavioral/TrainingActivities>

To register for all trainings
 please email to
mtrainingprogram@ochca.com

If you have any questions
or concerns, please call
(714) 667-5600.

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Greeting From New Staff Members

Margo Moton, Office Assistant

My name is Margo Moton and I am a new Office Assistant for the MHSA Training Program. Previously, I was a Store Manager at Footlocker. I am currently attending Ashford University to obtain a B.A. in Health Management Administration. I have worked in the medical field for five years as a ward clerk and Certified Nurse's Assistant, and would like to pursue a career in the medical field.

Minh-Ha Pham, Research Analyst III

Minh-Ha Pham, Psy.D. recently joined our Behavioral Health Services-MHSA Training Program from Cultural Competency and Multi-Ethnic Services of the Orange County Health Care Agency. Dr. Pham also teaches at the University of California, Irvine, School of Medicine, Department of Psychiatry and serves on the Curriculum Advisory Board of the Doctorate and Master programs in Counseling Psychology at Argosy University, Santa Ana. She is also a part-time counselor at the Family Counseling Program at the Rancho Capistrano Campus of Crystal Cathedral.

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). Provider approved by the California Board of Registered Nursing, Provider No. CEP 15019 for 3 contacts hours, 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.



Non-Violent Crisis Intervention

Presenter: Michael Parra, Ph.D.

Date and Time: April 17, 2008 9:00 a.m. - 4:00p.m.

Location: 600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701

Limited to 12 attendees, please dress casually, as you will be doing physical exercises.

Children and Youth Services is re-instituting **mandatory** Non-Violent Crisis Intervention Training. This training is **only mandatory for HCA CYS** clinical and support staff who work in County CYS clinical programs and who have not taken this training within the last 12 months. The training does not apply to other staff, such as contract agency staff or central administrative staff at this time.

Trainings will occur over the next year. The Training teaches you how to de-fuse potentially violent confrontations, how to de-escalate confrontations, and methods of handling physical confrontations, if necessary.

6 Continuing Education Credits are available for LCSWs and MFTs.

Basic Cultural Competency: Lesbian, Gay, Bisexual, Transgender

Presenter: Christine Browning, Ph.D.

Date and Time: April 9, 16, 23, & 30, 2008 1:00 p.m. - 4:00 p.m.

Location: 405 W. 5th Street Suite 433A, Santa Ana, CA 92701

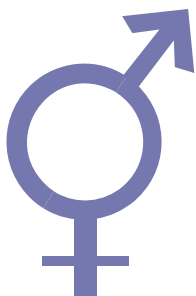
This MHSA Plan Approved training entitled Basic Cultural Competency: Lesbian, Gay, Bisexual, Transgender is targeted toward direct providers and supervisors of a clinical nature in Behavioral Health Services (BHS), including contract agencies and new CCS/FSP contractors. This curriculum was developed especially for direct providers and clinical supervisors in the community mental health field and is intended to assist in understanding of the culture. This is a 3-hour training.

Objectives:

1. Provide knowledge about the lives of LGBT in order to create a safe environment for LGBT clients, their families, and OCHCA employees
2. Learn basic information about LGBT people and societal influences
3. Learn to become an ally to the LGBT community

This is a reminder that the above training is **mandatory** for all staff, both county and contract agency. If you have already taken this training please disregard.

3 continuing education credits are available for Psychologists, LCSWs, MFTs, and RNs.



**BHS MHSA
Training Team**

Casey Dorman, Ph. D.
Training Coordinator

Joshua Taylor, Psy. D.
Assistant Training
Coordinator

Zanetta Moloi
Program Supervisor

Richard Krzyzanowski
Consumer Employee
Advocate

Minh-Ha Pham
Research Analyst III

Dung Le
Mental Health Worker III

Joaquin Granado
Mental Health Specialist

Guadalupe Montoya
Office Assistant

Margo Moton
Office Assistant

Hiromi Williams
Information Processing
Specialist

Contact MHSAs Training Staff
Main Line: (714) 667-5600
Fax: (714) 667-5612
mtrainingprogram@ochca.com

The Adult LGBT Client and Their Specific Issues (ages 18 to 50) Gender and Orientation Issues

Presenter: Nikki Yocham

Date and Time: April 11, 2008 9:00 a.m. – 12:00 p.m. or 1:00 p.m. – 4:00 p.m.
April 18, 2008 9:00 a.m. – 12:00 p.m. or 1:00 p.m. – 4:00 p.m.
April 21, 2008 9:00 a.m. – 12:00 p.m. or 1:00 p.m. – 4:00 p.m.

Location: 405 W. 5th Street Suite 433A, Santa Ana, CA 92701

- Gender and orientation issues
- A sign of the times 1958-2008 and the issues that impacted the LGBT development and generational differences
- HIV and AIDS the impact on each orientation yesterday and today
- The transgender individual's experience-comes out
- Political and Legal impact of LGBT awareness and self expression
- The sexual revolution the different changes that have been experienced by the LGBT Community
- Changes in the family tree-acceptance and rejection

3 continuing education credits are available for Psychologists, LCSWs, MFTs, and RNs.



Involuntary Hospitalization (5585)

Presenter: Manny Robles, LCSW, Diane McDowell, Ph.D., OC HCA

Date and Time: April 22, 2008 9:00 a.m. – 12:00 p.m.

Location: 744 N. Eckhoff (Auditorium), Orange, CA 92868

This is a mandatory workshop for all county staff who have recently become certified to hospitalize patients without their consent or who will become certified in the next 3 months. The workshop will cover 5585 laws, the latest CYS policies, and clinical procedures for determining that a client is dangerous to themselves or to others.

Course objectives:

1. To be able to describe the clinical situations in which a person should be hospitalized against his or her will
2. To be able to describe the laws relating to involuntary hospitalization
3. To be able to identify the forms and procedures for carrying out an involuntary hospitalization

3 continuing education credits are available for Psychologists, LCSWs, MFTs, and RNs.



QRTIPS

This section provides monthly critical reminders in relation to CYS documentation standards.

1. Targeted Case Management means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development.

In other words, Case Management Notes generally reflect:

- Planning
- Linking
- And coordinating services with others
- On behalf of the child/youth
- Best practice recommends...progress notes that reflect what was discussed, what is the plan and what "next step actions" specific are needed to assist the client in linking to an activity or a service that will benefit the child/youth
- The service must be tied to the mental health condition.

As per direction from Julie Agojo (on 3/20/08), from DMH MediCal Oversight, calling to report a child abuse incident is a billable service to MediCal. Writing the report that follows the call is a non-billable service to MediCal. The writing of the report is considered an administrative function.



CONSUMED!

By Richard Krzyzanowski, Consumer Employee Advocate

On Diversity

On a couple of occasions, I have had the honor of being a panelist for an excellent training on Client Culture offered through our Department of Cultural Competency and Multi-Ethnic Services.

I spoke about my journey as a consumer who eventually became a mental health professional, which is the theme I am most often asked to explore in my various presentations. This venue had a twist, however: Since this event was sponsored by Cultural Competency, the trainer asked me to frame my story in the context of my Polish cultural background and, more specifically, my parents' difficult experiences as survivors of the wars, revolutions and concentration camps by which their world self-destructed in the last century, followed by their equally heartbreaking journey to these American shores as refugees from that chaos that was once home.

I found this a demanding, even painful exercise, but feel that the experience helped me to grow in my self-understanding and appreciation of the cultural factors which make me the person I am, including both the influences of the "old world" in whose shadow I live, but also my identity as the first "American" in my family.

I admit that I'm a rather odd American, and I'm not sure I'm very good at it! Growing up, I was a Polish-speaking, blue-eyed child living in a predominantly Spanish-speaking neighborhood with a proud history predating the American conquest by generations. Sprinkled in amongst my neighbors were many Italian-Americans as well, along with a diverse constellation of people with many differing backgrounds and experiences.

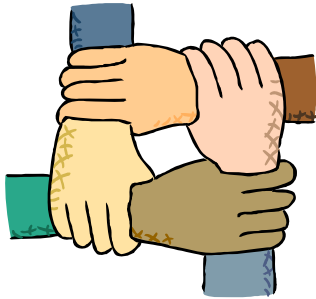
English-speaking Anglo-Americans were in rather short supply, and were a rarity more easily glimpsed on my television screen, in the form of *Leave It To Beaver* or *Ozzie & Harriett*, than encountered in daily life.

This was the America to which I was assimilated, and of which I very much felt a part. And it still is a part of me, as is reflected in the sad fact that my first language, Polish, has atrophied in comparison to my abilities in English, my second tongue, and Spanish, my third.

Perhaps due to these factors, discussions of diversity often touch me on a deeply personal level, and I have been accused of being hyper-sensitive to issues related to this theme. Maybe so, but I'd also like to think that such awareness has enhanced my capacity for understanding and respecting what both unites and divides me from my fellow human beings.

Typically, when we speak of "diversity" in our culture, we refer to matters of ethnicity, language and national background, important distinctions, to be sure: Yet – I think – we paint that canvas with broad brushstrokes and use vast generalizations that often risk missing the subtler, more intimate levels on which diversity also operates.

"We must be mature enough, strong enough to "agree to disagree," and learn and grow through the dialog that follows."



I think of this as I reflect on the concept of Client Culture, as in the theme of the training I mentioned above. I am ambivalent about this idea. I appreciate its usefulness in creating an identity through which we client/consumer/survivors can teach others about what is unique about us, and in fostering a sense of solidarity within our own consumer community.

Yet, I am apprehensive about the way in which some consumers use such ideas, as if there was some monolithic consumer identity, a mold into which we all must fit. I sometimes hear fellow consumers pontificate with grand statements about who “we” are and what “we” believe in, and it truthfully sends a shiver down my spine.

Yes, there certainly are vast areas of common experience, and we also often share common goals. The ongoing fight to eliminate stigma through education is one example that comes to mind. But we must not confuse the tactical necessity to speak with one voice, when engaged in advocacy, for instance, with an impulse to somehow constrict the wide array of feelings, insights and opinions, derived from an experience as intensely personal as one’s own mental illness, into some narrow, “politically correct” channel.

If we really are proud about having rediscovered our voices as individuals and members of society; if we truly appreciate the accomplishment of having built, against heavy odds, a sense of community and of having a “movement,” then I feel we consumers need to acknowledge that, like any other community, we embrace a diversity of voices and opinions.

We must be mature enough, strong enough to “agree to disagree,” and learn and grow through the dialog that follows. It can only result in a greater array of tools and skills at our command as consumers sit down with others and tackle the task of improving our mental health system and building a healthier community for everyone.

Richard Krzyzanowski is the Consumer Employee Advocate for HCA’s Behavioral Health Services. He can be reached at (714) 796-0138, or at krzyzanowski@ochca.com. He welcomes your comments and suggestions, and is available to assist all consumer employees, their coworkers and supervisors.

Your Culture and Mine

Clinical Evidence-Based Practice

Minh-Ha Pham, Psy.D., BHS-MHSA Training Department



Effective clinical practice often derives from a sound decision making process, working knowledge and relationship with clients, accumulative wisdom and experience, and at times via good consultation with an interdisciplinary team or other skilled professionals. According to Maudsley (2000), clinical decision making is the end point of a process that includes clinical reasoning, problem solving, as well as an accurate awareness of our client's health care, individual needs, ecosystem and cultural context. Evidence-Based Practice requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the explicit knowledge of care providers within the context of available resources. In addition, this best practice model requires a health care infrastructure committed to culturally sensitive delivery, capable of overcoming language barriers and providing full and rapid access to electronic databases at the point of care delivery. Evidence-Based practitioners will need critical appraisal skills as professionals to supplement traditional training designed to meet basic state and board requirements that ensure public safety standards. With best practice approach, professional care providers will need to have the ability to gain, assess, apply and integrate new knowledge and the necessary skills to adapt to uncertainties and changing circumstances throughout their professional lives. Observational studies (Shin, Haynes, & Johnston, 1993) suggest that an effective way to produce quality clinicians of tomorrow is to train interns the five-step model of the Evidence-Based Practice as the basis for both training and clinical approaches. These steps were first described in 1992 by Cook, Jaeschke, and Guyatt to include: (1) translating uncertainty to an answerable question, (2) systematic retrieval of best evidence available, (3) critical appraisal of evidence for validity, clinical relevance, and applicability, (4) application of results in practice, and (5) evaluation of performance outcome. With the ability to critically appraise outcome data, clinicians will be able to distinguish evidence from theoretical assumptions, certainty from probability, data from assertions, measurable science from trials and errors. However, the very critical components to this Evidence-Based model and practice will be the trials of training effectiveness and clinical applications in the multi-ethnic and cultural context.

References:

- Cook, D.J., Jaeschke, R., & Guyatt, G.H. (1992). Critical appraisal of therapeutic interventions in the intensive care unit: Human monoclonal antibody treatment in sepsis. *Journal of Intensive Care Medicine*, 7, 275-282.
- Maudsley, G. S. (2000). Science, critical thinking and competence for tomorrow's doctors: A review of terms and concepts. *Journal of Medical Education*, 34, 53-60.
- Shin, J.H., Haynes, B., Johnston, M. (1993). Effect of problem-based, self directed undergraduate education on life-long learning. *CMAJ*, 141, 969-976.