MPAC

MANAGEMENT PLANNING & ADMINISTRATION CONSULTANTS, INC.

# CENTRAL OAHU COMMUNITY MENTAL HEALTH CENTER PLAN

prepared by: Ross Prizzia, Ph.D.
Program Planner
Stanley Rosenthal
Community Planner
George Warfel
Grant Writer/Social Planner
Odette Villanueva-King
Evaluation Specialist
Brian Nakamura
Program Planner II/Community Organizer

with
the staff of consultants and
clerical assistance of
Management Planning & Administration
Consultants, Inc.

October, 1977

# INTRODUCTION TO THE 1978 CENTER PLAN

The 1973 Center plan has been developed from a year-long study of the catchment area; its geography, people, institutions and social problems as well as its mental health needs; and of the Center itself. This study, conducted by MPAC, Inc., under the direction of the Center Chief and the Center Advisory Board, has included a 239 item survey of a sample of over 1,100 residents of the catchment area followed by 6 months of intensive meetings of residents, members of social service, business and other organizations, private providers of service, staff of state agencies and the staff of the Center. The complete planning process is described in Section H of this Plan and further in "Central Oahu Community Mental Health Needs Assessment Survey Part III: A survey of the General Population" and pages 30 through 53 of the "Application for An Initial Operations Grant" submitted by the Center to the National Institute of Mental Health.

The 1978 plan has been based on the comments made by the State Advisory Council on Mental Health and others on the 1977 plan.

The standard format of the state planning system has been retained. This allows for easy comparison of the 1978 Plan to the 1977 and previous plans as well as to the plans of other Centers. The format has been basically to describe first the catchment area, Section A, then the present services of the Center, Section B. These sections are followed by: Section C - Sources of Financing, Section D - Planning and Development of Services In Conjunction with Other Government Supported Programs, both of which have been expanded; comments on the new facilities; Section E; and Section F - Manpower Needs. This latter section describes the positions being requested in the federal grant application. Section G - Program Plans, has been completely re-written. A number of new programs, 14 in all, are described in detail. For each a statement of need, goals and objectives, staffing, budget and evaluation plans are given.

Section H - Community Input, has been expanded to include a discussion of the issue of Center governance which has come to the forefront in the year's planning effort.

This plan, more comprehensive and at a much greater level of detail than previous Center plans, is intended to be used as the programming and operations plan for the Center over the coming year. Through the evaluation and management information systems that have been developed and which will be staffed by new positions requested in the grant application, a relatively real-time, decision research model will be installed in the Center's planning and operations activities. The intent of the plan is to provide the Center staff, the community at large, and the Center Governing Board with accurate useful information on the operations of the Center (especially the development of the 14 new services) to enable them to take action as needed.

This approach to planning will be given a thorough pilot test in the Center's coming year's operations. It is expected that it will demonstrate improved levels of client satisfaction, community support, staff interest and satisfaction, and cost effectiveness.

# REVIEW OF THE CATCHMENT AREA - CENTRAL OAHU

Central Oahu has an area of 237 square miles within which resides a population, as of 1976, of 162,923*. Current administrative boundaries of the Center generally eliminate most geographic barriers to the receipt of ambulatory mental health services. The four clinics in Central Oahu are geographically distributed so as to assure maximum physical accessibility by the populace. Every resident is within ten miles, or less than half an hour drive, from a clinic. Most residents live within two miles of a clinic as the result of the establishment of the clinics in each of the four major Central Oahu communities - Aiea, Pearl City, Wahiawa and Waialua-Haleiwa.

The current and projected population growth in the area presents a problem for the future allocation of resources and manpower. A specific concern, at the present time, is the large Mililani Town development. This community is about four miles from the Wahiawa Counseling Service, which is the mental health clinic serving the area. The possible need for another clinic, or satellite facility, to provide services to the growing Mililani population is under active study. Beyond this immediate problem, the dynamics of population growth and distribution as it relates to the allocation of facilities and services requires constant evaluation.

The delivery of comprehensive health and social services requires the cooperation and coordination of a number of provider agencies. Currently, however, there is little conformance among agencies in establishing administrative and/or service boundaries. For example, the Department of Education, Department of Social Services and Housing, Public Health Nursing, Comprehensive Health Planning, Honolulu Police Department, Congressional and other political subdivisions, and the Central Oahu Community Mental Health Center have established geographic service areas which do not totally conform to one another.

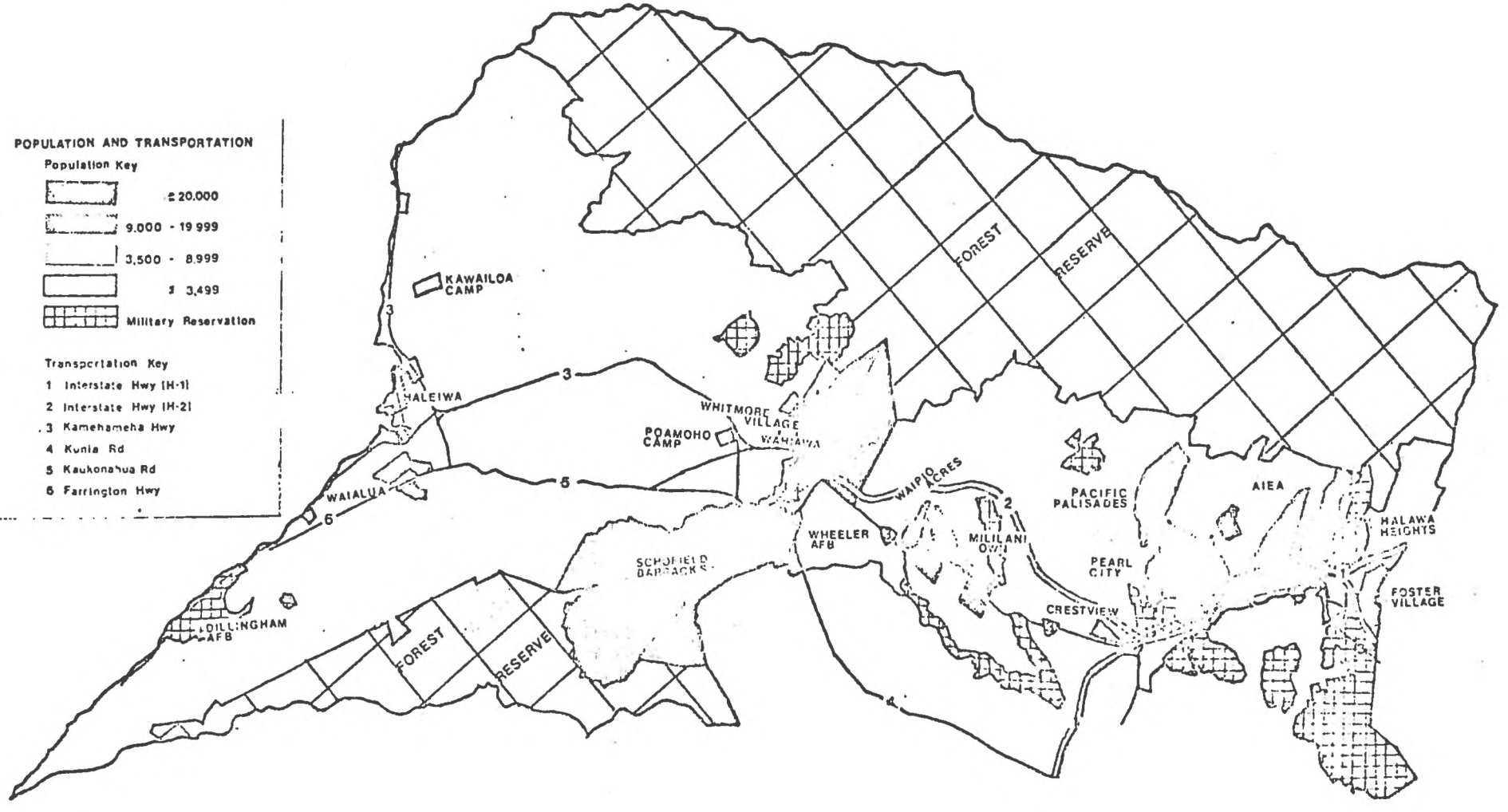
The overall configuration of the Central Oahu catchment area provides a good fit to physical characteristics, residential patterns, economic and social groupings, and available transportation. Kamehameha Highway provides a corridor of inexpensive bus transportation the length of the catchment area. All clinics are located on, or near, the bus line.

## A. Description - Catchment Area

### Geography and Topography

The Central Oahu catchment area consists of the plain joining Oahu's two mountain ranges, the Waianaes and the Koolaus. The area is bounded on the northwest by Oahu's Pacific north shore from the Kaena Point to the Kawailoa Beach side of Waimea Bay. On the northeast, the catchment area is separated from the Windward Community Mental Health Center Branch catchment area by the crest of the Koolau Mountain Range from Waimea Bay to the Honolulu Judicial District boundary. The Honolulu-Ewa

*linear projection from 1970 census and 1974 update


POPULATION AND TRANSPORTATION
Population Key
± 20,000
9,000 - 19,999
3,500 - 8,999
≤ 3,499
Military Reservation
Transportation Key
1 Interstate Hwy (H-1)
2 Interstate Hwy (H-2)
3 Kamehameha Hwy
4 Kunia Rd
5 Kaukonahua Rd
6 Farrington Hwy
KAWAILOA CAMP
HALEIWA
WHITMORE VILLAGE
WAHIAWA
POAMOHO CAMP
WAIALUA
WAIPIO ACRES
PACIFIC PALISADES
AIEA
HALAWA HEIGHTS
WHEELER AFB
MILILANI
PEARL CITY
FOSTER VILLAGE
CRESTVIEW
SCHOFIELD BARRACKS
DILLINGHAM AFB
FOREST RESERVE
FOREST RESERVE

Judicial District boundary to the southeast delineates the Central Oahu catchment area from the Kalihi-Palama Community Mental Health Center Branch catchment area. To the southwest, Central Oahu shares the boundary of the Leeward Community Mental Health Center Branch. This boundary begins at Kaena Point, then cuts north at the Wahiawa-Ewa Judicial District boundary to Kunia Road. It then runs along Kunia Road to the town of Waipahu which is excluded from the catchment area. This leg of the perimeter then runs down the middle loch of Pearl Harbor out the harbor entrance and along the Hickam Air Force Base coast to the Honolulu-Ewa Judicial District boundary.

Major Communities

The major residential areas in Central Oahu are the older community of Aiea with nearby Halawa and Foster Village; a newly developed condominium, townhouse, and single family region between Aiea and Pearl City; the older Pearl City region with adjacent Waimalu and Pacific Palisades; the large Mililani development located between Pearl City and Wahiawa; the older Wahiawa community; and the Waialua-Haleiwa community. Military residences are located at Hickam Air Force Base, Camp Smith, Pearl Harbor, Schofield Barracks and Wheeler Air Force Base.

Residents of Central Oahu have access to numerous retail outlets and small businesses. A large older shopping center and some small businesses are located in Aiea. A major shopping center, the second largest on Oahu, has opened between Aiea and Pearl City at Pearlridge. Another new shopping center of smaller scale is located in Waimalu. Pearl City contains a few old shops and a fair sized shopping center. Wahiawa contains an older business district as well as some newer stores. A small area of shops serves Waialua, and Haleiwa has a mixture of quaint shops and a small new shopping center.

Central Oahu industries include a rock quarry, sugar mill and brewery near Aiea; the Hawaiian Electric Company in Pearl City; pineapple packing in Wahiawa; and a sugar mill, rock quarry, poi factory and fishing in the Waialua-Haleiwa area. Tourism is not a major industry to the area.

There are various types of agricultural endeavors including watercress farms interspersed among highways, shopping centers, and residential areas surrounding the east loch of Pearl Harbor; pineapple fields replaced to a great extent by the Mililani development but still a major agricultural crop in the Wahiawa area; sugar cane grown to some extent near Pearl City with the major cane fields found in Waialua-Haleiwa; and taro and lotus farms in Waialua.

Low Income and Immigrant Groups

Lack of knowledge about available resources and the inability to purchase health and social services are problems associated with low income and recent immigrant groups. In the Central Oahu catchment area, these two groups tend to be more concentrated in the Wahiawa and Waialua-Haleiwa districts.

A study by the Hawaii Department of Industrial and Labor Relations in 1974 found that the Waialua-Haleiwa district (CT 99 and 100) had the highest rate of unemployment on Oahu (15%); and Wahiawa (CT 90 to 95) had the third highest unemployment rate (11%).

Immigrants also tend to settle in these two geographic areas. The Personnel Administrator of the Waialua Sugar Company estimated that about one thousand Filipinos who have immigrated to Hawaii in the last ten years live in company housing. Filipino immigrants also may be found in other plantation settlements such as Poamoho near Wahiawa.

In Aiea and Pearl City, there are "pockets" of immigrant and low income groups. In 1970, census tract 75.03, Halawa Housing, reported that 26% of its families were below the poverty level. Statistics from a study conducted in 1973 by the Hawaii Department of Social Services and Housing indicated that 19% of the social assistance recipients in census tract 75 were Samoan, a recent immigrant group. Other low income and immigrant groups, primarily Samoan, are found in old Pearl City and near Leeward Community College.

## Military Bases

Military bases in the catchment area include Hickam Air Force Base, adjacent to the Honolulu International Airport; Wheeler Air Force Base, located next to the Army's Schofield Barracks; Camp Smith, a Marine base, located above Aiea; and the Pearl Harbor Navy Base. In 1970, 41,643 residents of the catchment area lived in military housing.

## Transportation

Public transportation is provided by Mass Transit Lines (MTL, Inc.) bus system. This system runs the length of the catchment area. Inadequate feeder lines to the main routes may present a barrier to potential users of the mental health services who rely on this mode of transportation. An extensive freeway, highway and surface street system provides easy access by automobile to services in the area. A new bicycle path lines the east loch of Pearl Harbor from the Naval Base past Aiea to Pearl City.

## Population

### 1. Total Population

Based on the 1970 census of the population, the Central Oahu catchment area consisted of 131,250 resident civilian and military personnel and their dependents. A 1974 estimate by the Hawaii Census Tract Committee placed the population at 152,365, a sixteen percent increase.

Table 1

Change In Population - Central Oahu

| Year | Population |
|---|---|
| 1970 | 131,250 |
| 1974 | 152,365 |
| 1976 | 162,923* |
| 1980 | 184,038* |

*Projection based on conservative assumption of linear increase in population of 5,279 per year.

Implications: The rapid, and as yet undefined, growth in the area, looms as a major force on individuals and communities in the area. Specifically, the traditional rural life-style is under increasing pressure, which may lead to greater individual and societal dysfunction. Concomitantly, this growth has implications for the allocation of manpower, services and facilities.

2. Selected Characteristics

a. Age/Sex: The distribution of age and sex of Central Oahu residents is unusual because of the large military population included in the area. For example, according to the 1970 census, seventy-four percent of Central Oahu residents between the ages of 18 and 24 years old are male. The overall distribution of the population by age and sex is presented in Table 2.

Table 2

Age/Sex Distribution of Population - Central Oahu

| Age Groups | Males | % of Ctr's Male Pop. | Females | % of Ctr's Female Pop. | Total | % of Total Ctr's Pop. |
|---|---|---|---|---|---|---|
| Under 5 | 6,455 | 8.7 | 6,138 | 10.8 | 12,593 | 9.6 |
| 5 - 13 | 14,087 | 18.9 | 12,997 | 22.9 | 27,084 | 20.6 |
| 14 - 17 | 5,056 | 6.8 | 4,777 | 8.4 | 9,833 | 7.5 |
| 18 - 54 | 44,705 | 59.91 | 29,198 | 42.2 | 73,903 | 56.3 |
| 55 and over | 4,316 | 5.78 | 3,521 | 6.2 | 7,837 | 6.0 |
| Totals | 74,619 | | 56,631 | | 131,250 | |

Source: 1970 Census of Population

Central Oahu has the second highest proportion of the population under eighteen years compared to the other catchment areas; Leeward Oahu is the highest. Children comprise 38% of the Central Oahu population.

The elderly (65 + years) make up 3.3% of the population. They are found in greater proportions (6% to 8%) in Waialua-Haleiwa, lower Aiea, and a few other tracts; however, all civilian areas have significant numbers of senior citizens.

The MPAC Needs Assessment Survey* found the sex ratio to be 47% male to 53% female for the entire sample. When the military were excluded, the sex ratio became 42% male to 58% female.

The survey also found significant differences in the age composition of females from males in the civilian population. The data shown below indicate that females are predominant in the 18-26, 27-38 and 39-54 year age groups while males are over-represented in the 55 and over age group.

Table 3

| | Age | | | |
|---|---|---|---|---|
| Sex | 18-26 | 27-38 | 39-54 | 55 + |
| Males | 46 | 37 | 39 | 59 |
| Females | 54 | 63 | 65 | 41 |

Age differences were also found among five residential areas. The data shown below indicates that Mililani and Kunio-Waipio have higher percentages of younger residents than Pearl City/Aiea, Wahiawa, and Haleiwa/Waialua.

Table 4

| | Age | | | |
|---|---|---|---|---|
| Income | 18-26 | 27-38 | 39-54 | 55 + |
| Less than $7,500 | 34 | 18 | 16 | 30 |
| $7,500-$15,000 | 27 | 22 | 29 | 18 |
| Over $15,000 | 23 | 30 | 35 | 11 |
| Location | | | | |
| Pearl City/Aiea | 23 | 18 | 37 | 20 |
| Mililani | 34 | 32 | 24 | 9 |
| Wahiawa | 15 | 45 | 25 | 13 |
| Haleiwa/Waialua | 32 | 20 | 28 | 15 |
| Kunia/Waipio | 18 | 54 | 18 | 4 |

Implications

Children's problems
Services for children
Services for women

*MPAC, Inc. conducted a survey of catchment area residents in 1976 as the first phase of this planning effort. The data which follows which are from that survey are accurate within sample tolerances indicated. Further information of the intentional oversampling and subsequent re-weighting of certain ethnic groups and other technical data are available on page 45 of the attached appendix D.

b. Family Status: Tables 5, 6 and 7 summarize some census data on Central Oahu marital and family status.

Table 5

Marital Status - 14 Years and Older

| | Number | % |
|---|---|---|
| Single | 31,294 | 33.3 |
| Married | 58,416 | 62.0 |
| Separated | 522 | .6 |
| Widowed | 2,197 | 2.3 |
| Divorced | 1,656 | 1.8 |

Source: 1970 Census of Population

The MPAC survey included 18 years and older while the 1970 census data included 14 years and older. The differences in the breakdown on marital status between these two sets of data can be largely attributed to the difference in the age range surveyed. This is particularly true in the single, married, and divorced categories. The MPAC data show higher percentages. These data are shown below.

Table 6 - Marital Status

| | Single | Married | Divorced | Separated | Widowed | Common Law |
|---|---|---|---|---|---|---|
| Total Civilian Population | 19.4 | 74.2 | 2.9 | 1 | 2.1 | .5 |
| Age | | | | | | |
| 18-26 years old | 65 | 31 | 1 | 2 | 0 | 1 |
| 27-38 years old | 6 | 89 | 4 | 0 | 0 | 0 |
| 39-54 years old | 3 | 89 | 4 | 1 | 3 | 0 |
| 55 years & over | 4 | 88 | 0 | 0 | 8 | 0 |

The data shown in the table above also indicate that there are significantly more single males (25%) than females (15%) and that there are more married females (78%) than males (69%). They also show that there are slightly more widowed females (3%) than males (1%).

The differences found in marital status breakdown among age groups are in the predicted direction. The incidence of separation seems slightly higher among the 18-26 year age group (2%).

Table 7

Type of Family and Number of Children

| Family Type | Number | Percent | Children | Percent |
|---|---|---|---|---|
| Husband and Wife | 23,769 | 91 | 42,255 | 91 |
| Single Parent | 2,480 | 9 | 4,181 | 9 |

Source: 1970 Census of Population

c. Household Size: The MPAC survey data of the civilian population show that only 4% of the sample live alone. They also indicate significant differences in marital status associated with income and location. These data are shown below.

Table 8

Household Size

| | Live alone | Live with one other | Live with 2-5 others | Live with 6-10 others | Live with 11 and over |
|---|---|---|---|---|---|
| Total Civilian Population | 3.9 | 15.7 | 68.6 | 9.9 | 1.9 |
| Age | | | | | |
| 18-26 | 2 | 12 | 72 | 12 | 3 |
| 27-38 | 2 | 13 | 72 | 11 | 2 |
| 39-54 | 4 | 9 | 72 | 12 | 2 |
| 55 and over | 9 | 33 | 55 | 2 | 1 |
| Income | | | | | |
| Less than $7,500 | 13 | 14 | 56 | 11 | 6 |
| $7,500-$15,000 | 6 | 15 | 65 | 10 | 3 |
| Over $15,000 | 1 | 15 | 73 | 10 | 1 |
| Location | | | | | |
| Pearl City/Aiea | 6 | 17 | 67 | 7 | 2 |
| Mililani | 1 | 8 | 78 | 10 | 2 |
| Wahiawa | 0 | 24 | 69 | 7 | 0 |
| Haleiwa/Waialua | 4 | 14 | 64 | 17 | 1 |
| Kunia/Waipio | 5 | 26 | 42 | 26 | 0 |

Women do not differ from men in household size. However, older age groups tend to have higher percentages of these who live alone (9%) compared to 2-4% among the younger age groups. The live alone statistics of this age group is similar to the national average (4%).

High income households have significantly less living alone than low and middle income households (13% and 6%, respectively). Also, living with 2-5 others is more predominant among the high income (73%) than low and middle income groups (56% and 65%, respectively). Living with 2-5 others is less predominant in Kunia/Waipio (42%) than in other areas (64-78%).

The changing status of the family is a serious mental health concern in Central Oahu. Traditional extended family structures of the Hawaiians and some immigrant groups which formerly were strong factors in community life are disappearing.

d. Military Population: In 1970, the military population, including dependents, totaled 54,343, or 41 percent of the catchment's total population - the highest in the state (Table 9).

Table 9

Military Population - Central Oahu

| | |
|---|---|
| Members of Armed Forces | 27,210 |
| Family Members (dependents) | 27,133 |
| Total | 54,343 |
| % of Total Population | 41.3 |

Source: Population Characteristics of Hawaii by Military Status, 1970, Research and Economic Analysis Division, Department of Planning and Economic Development, State of Hawaii.

Eighteen percent of military men live in all male barracks, and 80-90 percent of these men are Caucasian. Blacks are the largest minority group in the military comprising 16 percent of one Schofield Barracks census tract. 58 percent of Central Oahu men who are in the labor force are employed by the military.

The MPAC Needs Assessment Survey showed that 20% of the Central Oahu residents considered themselves a member of the military community while 75% said they were civilians. The statewide percentage of military in the population as of 1976 is only 14% according to the Department of Planning and Development's 1976 Hawaii State Data Book*.

In response to a probe question meant for those who indicated military membership to signify their military status, 15% indicated that they were Active Military; 5.5% were Military Dependent; 3.3% were Veterans; 3.3% were Military Retirees; and 1.5% were in the Reserves.

Implications: Military personnel, including dependents, have many special problems such as isolation from the mainstream of community life, transient status, and extended separation of sailors from their families. Some of their needs are met through military service organizations; however, military personnel and their dependents are also served by state mental health services.

*The differences in these figures (41.3% - DPED data; 20% - MPAC, Inc. data) stem from the definition of "member of the military community" and from the fact that the MPAC survey was conducted solely in the off-base community.

e. Cultural Variations

Ethnic Groups: The civilian population is demographically distinct from the military. In most areas, the largest ethnic group is Japanese. In some rural census tracts Filipinos are the largest group. In census tract 91, 49% of the population are Filipinos and males outnumber females by nearly two to one. Two other groups with substantial representation are the Hawaiians and Chinese. There are smaller numbers of Korean (up to 5% in some census tracts), Samoan (not reported in census summaries), and other ethnic groups. Significant numbers of Caucasians are found in all census tracts. Many Caucasians living in civilian areas are military families. Blacks are not highly represented in civilian areas.

Table 10

Total Percentage of Ethnic Groups - Central Oahu

| Race | Number | % of Area Population |
|---|---|---|
| Caucasian | 67,047 | 51.1 |
| Black | 3,192 | 2.4 |
| Indian | 279 | 0.2 |
| Japanese | 30,595 | 23.3 |
| Chinese | 4,582 | 3.5 |
| Filipino | 15,628 | 11.9 |
| Hawaiian | 5,926 | 4.5 |
| Korean | 1,582 | 1.2 |
| Other | 2,419 | 1.8 |

Source: Department of Information Systems, City and County of Honolulu.

According to the MPAC survey, the civilian population in Central Oahu is predominantly Japanese (39.2%). The next largest ethnic groups are the Caucasian (25%), Filipinos (14%), and Cosmopolitan-Mixed (10.6%). Significant differences in ethnic breakdown associated with age, income, and location of residence were also found. These data are shown below.

As required by the contract specifications, the MPAC sample intentionally over-sampled Filipinos and Samoans. This was specified and required due to the previous self-exclusion of these groups from random sampling efforts. Using interviewers from these ethnic communities, the MPAC survey achieved usable data on each sub-group. When compiling area-wide statistical pictures, the data from these two subgroups has be re-weighted to match their normal distribution in the population.

Table 11

MPAC Survey Data on Ethnicity

| | Cauc | Jpse | Chnse | Hwn | Fil | Cosm | Other |
|---|---|---|---|---|---|---|---|
| Total Civilian Population | 25.0 | 39.2 | 3.7 | 3.7 | 14.5 | 10.6 | 3.4 |
| Age | | | | | | | |
| 18-26 | 22 | 44 | 3 | 6 | 12 | 2 | 1 |
| 27-38 | 30 | 31 | 3 | 2 | 16 | 15 | 2 |
| 39-54 | 24 | 47 | 4 | 5 | 11 | 6 | 4 |
| 55 and over | 28 | 25 | 3 | 1 | 28 | 8 | 6 |
| Income | | | | | | | |
| Less than $7,500 | 33 | 8 | 4 | 7 | 27 | 17 | 4 |
| $7,500-$15,000 | 23 | 28 | 2 | 6 | 28 | 9 | 3 |
| Over $15,000 | 25 | 46 | 4 | 3 | 11 | 9 | 3 |
| Location | | | | | | | |
| Pearl City/Aiea | 30 | 35 | 5 | 3 | 8 | 15 | 4 |
| Mililani | 13 | 54 | 3 | 4 | 17 | 8 | 1 |
| Wahiawa | 48 | 22 | 2 | 4 | 9 | 10 | 4 |
| Haleiwa/Waialua | 12 | 46 | 1 | 5 | 28 | 4 | 4 |
| Kunia/Waipio | 43 | 4 | 0 | 4 | 43 | 0 | 4 |

Filipinos are significantly more predominant among the 55 years old and over (28%) compared to the other age group (11-16%). The Japanese are significantly less predominant in the 55 year old group (25%) than in the other age groups (31-41%). The Cosmopolitan-mixed are more predominant in the younger than in the older age groups.

Filipinos, Hawaiians, Caucasians and Cosmopolitan-mixed are represented in greater percentages in the low middle income groups while the Japanese are more predominant in the high income group.

The Caucasians are more predominant in Wahiawa, the Japanese in Mililani and Haleiwa/Waialua, and the Filipinos in Kunia/Waipio.

Immigrant Groups: The major immigrant group, the Filipinos, are located in Wahiawa and Wailaua/Haleiwa agricultural areas. Samoan immigrants are found more frequently in Aiea and Pearl City.

The MPAC Mental Health Needs Assessment Survey found the following significant items on place of birth. The breakdown of the civilian population shows that 46.4% were born in Oahu, 16.4% in the other islands, 20.1% in the U.S. Mainland, 11.5% in the Philippines, and 4.6% in other

country. The native/foreign born population ratio was 84% to 16% or 5 to 1. Significant differences in place of birth which are associated with sex, age, income, and residence were also found. These data are shown below.

Table 12

Place of Birth

| | Oahu | Other Island | Mainland U.S. | Philip-pines | Other Country |
|---|---|---|---|---|---|
| Total Civilian Population | 46.4 | 16.4 | 20.1 | 11.5 | 4.6 |
| Sex | | | | | |
| Male | 43 | 17 | 25 | 14 | 1 |
| Female | 48 | 14 | 17 | 12 | 7 |
| Age | | | | | |
| 18-26 | 61 | 6 | 18 | 10 | 5 |
| 27-38 | 48 | 13 | 22 | 12 | 5 |
| 39-54 | 44 | 25 | 21 | 7 | 3 |
| 55 years and over | 30 | 17 | 21 | 24 | 4 |
| Income | | | | | |
| Less than $7,500 | 26 | 8 | 31 | 26 | 4 |
| $7,500-$15,000 | 37 | 15 | 17 | 25 | 4 |
| Over $15,000 | 52 | 17 | 20 | 6 | 4 |
| Location | | | | | |
| Pearl City/Aiea | 46 | 17 | 25 | 6 | 5 |
| Mililani | 52 | 19 | 9 | 13 | 6 |
| Wahiawa | 28 | 17 | 40 | 6 | 8 |
| Haleiwa/Waialua | 56 | 13 | 7 | 23 | 0 |
| Kunia/Waipio | 17 | 0 | 39 | 39 | 4 |

More females than males were born in Oahu (48% vs. 43%) and foreign countries other than the Philippines (1% vs. 7%). More males were born in the U.S. Mainland (25% vs. 17%).

Only 47% of the 55 years old and over were born in Hawaii (Oahu and Other Islands) compared to over 60% of those in the younger age groups. Also, 24% of the 55 years old and over were born in the Philippines compared to between 7-12% of those in the younger age group.

About a quarter of the low and middle income groups were born in the Philippines compared to only 6% of the high income group. Also, about 2/3 of those households earn $15,000 and over (high income) were born in Oahu, compared to 50% and 34% in the middle and low income group respectively. Also, 31% of the low income group were born in the Mainland compared to 17% and 20% of the higher income groups.

Over 2/3 (63-71%) of those who reside in Pearl City/Aiea, Mililani and Haleiwa/Waialua compared to 17% in Kunia/Waipio and Wahiawa were born in Hawaii. Also, about 3/5 of Wahiawa and Kunia/Waipio residents were born in the Mainland compared to 4% and 7% in Mililani and Haleiwa/Waialua, respectively. Furthermore, 23% and 39% of Haleiwa/Waialua and Kunia/Waipio residents were born in the Philippines compared to 6-13% of those in other locations.

f. Length of Residency: Most of the residents in the MPAC civilian sample have resided in Hawaii longer than 5 years (88%). Only 2.5% have lived in Hawaii one year or less. Differences in length of residency associated with income and location of residence were found.

Table 13

Length of Residency

| | One year or less | 2-5 years | 6-14 years | 15-25 years | 26 years and over |
|---|---|---|---|---|---|
| Total Civilian Population | 2.5 | 9.9 | 15.5 | 22.4 | 49.7 |
| Income | | | | | |
| Less than $7,500 | 8 | 24 | 13 | 18 | 36 |
| $7,500-$15,000 | 3 | 12 | 24 | 15 | 46 |
| Over $15,000 | 1 | 7 | 15 | 23 | 54 |
| Location | | | | | |
| Pearl City/Aiea | 3 | 8 | 15 | 20 | 53 |
| Mililani | 3 | 9 | 8 | 29 | 51 |
| Wahiawa | 2 | 20 | 26 | 11 | 41 |
| Haleiwa/Waialua | 0 | 7 | 15 | 29 | 48 |
| Kunia/Waipio | 0 | 22 | 48 | 9 | 22 |

Significantly more individuals from high income (77%) than low and middle income (54% and 61% respectively) households have lived in Hawaii over 14 years. Also, more residents in Pearl City, Mililani and Haleiwa/Waialua (73-80%) compared to residents in Wahiawa (52%) and Kunia/Waipio (31%) have lived in Hawaii longer than 14 years.

g. Employment and Unemployment: The Central Oahu catchment area may be divided rather grossly into a rural, economically depressed region served by clinics at Wahiawa and Wailua/Haleiwa and a generally prosperous suburban region including Aiea, Pearl City, and Mililani. For example, during the fourth quarter of 1974, the unemployment rate in Waialua/Haleiwa was the highest of any district on Oahu at 15%. In Wahiawa it was third highest at 11%, in Aiea unemployment was at the Oahu average of 7%, and in Pearl City it was 6%.

The overall employment status of Central Oahu residents 16 years of age and older according to the 1970 census is summarized in Table 14. As shown in the table, 91% of men were in the labor force with 58% of them employed by the military and with 3% of the civilian labor force unemployed. It is not clear why the latter unemployment figure is so much lower than the 1974 rate. 43% of women are in the labor force with nearly 99% in the civilian labor force and 5% of civilian workers unemployed.

Table 14

Labor Force - Central Oahu

| Employment Status* | No. | % |
|---|---|---|
| Male, 16 years and over | 50,792 | 38.7 |
| Labor Force | 46,172 | 90.9 |
| Civilian Labor Force | 19,329 | 41.9 |
| Employed | 18,775 | 97.0 |
| Unemployed | 554 | 3.0 |
| Military Labor Force | 26,843 | 58.0 |
| Not in Labor Force | 4,620 | 9.1 |
| Female, 16 years and over | 34,968 | 26.6 |
| Labor Force | 15,064 | 43.0 |
| Civilian Labor Force | 14,718 | 97.7 |
| Employed | 14,001 | 95.0 |
| Unemployed | 717 | 5.0 |
| Military Labor Force | 346 | 2.3 |
| Not in Labor Force | 19,904 | 57.0 |
| Low Occupation Status (operatives, transport, laborers, farmers) | 16,944 | 41.3 |

*Excluding inmates of institutions.
Source: 1970 Census of Population

The MPAC survey show that 84% of the civilian population were in the active workforce. Those who were not in the active workforce consisted of the homemakers (17.3%, all females), unemployed (3.2%), and retired workers (8.9%). Differences in occupation and employment characteristics were associated with sex, age, income and location of residence. These data area shown below.

Table 15

Occupational/Employment Status

| | Prof Mgrl | Mid-Mgt | Sales Clerical | Skilled | Semi-skilled | Un-skilled | Other | Homemaker | Unemployed | Retired |
|---|---|---|---|---|---|---|---|---|---|---|
| Total Oahu Population | 19.8 | 6.2 | 14.6 | 10.4 | 5.8 | 2.8 | 11.0 | 17.3 | 3.2 | 8.9 |
| Sex | | | | | | | | | | |
| Male | 21.6 | 8.7 | 9.5 | 18.6 | 5.7 | 3.0 | 12.5 | 0.0 | 3.4 | 17.0 |
| Female | 18.4 | 4.2 | 18.4 | 4.2 | 5.9 | 2.5 | 9.9 | 30.3 | 3.1 | 2.8 |
| Age | | | | | | | | | | |
| 18-26 | 14.0 | 2.5 | 17.8 | 10.2 | 5.1 | 3.8 | 29.3 | 8.9 | 8.3 | 0.0 |
| 27-38 | 27.0 | 8.8 | 14.5 | 11.9 | 8.2 | 1.3 | 6.9 | 17.6 | 1.9 | 1.9 |
| 39-54 | 23.8 | 9.0 | 16.4 | 11.6 | 5.3 | 2.6 | 3.2 | 22.8 | 2.1 | 3.2 |
| 55 + | 10.3 | 3.1 | 7.2 | 4.1 | 4.1 | 2.1 | 4.1 | 21.6 | 1.0 | 42.3 |
| Location | | | | | | | | | | |
| Aiea/ Pearl City | 17.9 | 7.1 | 17.5 | 7.8 | 6.0 | 0.4 | 10.8 | 18.7 | 3.0 | 10.8 |
| Mililani | 22.1 | 7.9 | 15.0 | 12.9 | 5.0 | 3.6 | 14.3 | 11.4 | 3.6 | 4.3 |
| Wahiawa | 36.2 | 4.3 | 6.4 | 19.1 | 2.1 | 0.0 | 2.1 | 19.1 | 2.1 | 8.5 |
| Haleiwa/ Waialua | 12.2 | 4.9 | 15.9 | 7.3 | 8.5 | 6.1 | 12.2 | 14.6 | 3.7 | 14.6 |
| Kunia/ Waipio | 21.7 | 4.3 | 4.3 | 17.4 | 17.4 | 0.0 | 0.0 | 26.1 | 4.3 | 4.3 |
| Income | | | | | | | | | | |
| $0-$7,500 | 8.3 | 5.6 | 11.1 | 4.2 | 5.6 | 6.9 | 12.5 | 18.1 | 9.7 | 18.1 |
| $7,500-$15,000 | 5.6 | 5.6 | 16.8 | 13.6 | 10.4 | 28.6 | 7.2 | 25.6 | 2.4 | 9.6 |
| $15,000 + | 26.6 | 6.7 | 15.2 | 11.1 | 5.2 | 1.3 | 11.1 | 14.5 | 2.1 | 6.2 |

h. Low Income Housing Projects

Family Income: According to the 1970 census, the median family income was $10,154, and 1,804 or 6.8% of the families in the catchment area had incomes below the poverty level.

When the military population was included in the first data set, there were approximately a third of the sample in each of the low, middle and high income category. The breakdown of the civilian sample show considerable difference.

Table 16

Income

| | Less than $7,500 | $7,500-$15,000 | Over $15,000 |
|---|---|---|---|
| Total Civilian Sample | 11.7 | 21.5 | 66.8 |
| Age | | | |
| 18-26 | 17 | 24 | 59 |
| 27-38 | 8 | 18 | 74 |
| 39-54 | 6 | 20 | 73 |
| 55 and over | 24 | 27 | 49 |
| Location | | | |
| Pearl City/Aiea | 15 | 20 | 65 |
| Mililani | 6 | 20 | 75 |
| Wahiawa | 0 | 11 | 89 |
| Haleiwa/Waialua | 15 | 32 | 53 |
| Kunia/Waipio | 25 | 35 | 40 |

Individuals whose households earn $15,000 or more yearly are more predominant among the 27-54 years old (73%) than among the younger and older age groups (60% and 49% respectively).

Individuals whose households earn $15,000 or more are more predominant in Wahiawa (89%), Mililani (75%), and Pearl City/Aiea (65%) than in Haleiwa/Waialua (53%) and Kunia/Waipio (40%). Conversely, 25% of the Kunia/Waipio residents are from low income households compared to 0-15% in other areas.

Low Income Housing Projects: The Central Oahu catchment area has 888 public housing units according to data provided by the Hawaii Housing Authority. In addition, in 1970 there were 5,481 military housing units as well as other low rent housing managed by sugar and pineapple companies.

Public Assistance Recipients: There were 3,533 cases with 4,334 adults and 6,566 children receiving assistance from the Department of Social Services' Public Welfare Division, as of December, 1975. These figures represent 8.3 percent of the catchment population.

i. Education

Number of Schools and Enrollment: The elementary-secondary enrollment totaled 37,213 for 1975-76. In addition, 3,681 full-time and 2,729 part-time students were enrolled in Leeward Community College located in Pearl City. Classes for a new four-year West Oahu College began in 1976 with fewer than one-hundred students enrolled and no campus.

Table 17

School Enrollment - Central Oahu

| | 1974-75 | | 1975-76 | |
|---|---|---|---|---|
| | No. of Schools | No. of Students | No. of Schools | No. of Students |
| Public | 38 | 34,996 | 38 | 34,726 |
| Private | 11 | 2,210 | 12 | 2,394 |
| Special Educ. | 5 | 123 | 4 | 93 |
| Totals | 54 | 37,329 | 54 | 37,213 |

Source: Office of Planning and Budget, Department of Education, State of Hawaii.

School Years Completed: Of the population 25 years and older, 2.4 percent did not complete any school years; 39.2 percent completed high school; and 14.1 percent completed four years of college.

Table 18

Years of School Completed - Persons 25 Years and Older

| | | Number | Percentage |
|---|---|---|---|
| No school years completed | | 1,388 | 2.4 |
| Elementary: | 1-4 years | 2,100 | 3.7 |
| | 5-7 years | 3,021 | 5.4 |
| | 8 years | 3,061 | 5.4 |
| High School: | 1-3 years | 9,430 | 16.8 |
| | 4 years | 22,070 | 39.2 |
| College: | 1-3 years | 7,337 | 13.0 |
| | 4 years + | 7,946 | 14.1 |
| Median School Years Completed: | | 11.9 | |
| % of High School Graduates: | | 66.3 | |

Source: 1970 Census of Population

The MPAC civilian sample of 18 years and older showed higher percentage of residents with high school education and above than that shown by the 1970 census of persons 25 years and older. The MPAC survey percentage was 90% while the 1970 census percentage was 83%. The total civilian sample breakdown and differences associated with income and location are shown below.

Table 19

Educational Level

| | Elementary (Grades 1-6) | Junior High (Grades 7-9) | High School (Grades 10-12) | College (1-3 years) | College Completed | Post-Graduate Work |
|---|---|---|---|---|---|---|
| Total Civilian Sample | 4.9 | 5.3 | 36.5 | 27.2 | 13.1 | 13.1 |
| Income | | | | | | |
| Less than $7,500 | 16 | 6 | 38 | 22 | 10 | 9 |
| $7,500-$15,000 | 9 | 8 | 42 | 26 | 10 | 4 |
| Over $15,000 | 2 | 5 | 33 | 28 | 14 | 17 |
| Location | | | | | | |
| Pearl City/Aiea | 2 | 5 | 38 | 29 | 13 | 12 |
| Mililani | 4 | 5 | 31 | 29 | 16 | 14 |
| Wahiawa | 6 | 4 | 28 | 32 | 4 | 25 |
| Haleiwa/Waialua | 12 | 7 | 46 | 16 | 12 | 5 |
| Kunia/Waipio | 14 | 4 | 36 | 18 | 14 | 14 |

Individuals with elementary education are more predominant among those who come from low income (16%) than higher income households (29%) while those with post-graduate education are more predominant in the high income groups. Individuals with college education are more predominant among Pearl City/Aiea, Mililani and Wahiawa (54-61%) than among Haleiwa/Waialua and Kunia/Waipio residents (33 and 45%).

j. Communications Media: There are 16 AM and 4 FM stations in Honolulu, many offering programs in two or more languages, including Japanese, Chinese, Korean, Hawaiian, Filipino, and Samoan. There are four commercial television stations and a fifth station which is an educational outlet.

The Honolulu newspapers have public service announcement columns (Star-Bulletin's "Pulse" and "It's Up to You" columns and Advertiser's "Honolulu Calendar"). The Leeward Sun Press also accepts such announcements.

Other media include bulletin boards in libraries and supermarkets, community association newsletters and information booths.

## ACCESSIBILITY OF CLINIC LOCATIONS BY REGION OF RESIDENCE

| Accessibility Indicator | Clinic Location | Region of Residence: Aiea n=275 | Pearl City n=144 | Mililani n=48 | Wahiawa n=85 | Haleiwa n-23 |
|---|---|---|---|---|---|---|
| convenient or very convenient | Aiea | 97% | 85% | 57% | 21% | 4% |
| | Pearl City | 78% | 100% | 63% | 24% | 9% |
| | Mililani | 16% | 17% | 87% | 69% | 29% |
| | Wahiawa | 6% | 3% | 85% | 96% | 78% |
| | Waialua | 2% | 4% | 9% | 27% | 96% |
| very inconvenient or almost impossible | Aiea | 0% | 0% | 9% | 36% | 48% |
| | Pearl City | 4% | 0% | 4% | 36% | 44% |
| | Mililani | 35% | 28% | 11% | 14% | 33% |
| | Wahiawa | 70% | 71% | 2% | 2% | 4% |
| | Waialua | 86% | 82% | 56% | 38% | 4% |

The strong need to establish and/or maintain neighborhood clinics is shown by the rapid fall-off in accessibility indicator as one moves away from the respondents "home" clinic. For example, for respondents of Pearl City, the Pearl City clinic rates 100% as "convenient" or "very convenient". The next nearest clinic, Aiea, rates 85%. The next nearest, which is about a 20 minute drive, rates only 17%. The outlying clinics in Wahiawa and Waialua-Haleiwa rate only 3 and 4%. This pattern of relatively steep drop-off of each neighborhood and each clinic.

The second table represents the data in negative form, asking that the respondent rate the inconvenience of going to another clinic. Again, a very strong need for community clinics is shown.

B. Description - Program

1. Inpatient Services: Inpatient mental health services for Central Oahu adults who require 24-hour care in a hospital setting are provided at the Hawaii State Hospital in Kaneohe and at Queen's Medical Center in Honolulu. The Queen's Medical Center offers short-term treatment (1-28 days). The State Hospital services both acute and chronic patients. The State Hospital is somewhat distant from Central Oahu by local standards; however, it is accessible via a one-hour bus ride at a fare of twenty-five cents.

Children's inpatient services are provided by the Leahi Hospital in Honolulu for 4 to 12 year olds and at the Adolescent Unit of Hawaii State Hospital in Kaneohe.

Current Staffing Pattern and Utilization: Central Oahu Community M ntal Health Center has been contributing to staffing of adult inpatient services at Hawaii State Hospital. Positions allocated to the hospital by the Center include a half-time psychiatrist, a half-time social worker, a half-time registered professional nurse, and a half-time para-medical assistant. There have been difficulties in coordinating inpatient services provided by Center staff with services provided by regular hospital staff. The hospital has recently proposed that Center input to hospital programs be limited to one half-time social worker position, and the Center is considering this.

Utilization of adult inpatient services at Hawaii State Hospital in the past twelve months (April 1, 1975 to March 31, 1976) included a total of 66 patients served with 59 admissions and 38 discharges. The census on March 31, 1976 was 28 patients. Assuming the census averaged 28 patients throughout the year, the number of inpatient days would have been 10,220.

Gaps in Services

Continuity:

A. Lack of coordination between COCMHC/HSH/DSSH regarding discharge, placement and follow-up. No formally established mechanism or lines of authority.

1. Occasional payment difficulties and inappropriate placement.
2. Patients sometimes "lost" by agency supposedly responsible for follow-up care.

B. No formal treatment liaison program with other agencies to insure appropriate follow-up services. Problem not specifically one of COCMHC.

Comprehensiveness:

Treatment responsibility at HSH unclear regarding the role of Center staff who service patients in the hospital. No clearly established lines of authority regarding responsibility for patients from Central Oahu. Center staff appears to have principal responsibility but are occasionally overruled or bypassed by HSH staff.

Cost:

Cost ineffectiveness of current arrangement between Center and HSH.

1. Transportation.
2. Overlap and duplication of responsiblities and efforts.

Quality of Care:

A. Possible inappropriate hospitalizations due to lack of alternatives in Central Oahu Catchment Area.

B. Lack of clearly defined authority and lack of full-time status of Center staff may lead to an inability to respond to emergency or other situations or insure consistent and continuous care at HSH.

## Recommendations and Possible Programs

1. Establishment of a liaison team to conduct, coordinate and follow-up released mental patients from the Central Oahu Catchment Area.

2. Abolish current arrangement or clearly define the roles of responsibility of Center staff.

3. Establish alternatives to hospitalization (see TLU and day program recommendations).

4. At very least, coordination between Center and HSH to establish procedures and lines of responsibility must be developed.

2. Outpatient Services: A range of outpatient services including individual, group, and family therapy and chemotherapy is available to Central Oahu residents of all ages. Consultation and education services are discussed separately below. Four mental health clinics, located in Aiea, Pearl City, Wahiawa, and Waialua-Haleiwa, offer outpatient services Monday through Friday from 7:45 a.m. to 4:30 p.m.

Current Staffing Pattern and Utilization: Outpatient staffing patterns at the four mental health clinics and the Central Oahu Children's Mnetal Health Services Team are summarized in Table 20. Staff assigned to Day Activity Programs are not included in the table. Day Activity staff do provide some outpatient services; however, this service tends to be balanced by services to Day Activity Programs by outpatient staff.

Table 20

Current Staffing of Central Oahu Outpatient Services

| Mental Health Clinic/Team | Discipline[a] | | | | | |
|---|---|---|---|---|---|---|
| | M.D. | Ph.D. | S.W. | R.P.N. | P.M.A. | Clerk |
| Aiea Counseling Service 99-115 Aiea Heights Dr | 1 | 0 | 1 | 1 | 0 | 1 |
| Pearl City Mental Health Clinic Hale Mohalu Hospital | 1 | 0 | 1 | 1½[b] | 0 | 1[c] |
| Wahiawa Counseling Service 910 California Ave | 1 | 0 | 1 | 2 | 1 | 1 |
| Waialua-Haleiwa Counseling Service 66-496 Haleiwa Road | ½[b] | 0 | ½[b] | 1 | 0 | 1 |
| Central Oahu Children's Mental Health Svs Team Hale Mohalu Hospital | 1[d] | 1 | 2 | 1 | 0 | 1 |

[a]M.D. = psychiatrist; Ph.D. = psychologist; S.W. = social worker; R.P.N. = registered professional nurse; P.M.A. = para-medical assistant; Clerk = typist or stenographer.

[b]Half-time positions result from allocation of outpatient staff time to inpatient services. The half-time psychiatrist and nursing positions may resume full-time outpatient status pending negotiations with the State Hospital.

[c]Temporary position.

[d]Child Psychiatrist position (presently vacant). Currently under fee-for-service hire.

Utilization of outpatient services during the previous twelve months (April 1, 1975 to March 31, 1976) is summarized in Table 21. This table does not include Day Activity Program clients, inpatients, or unregistered cases.

Table 21

Central Oahu Annual Outpatient Caseload

| Clinic/Team | Cases | | |
|---|---|---|---|
| | Admissions | Terminations | Active (3/31/76) |
| Aiea | 90 (21%) | 90 (25%) | 101 (21%) |
| Pearl City | 88 (21%) | 70 (19%) | 81 (17%) |
| Wahiawa | 152 (36%) | 140 (39%) | 199 (41%) |
| Waialua-Haleiwa | 39 (9%) | 27 (8%) | 60 (12%) |
| Children's Team | 52 (12%) | 32 (9%) | 45 (9%) |
| Central Oahu | 421 | 359 | 486 |

Gaps in Services

Accessibility -- Availability:

A. General

1. No after hours care for patients to whom such care might be appropriate.
2. Outreach policy regarding follow-up of discontinued cases or unkept appointments.
3. Possible unnecessary duplication of services (Aiea).
4. Absence of overall case finding system other than informal referral or walk in.

B. Immigrants

1. No bi-lingual professional staff (other than Japanese).
2. Cultural dissonance in dealing with immigrants.
3. Limited availability of translators.

C. Children

Closer liaison with schools necessary - lack of defined therapeutic roles between MH and DOE; referral mechanism is a major problem between MH and DOE.

D. Women

No services in area.

Acceptability:

A. Military

General unwillingness to use own services (confidentiality problem).

B. Children and Youth

1. Stigma of counseling center.
2. Need to attract and identify teenagers in need of services through the availability of a flexible counseling program.

Comprehensiveness:

A. Children

Lack of informal environment for children.

B. Elderly

Lack of outreach and health screening.

C. Immigrants

Services to isolated or non-English speaking.

D. General

Overall coordination with existing agencies necessary.

Continuity:

General

1. Need for more effective use of other agencies.
2. Need to cut down "red tape" that patient must go through and insure more consistent follow-up.

Cost:

1. Third party reimbursement - better collection necessary.
2. More realistic fee schedule necessary.

Quality of Care:

1. Professional peer review and consultation program necessary.
2. Therapist need to become more knowledgeable of other resources.
3. Quality control must insure systematic program for patients.

Recommendations and Possible Programs

1. Make available night and weekend non-emergency clinic scheduling (24-hour non-emergency).
2. Systematic training for outreach workers (more pro-active rather than re-active).
3. Availability of translators and training (possible POS with KP immigrant services center or recruitment of volunteers from community).
4. Women's programs (rap group for military wives, CEW, etc.).
5. Military outreach.
6. Off-post facilities for military therapist at the counseling center.
7. Teenage rap center/Haleiwa-Waialua or Wahiawa.
8. Tie in with City and County Elderly Health Screening Program.
9. Missed appointment and post discharge follow-up policy.
10. Professional peer review and consultation (evaluation program).
11. Permanent access to schools by children's team.
12. Parenting classes for parents of children receiving services from Children's Team.
13. Child Abuse/Family Stress Center.

3. Day Care and Other Partial Hospitalization Programs: Three day programs operated by Central Oahu Community Mental Health Center offer recreational and therapeutic services to clients, the majority of whom are former patients of Hawaii State Hospital currently living in boarding or care homes. The programs include recreational outings, groups to develop communication skills and appropriate expression of feelings, individual counseling, and instruction in cooking, arts and crafts, photography, bowling, tennis, and other daily living skills. Chemotherapy, prescribed by clinic psychiatrists, complements the psychosocial approaches. Home visits, follow-up, and consultation to boarding and care home operators are important aspects of the services.

The names, locations, and hours of the three day programs are as follows:

a. The Aiea-Pearl City Partial Hospitalization Program, Hale Mohalu Hospital, Pearl City, Monday through Friday, 7:45 a.m. to 4:30 p.m.

b. The Wahiawa Day Activity Program, 216 Koa Street, Wahiawa, Monday, Tuesday, Wednesday, Friday, 8 a.m. to 2:30 p.m.

c. The Waialua-Haleiwa Day Activity Program, 66-496 Haleiwa Road, Monday through Friday, 8 a.m. to 2 p.m.

Current Staffing Pattern and Utilization: The three day programs are staffed by Para-Medical Assistants formally allocated to the mental health clinics and by an Occupational Therapist. Psychiatric and nursing consultation to the day programs are provided by clinic personnel. Staffing and utilization of the day programs are summarized in Table 22.

Table 22

Staffing and Utilization of Central Oahu Day Programs

| Program | Staff[a] | | Utilization (7/75 to 4/76) | |
|---|---|---|---|---|
| | P.M.A. | O.T. | Patients/Month | Days/Month |
| Aiea-Pearl City | 3 | ½ | 54 | 482[c] |
| Wahiawa | 1½[b] | ¼ | 25 | 256 |
| Waialua-Haleiwa | 2 | ¼ | 20 | 268 |

[a]P.M.A. = Para-Medical Assistant; O.T. = Occupational Therapist.

[b]The half-time P.M.A. results from assignment of P.M.A. staff to inpatient services.

[c]Attendance at Aiea-Pearl City has averaged 550 days/month in 1976.

Gaps in Service

Accessibility -- Availability:

A. Released patients day program

1. Transportation between home and day program.
2. Transportation to other activities.

B. Elderly

Absence of elderly day program in area for "rap group"

C. Children

1. Absence of children's day program in area.
2. Difficulties in DOE/DOH linkages and cooperation.

Acceptability:

Day Program

Nature of program should enhance skill development and integrity of individual rather than purely recreational activities.

Cost:

Day Program

Possible unnecessary duplication of services among the three existing day programs.

Continuity:

Day Program

Lack of coordination and utilization of other service providers.

Quality of Care:

Day Program

1. Need for occupational therapist and other vocational and pre-vocational training.
2. Role of Day Care needs to be defined; measures of effectiveness established.

Recommendations and Possible Programs

1. Elderly day care program/rap group/Wahiawa.
2. Children's day program with DOE.
3. Hire O.T. for day programs.
4. (POS) purchase of service from Adult Education.
5. Buses or vans.
6. Possible merging of existing programs.

4. Emergency Services: Emergency services are provided as needed by regular staff at the four clinics from 7:45 a.m. to 4:30 p.m., Monday through Friday. After hours and on weekends, a Honolulu-based suicide and crisis telephone service responds to emergencies. The Mental Health Division maintains an on-call rotation among state psychiatrists to respond to emergencies. Emergency hospitalization is available at all times at Queen's Medical Center.

Current Staffing Pattern and Utilization: No special staffing pattern to handle emergencies is in effect at Central Oahu Community Mental Health Center. Emergencies during working hours occur infrequently.

Gaps in Service

Accessibility -- Availability:

1. Lack of 24 hour emergency capability by MH clinics on island.
2. Lack of "crash" type emergency environment.

Continuity:

Lack of formal post emergency follow-up.

Recommendations and Possible Programs

1. MH clinic on island open 24 hours.
2. Emergency "crash" facility.
3. Telephone answering machine.
4. Development of a post emergency follow-up system.

5. Services for Children and Youth: A range of services to children and youth is provided by the four mental health clinics and the Central Oahu Children's Mental Health Services Team which was established during 1975. Services include individual, family, and group therapy, parent training, consultation with other agencies such as Head Start, Family Court, Public Health Nursing, Police Department, and Department of Education.

Current Staffing Pattern and Utilization: Staffing of the Central Oahu Children's Mental Health Services Team was summarized in Table 20. Regular clinic staff also provide services to children.

Utilization of direct children's services during the previous twelve months (April 1, 1975 to March 31, 1976) is summarized in Table 23. These caseloads are a subset of the outpatient caseloads reported in Table 21 and do not include unregistered cases.

Table 23

Utilization of Mental Health Services
By Children (0-17 Years)

| Clinic/Team | Utilization (4/1/75 to 3/31/76) | | |
|---|---|---|---|
| | Admissions | Terminations | Active (3/31/76) |
| Aiea | 27 | 28 | 20 |
| Pearl City | 40 | 22 | 21 |
| Wahiawa | 39 | 35 | 17 |
| Waialua-Haleiwa | 2 | 6 | 1 |
| Children's Mental Health Team | 47 | 29 | 40 |
| CENTRAL OAHU TOTAL | 155 | 120 | 99 |

None of the children served were preschoolers, forty-eight percent were in elementary school (5-11 years old), eleven percent were in intermediate school (12-13 years old), and twenty-two percent were high school age (14-17 years old).

Data from the first nine months of 1975 as reported by the Children's Mental Health Services Branch are presented in Table 24.

Table 24

Central Oahu Child Caseload Data (1/1/75 to 9/30/75)

| CHILDREN'S TEAM | Age | | | | | No. of Families |
|---|---|---|---|---|---|---|
| | 0-4 | 5-11 | 12-13 | 14-17 | TOTAL | |
| 1. No. of children and youth identified with DOE and referred for treatment. | - | 27 | 0 | 26 | 53 | 0 |
| 2. No. of children and youth identified with other agencies and referred for treatment. | 0 | 0 | 0 | 0 | 0 | 0 |
| 3. No. of children and youth accepted as referrals from DOE personnel. | | | | | | |
| a. Evaluation Only | - | 2 | 1 | 2 | 5 | 0 |
| b. Evaluation & Treatment | - | 8 | 3 | 0 | 11 | 4 |
| 4. No. of children and youth accepted as referrals from others. | | | | | | |
| a. Evaluation Only | 0 | 8 | 1 | 0 | 9 | 0 |
| b. Evaluation & Treatment | 3 | 18 | 2 | 6 | 29 | 10 |
| 5. No. of children and youth who have received informationl and counseling services <u>without</u> formal "admission" to the clinic/center. | - | 27 | 1 | 27 | 55 | 5 |
| SUB-TOTAL | 3 | 90 | 8 | 61 | 162 | 19 |
| 6. Total No. of children, youth and families served by other Center personnel. | 0 | 27 | 9 | 55 | 91 | 15 |
| TOTAL | 3 | 117 | 17 | 116 | 253 | 34 |

Source: Second Annual Progress Report on Mental Health Services for Children and Youth, State Department of Health, December, 1975.

Utilization of consultative services by schools is summarized in Table 25.

Table 25

School Consultation Services

| | Type of School | |
|---|---|---|
| | Preschools | Public Schools |
| Serviced Schools | | |
| Number | 11 (39%) | 13 (34%) |
| Enrollment | 768 (43%) | 8,717 (25%) |
| Unserviced Schools | | |
| Number | 17 (61%) | 25 (66%) |
| Enrollment | 1,024 (57%) | 26,702 (75%) |
| Children's Team Consultation | | |
| 1975 | 5 hours/mo. | 32 hours/mo. |
| 1976 | 18 hours/mo. | 47 hours/mo. |

The discrepancy between consultation and direct services to preschool is due to the very recent introduction of screening and consultative services which is expected to be followed by referrals for direct service in the future.

Time devoted to various indirect services to children in the first nine months of 1975 is summarized in Table 26.

Table 26

Indirect Services to Central Oahu Children
(1/1/75 to 9/30/75)

| | Time (Hours) | | |
|---|---|---|---|
| | Delivery | Preparation | Travel |
| Case Consultation | 92 | 3 | 12 |
| Consultee Consultation | 6 | 0 | 4 |
| Program Consultation | 28 | 0 | 4 |
| Training Given | 40 | 6 | 11 |
| Mental Health Education | 76 | 18 | 14 |
| Mental Health Promotion | 17 | 2 | 2 |
| Community Planning: 28 hours | | | |

Gaps in Service

(a) Extending current consultative and direct services to children in all age groups and schools requires additional staff. Specifically, a Social Worker IV is needed in the area of direct clinical service and liaison and consultative work with schools. A Psychologist VI is needed to perform consultative and training functions at the intermediate and high school levels. These positions will be requested in the 1977-79 biennium budget request.

(b) There is a gap between Department of Education classes for emotionally handicapped children and Department of Health day treatment program for children and the Leahi Hospital children's ward in Honolulu. The Central Oahu Children's Mental Health Services Team has plans for developing a Children's Day Treatment Program to be located at the Leeward Health Center, currently under construction in Pearl City. Such a program with an enrollment of approximately eighteen children would serve both to reduce the need for placing children in Honolulu facilities and to facilitate the transition from Honolulu back into the catchment area. Staff to be requested in the 1977-79 biennium budget request include a Registered Professional Nurse V, as program director, and an Educational Therapist III, as head teacher, beginning in 1977-78 to plan and develop the program. Implementation of the program in 1978-79 would require the addition of an Educational Therapist II, as associate teacher, a Para-Medical Assistant IV, as teacher's aide, and a Social Worker IV to work with families and the regular school.

6. Services to the Elderly: Services to the elderly provided by regular clinic and day program staff include individual, group, and family therapy, day care for emotionally disturbed elderly, and other mental health services. Other organizations, such as Areawide Horizons and the Wahiawa Rainbow Club, provide social and outreach services to the elderly.

Current Staffing Pattern and Utilization: Staffing is provided by regular clinic personnel.

Utilization of mental health services by the elderly in the previous twelve months is summarized in Table 27.

Table 27

Utilization of Central Oahu Services
by the Elderly (65+)

| Clinic | Utilization (4/1/75 to 3/31/76) | | |
|---|---|---|---|
| | Admissions | Terminations | Active (3/31/76) |
| Aiea-Pearl City | 9 | 9 | 21 |
| Wahiawa | 5 | 6 | 18 |
| Waialua-Haleiwa | 3 | 1 | 15 |
| Children's Team | 4 | 1 | 3 |

7. Consultation and Education: Services, including training, consultation, and education to schools, agencies, and other community groups, are provided during and after regular clinic hours by clinic, team, and Center staff.

Current Staffing Pattern and Utilization: Staffing involves regular clinic personnel.

Utilization of consultation and education services is summarized in Table 28. (Also, see number 5. Services to Children and Youth.

Table 28

Central Oahu Consultation and Education Services
(6/75 to 2/76)

| CLINIC | TIME (HOURS) |
|---|---|
| Aiea Counseling Service | 21 hours/month |
| Pearl City Mental Health Clinic | 12 hours/month |
| Wahiawa Counseling Service | 26 hours/month |
| Waialua-Haleiwa Counseling Service | 21 hours/month |

Gaps in Service

Consultation and education services are provided by the Center on request; however, requests are necessarily limited by the lack of knowledge of the availability of these services. Both the recent survey of knowledgeable resources and needs assessment survey conducted by the Center, suggest the necessity of developing a comprehensive network of community education and professional consultation. The success of such a program would be dependent upon adequate coordination and publicity of the resources of the Center in the community.

The principal focus of the initial stages of a C and E program must therefore emphasize the establishment of appropriate linkages to the community. This role will be filled by a program of community advocacy performed by the patient advocate team and administration assistant. A major responsibility of these people will be to establish contact with and determine the needs of the various professional and lay elements of the community

Conceptually, consultation and education will serve as the "glue" which ties the system together. It is the element which turns the discrete components into a "comprehensive" system.

Recommendations and Possible Programs

1. Consultation to clergy, police, teachers, counselors, PH nurses, DVR, DSSH, etc.
2. Training to other agencies by staff.

8. Screening Assistance to Courts and Other Public Agencies: Service to screen patients referred for hospitalization at psychiatric facilities is available from 7:45 a.m. to 4:30 p.m. at the four clinics.

Current Staffing Pattern and Utilization: Staffing is by regular clinic personnel.

Utilization of this service is minimal.

9. Follow-up Care Service: Service to patients discharged from Hawaii State Hospital include placement, home visits, collateral consultation, boarding and care home consortiums, day activity programming, and outpatient therapy.

Current Staffing Pattern and Utilization: Follow-up of patients discharged from Hawaii State Hospital approaches 100 percent utilization. Staffing is provided by regular clinic and day program personnel.

10. Transitional Halfway House Services: The Center does not operate any transitional living facilities; however, there is a range of living arrangements available to Central Oahu residents. Consultation and supportive services are provided by clinic and day program staff to operators of boarding and care homes where patients reside.

Current Staffing Pattern and Utilization: There are not staff positions assigned to transitional living units, though regular clinic and day program staff do provide consultation and supportive services.

Availability and utilization of transitional living and nursing facilities are summarized in Table 29.

Table 29

Transitional Living and Nursing Facilities in Central Oahu

| TYPE OF FACILITY | AVAILABILITY | | UTILIZATION | |
|---|---|---|---|---|
| | Number | Beds | Currently Residing[a] | Awaiting Placement |
| Skilled Nursing | 1 | 45 | don't know | 0 |
| Intermediate Care[b] | 1 | 68 | 0 | 0 |
| Adult Care Homes | | | | |
| Aiea | 5 | 43 | 3 | 0 |
| Pearl City | 15 | 60 | 23 | 0 |
| Wahiawa | 9 | 32 | 26 | 0 |
| Waialua-Haleiwa | 8 | 31 | 13 | 0 |
| Adult Boarding Homes[c] | | | | |
| Aiea | 8 | 25 | 14 | 0 |
| Pearl City | 10 | 32 | 10 | 0 |
| Wahiawa | 4 | 11 | 6 | 0 |
| Waialua-Haleiwa | 7 | 30 | 13 | 0 |
| Halfway House | | | | |
| Aiea/Pearl City | 0 | 0 | 0 | 6 |
| Wahiawa/Waialua | 0 | 0 | 0 | 4 |
| Social Rehab. Residence | | | | |
| Aiea/Pearl City | 0 | 0 | 0 | 7 |
| Wahiawa/Waialua | 0 | 0 | 0 | 4 |

[a]Center cases residing in facility.

[b]Crawford Convalescent Home, the intermediate care facility located in Kahuku, has accepted Central Oahu patients who then are transferred to Windward Community Mental Health Center.

[c]Most of these are licensed by Department of Social Services and Housing.

Gaps in Service

Accessibility -- Availability:

A. Boarding and Care Homes

1. Operators may refuse patients.
2. Operators and patients have difficulty getting to supportive programs.

B. TLU - Adult

1. None in the area.
2. Limited number on island, many of which serve only specific areas of disabilities.
3. Lack of formal linkages between MH and existing facilities on island.
4. General lack in terms of number of available facilities.

C. TLU - Children

1. None in the area.
2. Same as B.2, 3 and 4 above.
3. Children tend to be less mobile than adults.

Acceptability:

A. Boarding and Care Homes

1. Concern regarding ethnic imbalance among operators.
2. Acceptability of care homes by community.

B. TLU

Acceptability of any TLU program by community must be insured before such a program can be totally successful.

Comprehensiveness:

A. Boarding and Care Homes

1. Lack of programs for patients within boarding or care home environments.

2. Little formal training for, or required of, operators.
3. Limited community supports for care home operators.
4. Prestige of care home operators.

B. TLU

1. Support services to TLUs essential to insure success of program.
2. General lack of range of environments and services on island.
3. Greater interagency communications and linkages necessary to insure appropriate placement and comprehensive service.

Continuity:

Boarding and Care Homes

1. Absence of comprehensive mechanism for reevaluation and reexamination of patient for movement to other environments.
2. Lack of formal relationships to support agencies.

Cost:

TLU's very expensive, therefore interagency referral system must be developed for any such environment developed in area to insure utilization.

Quality of Care:

Boarding and Care Homes

1. Licensing program concentrates primarily on physical environment.
2. No formal linkages between boarding homes and MH to insure appropriateness of environment.
3. DSSH payment schedule acts as disincentive to patient improvement.

## Recommendations and Possible Programs

A. Boarding and Care Homes

1. Development of a care home graduation pilot project - program would provide bonuses to selected operators for specified patient improvement, this would be linked to a program and evaluation component developed by MH with the assistance of other cooperating agencies.
2. Quality evaluation and consultation by MH staff.
3. Vans and buses to assist patients to get to other programs and activities.
4. Training programs for operators developed by MH staff.
5. POS with adult education for learning and skill development of patients.

B. Half-way Houses

1. Half-way house for adults/non-intensive/non-specific/Pearl City.
2. Group home for adults/Pearl City/Wahiawa.
3. Group home for children/GFS-model.
4. "Crash Pad"/24 hour place to stay.
5. Referral, Information and Service Exchange between agencies.
6. Transitional Sponsorships.
7. Increase prestige of operators.
8. TLU for alcoholics.

11. Alcohol Abuse Services: Regular clinic services including individual and family counseling are available to alcohol abusers and their families. Specialized services to the alcoholic including detoxification, transitional living, and self-help groups are provided by other agencies and groups, e.g., the Salvation Army and Alcoholics Anonymous. A one year alcoholism outreach demonstration project will begin soon in Leeward and Central Oahu to identify alcohol abusers and link them to service providers.

Current Staffing Pattern and Utilization: The outreach project will involve one Para-Medical Assistant IV shared by Leeward and Central Oahu Community Mental Health Centers.

Utilization of Center services by alcohol abusers (primary diagnosis) in the previous year (April 1, 1975 to March 31, 1976) is summarized in Table 30.

Table 30

Utilization of Services by Alcohol Abusers

| CLINIC | NUMBER OF CLIENTS |
|---|---|
| Aiea | 5 |
| Pearl City | 2 |
| Wahiawa | 9 |
| Waialua-Haleiwa | 2 |

Gaps in Service

Acceptability:

Probable large number of unidentified alcoholics.

Continuity:

Absence of formal coordination between MH and the many alcoholism and drug programs.

Comprehensiveness:

1. Glue and paint sniffing among adolescence identified as problems without formal program in area.
2. Necessity to work with schools regarding substance abuse identification, treatment and education.

Recommendations and Possible Programs

1. Continue outreach and education regarding alcoholism.
2. Establish substance abuse identification and education programs in schools emphasinzing gaps in current services such as glue and paint sniffing.
3. Develop greater coordination with existing substance abuse programs.

12. Drug Abuse Services: Regular clinic services including individual and family counseling are available to drug abusers and their families. Specialized services such as methadone maintenance are provided by other agencies, e.g., D.A.S.H. (Drug Addiction Society of Hawaii).

Current Staffing Pattern and Utilization: Regular clinic staff provide services to drug abusers.

Utilization of clinic services by drug abusers (primary diagnosis) in the previous twelve months (April 1, 1975 to March 31, 1976) is summarized in Table 31.

Table 31

Utilization of Services by Drug Abusers

| CLINIC | NUMBER OF CLIENTS |
|---|---|
| Aiea | 5 |
| Pearl City | 2 |
| Wahiawa | 9 |
| Waialua-Haleiwa | 2 |

Activity levels within these current services are reported on a monthly basis. The activity reports for April, 1976, indicate the Center's current activities by clinic location detailing age groups served and types of service. Separate reports for the military and for alcohol and drug abusers are included.

13. Mental Health Services for Special Population Groups:

Children have been a special focus of the Center since the founding of its Children's Team in 1975. The demographic predictions for the area make services to children of special significance. Already disproportionately bulging in the lower age brackets, the profile of the area is expected to become even more "child-centered" as the rest of the island residential areas which have ceased receiving new family resident's move through progressive stages of aging. The Central Oahu area, considered by most realtors as the last major buildable area on Oahu, will become the concentration point for new families and the young children that come with them. To the degree that services provided to children and youth can intervene successfully in developing programs, the mental health of the future adult population may be affected for the better.

Brief description: Persons under 18 constitute approximately 36% of the catchment area's total population. The Central district of the Department of Education, which includes most of the catchment area, is the fastest growing of the school districts on Oahu and the DOE further estimates that up to 12% of the children in school require some sort of mental health assistance.

Specialized Needs:

Geographic and environmental peculiarities compound the difficulties experienced by children in the catchment area. As the largest of Oahu's catchment areas, transportation difficulties as well as the overall absence of private support services severely inhibit the recreational and social alternatives available to children.

Many of the problems are those associated with other suburban communities where the manifestations of problems are not as obvious as in dense urban environments and therefore more active efforts at case identification are necessary.

Specifically, needs include:

1) Development of social and recreational outlets.
2) Availability of informal counseling environments given general unwillingness of children to utilize formal programs.
3) Availability of temporary or transitional living environments for runaways or abused children.
4) Greater communication and referral capability among social agencies servicing children in the area.
5) Involvement of parents in handling children's problems.

Goals and Objectives of Services to this Group:

A. Goals:

1) Insure that appropriate mental health services are available and acceptable to children and adolescents.
2) Provide appropriate linkages between planned and existing community resources to children.
3) Provide alternative or temporary living environments for children in need of such environments.

B. Objectives:

1) To expand and facilitate interagency referral and consultation capability.
2) To establish temporary or alternative living environments for children.
3) To involve parents in the treatment of children.
4) To identify and treat children in need of mental health services.

The elderly and their sons and daughters on whom falls the burden of caring for them are the target of several specialized programs. The success of these programs will have great significance not only in terms of the clients' immediate lives but in secondary impacts on their families. Without Senior Day Care programs, many families in Hawaii are virtually trapped in their homes by their elderly parents. Many of the various cultures which comprise the Central Oahu population stress duty of the adult children to care for the elderly parent. Unfortunately, this natural system of mutual care does not mesh smoothly with modern, Western economics, work patterns, zoning codes, etc. The provision of transportation, programs, and screening services for the elderly may likely be of more significance to the average adult in the area than services which he or she might be a potential direct recipient of.

Brief description: Persons over 55 years of age represent 6% of the population of the catchment area. They are found in great proportion in Waialua-Haleiwa, lower Aiea and other tracts. Twenty-eight percent of those 55 years or older are foreign born. Of those earning $7,500 or less, 30% were 55 years or older.

Specialized Needs:

While the needs assessment survey indicated a high level of concern for the elderly, specific mental health problems were not clearly defined. However, problems relating to physical health and economics have presented themselves to be the major problems of the elderly population. Insofar as existing mental health problems can be assumed to stem from these social problems, programs related to physical health, debilitation and public assistance in economic well-being would be indicated.

Goals and Objectives of Service to this Group:

A. Goals:

1) Determine, assess and identify mental health needs within the elderly population on continuing and individual basis.
2) Provide alternatives to institutionalization for those elderly in need of such environments.
3) Provide linkages with other resources within the community serving the elderly population.

B. Objectives:

1) To establish a mechanism for the assessment of the health needs of the elderly and development of relevant mental health programs to fulfill these needs.
2) To establish an elderly day program.
3) To develop an effective referral mechanism so as to direct the elderly to the most appropriate available service.

The immigrants are another group to whom the provision of service will have a significance greater than normal. For an immigrant, the lack of accessible mental health services becomes a self-compounding dilemma. A minor or transient problem may rapidly become aggravated into a debilitating one for the immigrant. The host society, often on the verge of rejecting the immigrant out of its own bias and misunderstanding, often will respond to symptoms in an immigrant with much stronger sanctions than would be true if the same symptoms appeared in a non-immigrant. As with all social problems, the inability to communicate across language and culture barriers acts to escalate mental health problems among immigrants. If real progress can be made in providing mental health services to the immigrant population through the programs and staff proposed, it is possible that the impact of this service will be felt in reduced demand on a variety of other social services which deal with immigrants.

Brief description: Recent needs assessment survey data found that foreign born residents of the catchment area represent approximately 16% of the total population. However, data further suggests that these are not recent immigrants since the majority of this population has lived in Hawaii for at least 5 years. Consequently, the immigrant population of Central Oahu is not principally composed of new arrivals but rather people who have already undergone substantial acculturalization and socialization.

The major immigrant group, the Filipinos, are principally located in Wahiawa and Waialua-Haleiwa. Samoan immigrants are found more frequently in Aiea and Pearl City.

Within the population of the catchment area, immigrants represent 28% of those persons 55 years of age or older, and approximately 30% of those households make less than $15,000 annually.

Specialized Needs;

A. Increased awareness of State social and health services system.

B. Bilingual/bicultural mental health services capability.

C. Problem and needs identification capability.

Goals and Objectives of Services to this Group:

A. Goals:

1) Insure that State mental health services are acceptable in terms of the cultural context of the foreign born population.
2) Continuous needs assessment and case finding.
3) Provide appropriate linkages to existing community resources.

B. Objectives:

1) Establish a mechanism for evaluating the acceptability to foreign born residents of mental health programs and services.
2) Establish a process whereby needs of the foreign born population can be determined and assessed.
3) Development of an effective outreach program.
4) Development of an effective referral system so as to direct this population to the most appropriate source of services.

Released patients comprise another group for whom specialized services need to be provided.

Brief description: The Central Oahu catchment area serves as a major resettlement area for persons released from various inpatient facilities. This is due partially to the large number of care and boarding homes providing custodial care for released patients within the area (approximately 66 such facilities). In addition to care and boarding home patients, the Center services approximately 95 clients in its day activity program, most of whom are released mental patients.

Specialized Needs

A. Individualized treatment and rehabilitation programs.

B. Assistance in transportation.

C. Greater range alternative living environments and access to relevant community resources.

D. Coordination of services to released patients.

Goals and Objectives for Service to this Group:

A. Goals:

1) Prevent inappropriate placement of Central Oahu residents following discharge from inpatient facilities.
2) Minimize confusion and duplication in treatment and placement of patients.
3) Provide adequate screening and service planning following release from an inpatient facility.
4) Insure coordination and continuity among the various supportive services available within the community to released patients.
5) Provide the necessary planning, liaison and follow-up services to clients moving within the system of transitional living units or admitted directly into such environments.

B. Objectives:

1) To provide comprehensive and individualized discharge planning and follow-up services to released patients.
2) To coordinate services available within the community to released patients.
3) To reduce duplication and confusion among agencies and personnel responsible for discharge placement and follow-up.
4) To insure that "red tape" and other sources of delay are minimized.
5) To insure appropriate placement.
6) To provide necessary information and planning to various elements of the patients' social and medical environment upon release.
7) To insure appropriate linkages and patient planning within the available range of environments when necessary.

In the Central Oahu Catchment Area, the military represent a special sub-group of the general population requiring special program response.

Brief description: The 1970 census indicated that the military population including dependents was 53,343 or 41% of the catchment's total population, the highest in the State. Since 1970, cutbacks in personnel attributable to the end of the Vietnam War have reduced this population. However, recent MPAC needs assessment survey data indicate that the military still comprise a disproportionately large sector of the population.

Military bases within the catchment area include Wheeler Air Force Base, Schofield Barracks (Army), Camp Smith (Marine) and parts of the Pearl Harbor Complex (Navy). Dependent populations are distributed throughout the area and are located principally in areas adjacent to the bases.

Specialized Needs

Military personnel, including dependents, have many special problems such as isolation from the mainstream of community life, transient status, and extended separation of active duty personnel from their families. There is some evidence to suggest that the military represent a high risk group for the problems of alcoholism, child and spouse abuse, and depression among wives.

Goals and Objectives for Service to this Group:

A. Goals:

1) Insure that State mental health services are accessible, available and acceptable to active duty personnel and their dependents.
2) Identify and treat problems associated with the military.
3) Coordination of mental health services between military and civilian mental health service sectors.

B. Objectives:

1) To expand information regarding mental health services available to the military through the COCMHC and its satellite clinics.
2) To provide a mechanism for problem identification and evaluation of treatment methods to insure appropriateness.
3) To establish a mechanism for the coordination of resources between the military and civilian resources and services.

C. Sources of Financing

The planning for the Center encompasses an 8 year span beginning on July 1, 1978 and ending June 30, 1986. The services described in section 2.10(3) as existing services will all be continued throughout the 8 year period. Of the services described as proposed, all but two are planned to continue for 8 years. The Spouse Abuse Shelter is to be supported by the project for 3 years during which time the project operations will be turned over entirely to the Shelter for Abused Spouses and Children and funding currently provided by the State in legislative appropriation will be expanded to replace the funds provided by this proposed grant. Similarly, the grant support of the Senior Day Care Center, Inc. is planned for 3 years during which time the funding will be sought from City and State agencies which have demonstrated an increasing interest in supporting this kind of service and whose plans indicate an intent to expand in these areas.

For each of the other 11 new programs proposed, funding must be located and/or services curtailed before the 8th year of the planned grant support. In the 5th year, a detailed plan for seeking and securing funding for each program, based on 4 years of evaluation of each program, will be presented in the Continuation Application. During the first 4 years, each program will be operated with attention given to activities that will enhance the search for future funding including: evaluation, community relations, the maximization of third party payment receipts, collection of fees from eligible clients, and the identification of opportunities for cost reduction in the operations of the particular programs.

A. Predicting Growth in Programs: Two forces drive patient counts upwards; growth in the population of the catchment and increases in the incidence of any one particular problem type. The demographic section (2.2) discusses the expected rapid growth of the catchment area. Population may well increase by 50% or more over the 8 year period. Accurate predictions, however, are difficult to make. Under Hawaii's strict land use and other planning laws and legal processes, growth can be somewhat controlled and limits on the growth of any one community can be established. The State is now just beginning to explore methods of restricting in-migration that will survive constitutional challenges. As out-migration more than matches natural population growth, the limiting of in-migration could stabilize population.

Certain types of mental health problems are clearly associated statistically with certain population charts, environmental conditions, etc. Should the population profile of the area grow proportionately in particular age groups (the elderly, edolescents, etc.), it will place a concomitant increase in demand on particular related services. For those mental health problems that are wholly or partially a response to environmental factors, the nature of the urban form taking place in the catchment are will cause changes in the service demand equation. It extremely dense, high-rise, urbanization becomes the norm or, alternatively, if a rural or semi-rural life-style re-emerges under controlled zoning, there are, in each specific case, implications for service types and delivery methods.

tax collections are committed to unalterable categories such as debt service and to permanent programs such as operation of the airports, the schools, the unemployment system etc. from which funds cannot be shifted to programs such as mental health.

There are, however, several factors over which the Center does have some control. The monitoring and evaluation of the new positions is designed to provide data for justifying their continuation. Through the established reporting system, the yearly determination of the effectiveness and impact of these new programs and positions will be made known the the Executive and Legislative branches.

The Center is structured in such a way, as described in sections 2.10(10) and 2.10(11) that the effect of the new programs and staff will become important to not only the Center but to a variety of other State and private agencies in the community. Additionally, the provision for an active and involved governing board, which has already demonstrated its ability to work with Executive and Legislative decision makers should increase the skill and effectiveness with which the Center can make its presentations and justifications.

Not all positions indicated in the proposed staffing chart (see 2.10(11)) need necessarily be continued for the full 8 years. Some, such as the Evaluation Specialists, may be needed intensively for the first year or two to set in place new mechanism and train staff, less intensively (reduce number of positions) during the 3rd and 4th years and possibly less beyond that. The positions will be advertised and hired as one year contracts with renewal being contingent upon continued need and continuing resources. As services work out their day-to-day operations, the opportunities to reduce workload through more efficient practices which will be identified by program managers and evaluators, will possibly yield re-programming decisions in which some positions are reduced or eliminated.

Although the specific dollar amounts to be generated from different sources cannot be specified and while particular phase out dates for personnel will not be clearly discernible until after at least 2 years of operation, it is planned to combine the securing of non-federal dollars, the spinning off of purchase of service programs and the turn-over of staff to achieve the effective transition of the proposed services to full non-federal funding by the beginning of the 9th year of operations.

Detailed budgets and the proportionate amounts of State and federal monies as well as a thorough discussion of third party payment options and client fees is contained in the Financial Plan (Form 5181) in section 3.

Against these two driving forces, one major constraining force, the resource limits of the Center, is active. Only a very small percentage, seldom approach even 10% of the estimated population at risk, are ever seen by the Center. As long as the resources available, especially in the area of case finding and public education, are enough to respond to only a fraction of the potential clients they question of responding to population growth and environmentally induced pressures will remain moot.

The factor that may have the most important effect on the expansion of services is neither population nor resources, but service delivery methods. The programs proposed are designed to be preventative, to intervene early in the patient's problem history, to maximize the therapeutic effect of other persons and environments outside the Center and its staff, and to return the client to a non-patient status as rapidly as possible. In the detailed program profiles in section 2.10(4), these philosophical tennets are implemented as program activities. For example, the provision of emergency protection services for abused spouses is predicted on the evidence that when an option other than remaining in the abuse environment is made available and accessible, women will not tolerate abuse situations and will seek to escape and preserve themselves. From the shelter, which operates on a philosophy of serving as a temporary transition and decision point between the abuse environment and a new chosen environment, most of the women move to a new, supportive and safe living situation either with relatives, with other women or in some interesting instances with other former clients of the shelter. In so doing, the women may well cut short what might have been a prolonged period of repeated abuse. It is clear that this drastically reduces the emotional and psychological damage resulting. Women coming to the shelter often need only minimal counseling whereas women forced (for lack of an alternative) to remain in an abusing environment often require intensive and lengthy therapy.

The monitoring and evaluation system proposed will provide information from which the Center director will be able, after 2 years of data collection, to make forecasts of future service demand levels. These forecasts will be used to write the Continuation Applications and to create the Center's budget requests to the division and the legislature.

For the present stage of planning, each program is costed out at a 5% rate of expansion (minus non-recurring items) over the 8 years. By the 3rd year Continuation Application, however, it is expected that detailed figures showing variable levels of increase or decrease in the levels of different programs will be available.

B. Preparation for Cessation of Federal Support: State positions are proposed to be supported by federal funds over the 8 years on the declining formula set forth in section 4. In each of its biennial budget requests to the State, the Center will request the addition of positions to its regular State authorization and the gradual transition of the support of the positions to State General Funds. The success of this strategy depends on several factors. The most obvious independent factor over which the Center can exercise no control whatsoever is the general level of State tax revenues. Like all states, the great majority of the

Most of the present sources of funding are really from one source, that being the State, which allocates to the various departments, e.g., DOH, their share of the funds, which in turn allocates funds to the various Centers. The amounts vary with staffing patterns, perceived needs, and often on legislative desire. The present Center State-funded budget can best be described as bare-bones and legislative lobbying efforts to secure additional support staff has been fortunately provided by certain board members. Other funding resources are the very meager amounts which are part of third party and direct payments. CHAMPUS has approved the Center for third party payments. Also, there is a divisional written agreement with the Department of Social Services and Housing for Medicaid reimbursement for psychiatric services. There are current provisions to have Medicaid coverage for emergency room and inpatient services and outpatient services provided by community mental health centers to substance abusers. Efforts are also being made by the division to secure Hawaii Medical Services Association reimbursement for outpatient services provided by the Center.

However, HMSA will not approve collection by the Centers until the State develops a uniform pay schedule. The exact amounts are still unclear and the Centers' involvement in these negotiations are minimal since the division is the primary negotiator with third party payers.

Reimbursement for current services consist of Medicaid, CHAMPUS, and direct patient payments. Medicaid accounts for approximately half of the total collected, CHAMPUS is next (approximately 25-30%), and the rest comes direct patient payments. While the State requires that patients pay for service whenever they can afford it, collections for service remains a sensitive issue.

Presently, third party and direct payments amount to approximately $100 a month. However, this is expected to more than double for FY 1978-79 due to a formalized rate structure which is scheduled to take effect in January of 1978.

The rate structure will be a uniform fee schedule for chargeable to all third party payers including HMSA. An accounting firm is in the process of completing the rate structure. A similar study conducted by the same firm (Ernst and Ernst) in FY 1976-77 for the State regarding Waimano Homes resulted not only in considerable increases in third party payments, but also provided the State with retroactive payments amounting to approximately $500,000. The retroactive payments for COCMHC may also be one of the results of the final report by Ernst and Ernst, but while this is a possibility, there is no way of knowing of even the range of amounts at this time. However, future increases in third party payments of $2,500-$3,000 per month, as a result of the Ernst and Ernst report is considered a conservative estimate. (See following Financial Plan Chart for details.) The increase of direct patient payments and third party payments of the combined total from $9,000 for FY 1976-77 to $11,112 for FY 1978-79 were due in large part to the encouragement on the part of

the present acting chief of COCMHC to make these collections of the direct payment whenever possible. It is expected that this trend upward will continue and further support the financial base of the COCMHC.

However, all of the above discussion must be seen in the proper perspective which include the following constraints:

1. Third party payments and direct payments combined in the past have not exceeded 5% of the total funding in any given year of Center total operations.

2. There is reason to believe that if the present State constraints continue to prevail, the 5% figure will not increase much, (See Future Funding possibilities for further explanation.) even if the State gets HMSA, Blue Shield and Blue Cross approval.

3. Even if the Center were to get 10-15% of its funding from third party and direct payments, the collection of these funds would not necessarily mean more funds for the Center since these collections would go to the State General Fund.

B. Other Sources of Funding: Other sources of funding include a very small amount of federal monies to support an alcoholic outreach worker for FY 1976-77. There is hope that funding for this worker can be continued. Also, the COCMHC has 6 CETA workers and 3 SCET workers obtained under these special federal employment assistance programs for FY 1977-78. (Note: Approximate dollar equivalent based on $580 a month for each worker or a total of $62,640 for the 12 month period for the 9 workers.) However, this assistance will only last as long as the programs remain in effect and as long as the COCMHC is seen as priority in obtaining these workers.

In Kind contributions are another source which might be counted but even these are minimal. Hale Mohalu Hospital presently has a rent free agreement with the Center for temporary occupation and use of these facilities. The State DOH has recently constructed a $7.6 million new Leeward Health Center which the COCMHC occupies an entire floor. Dollar equivalent for this new facility would surpass $6,000 a month if rented from a private source. Other in kind services include use of the Civic Center in Wahiawa and the use of two State owned cottages in Waialua where the Center only pays the electricity.

Theoretically, the Center could seek money from private foundations (with State approval at the divisional level), but this is only a remote possibility given the present constraints.

C. Future Funding Possibilities: This item is not as simple as it might appear because the State health system is in flux in this regard and State divisional policies are not always easily implemented at the Center level. While the State policy at the divisional level projects to begin collection of third party payments in every case possible, there is no real incentive for Center staff to do so. This is due in part to the fact that there is no guarantee that funds collected will be then given back to

the Center in the allocation of available resources. Funds collected go to the State General Fund and there is no present plan to change this policy in the near future. There are, however, some alternative models that are being discussed at the divisional level which the consultants will explore further in the development of the plan. One such alternative involves giving the Center and Center staff a percentage of what they collect through direct payments. Another more feasible alternative which has demonstrated some success in California is having some services provided under private auspices with an ongoing State subsidy. Such a subsidy arrangement, if worked out properly, would give the Center greater opportunities from supplementary funding sources which under the present situation are disallowed.

MPAC, Inc., as part of its plan, has explored possibilities of this alternative model with the core of services under State sponsorship and other services contracted out under private sponsorship. This would also allow the Center to seek private foundation funds, and other funds without undue constraints. Federal funds through this arrangement would be easier to obtain and would primarily be used to fill the gaps, i.e., make up the difference and supplement the ongoing programs at the Center much in the same way as other private non-profit organizations.

It should also be noted that the new rate structure discussed previously will be in place some 6 months prior to the expected operations monies from the federal government (pending grant approval). This will also provide a more stable and improved financial position for the COCMHC.

D. Planning and Development of Community Mental Health Services in Conjunction with Other Government-Supported Programs

Central Oahu Community Mental Health Center has been and will continue planning and developing services in conjunction with other government-supported programs. For example, in planning and developing children's mental health services, the Center has sponsored ongoing interagency meetings with representation from the Department of Social Services and Housing, the Leeward and Central Oahu Districts of the Department of Education, Family Court, Wahiawa and Pearl City Stations of the Honolulu Police Department, Public Health Nursing, and Head Start. Organizational meetings for the Central Oahu Community Mental Health Advisory Board were attended by representatives from Leeward Community College, the Honolulu Community Action Program, Public Health Nursing, Comprehensive Health Planning, the Honolulu Police Department, the Army and the Navy, the Department of Education, and Areawide Horizons, as well as private organizations. Plans for an alcoholism outreach program were developed with consultation from the Hawaii Committee on Alcoholism, the Alcohol Treatment Facility, the Kalihi-Palama Alcoholism Outreach Project, Blessing House, as well as members of Alcoholics Anonymous. The University of Hawaii has been involved with the Center in conducting a planning survey, in training staff, and in student practicum placements. Volunteer and training experiences for Leeward Community College students have been provided. The Center has worked jointly with the Department of Education in providing school consultation and parent training, with the Department of Health, Children's Health Services Division and the Children's Mental Health Services Branch in preschool screening and services, with the Department of Social Services and Housing and the Department of Health in program planning for care and boarding home clients and with Head Start in providing services to parents.

Appendix A gives a complete listing of the social services providing agencies in the catchment area. Many of the agencies are of course well known to the Center and its staff and the conducting of the community needs assessment has turned up many others. The picture of potential collaborating agencies which can be called upon to respond to any particular client or community problem is complete. A referral manual (appendix B) has been developed for use by each clinic.

It is proposed to establish 2 methods for increasing and improving interagency coordination. Joint Case Management will be established as a practice to be used whenever the preferred treatment for a client will involve the Center and any other agency. A Joint Case Management memorandum will be prepared by the principal therapist and the co-therapist and entered in the patient's individual treatment plan. This memorandum will state the agreed upon arrangement for providing therapeutic and other services to the client. These arrangements can be of many types: therapeutic activities can be shared; complimentary therapies can be provided at different sites (i.e., group therapy at the Center and work therapy at the co-therapy site) or the co-therapy agency may provide support services such as transporting the client to the Center for treatment, monitoring the client's behavior between sessions, etc. The Joint Case Management memorandum will include a date for review and re-agreement of not more than 6 months from the time of the original agreement. Joint Case Management therapists will have their activities as co-therapists reviewed by their peers, who will solicit the input of the co-therapist if appropriate, under the regular peer review procedures.

On a programatic level, a Council of Mental Health Co-Providers will be set up and chaired by the director. The council, to include administrative and service providing personnel from selected agencies, will be open to any agency with an interest. Agencies with major overlap of function, clients, etc., with the Center will be especially encouraged to join the council. Training, as made available through the Inservice Training Program that is regularly available to Center staff will be made available to members of the council. The council's minutes will be filed with the Advisory Board and at least one member of the Advisory Board will sit on the council. Its activities will be evaluated in the Advisory Board's evaluation of the Center.

Within the Consultation and Education program, many opportunities exist to improve interagency understanding and cooperation. The Consultation and Education program will be made known to appropriate agencies and their requests responded to on a priority basis.

For those agencies providing services to the Center's clients as a part of the Center's program, a formal contractual arrangement, discussed in section 2.10(12) on page 239 and appendix I exists.

Referral System: The Center has a well-developed system for receiving and making referrals. Within each catchment area, the community mental health center and its clinics or service delivery teams provides information to residents about available non-institutional services, alternative domiciliary resources and provides referral services to appropriate resources within and outside the Center to prevent inappropriate hospitalization.

In addition, on Oahu, the Volunteer, Information and Referral Service continues to supplement such services for those persons who seek assistance from this agency.

The conditions under which referrals are made to other community providers shall include the need for, 1) examination assessments, and consultations that are not within the domain or expertise of the staff, 2) special treatment services such as, various treatment modalities, language problems, etc., that are not available to the program, 3) the relief of any pending waiting lists, and 4) the assistance of other resources that can contribute to the client's well-being.

Each outpatient program identifies the positions/person(s) responsible for directing the referral activities of the program.

The staff or agency (whichever is more appropriate) making the transfer or referral to a non-Center program is responsible for the client until the transfer or referral is completed. A completed referral or transfer includes the following procedures:

(1) Documentation in the client's records of client's involvement, consent, and rationale for the transfer or referral.

(2) Documentation of a call or interview with the agency to whom the client is referred or transferred and an appointment date, if appropriate.

(3) Providing the agency receiving the transfer or referral with:

- (a) background information related to the transfer or referral,
- (b) treatment-related data; e.g., current treatment, diagnostic assessments, special requirements, and recommendations,
- (c) suggestions for continued coordination between the two (or more) resources,
- (d) the mechanism by which the client can be returned to the referring or transferring agency or program, if appropriate, and
- (e) an agency Transfer/Referral Form to precede or accompany the client to the agency, except for emergency room services.

(4) Documentation of a follow-up call or interview with the receiving agency or program to note the completion of the referral.

(5) Excepting for emergency room services, the referring or transferring agency shall document attempts, when possible, to contact the client who did not complete the referral or transfer (in order to re-establish the helping network).

(6) Transfer from one Center program or affiliate agency to another shall include all of the above except a consent form is not necessary.

Any person eligible for services within any one component of service shall be eligible for services within any other component of service.

Any authorized staff responsible for a client's care within one component of service can, when practicable and when not clinically contra-indicated, continue to care for that client within any of the other components of services. Such arrangements shall be documented and include: 1) justification, 2) client agreement, and 3) agreement by the service providers involved.

Clients serviced in one component of service are not subject to any unnecessary repetitive intake process involving identical data gathering information in another component of service of the transferring or receiving unit.

A client may request transfer to another component or program whether or not the program he/she is in provides that same service.

(1) Such a request shall be documented and action shall be taken if not contraindicated.

(2) Clients shall be informed periodically of alternative services available and assisted if they wish to be transferred or referred.

(a) The client shall be informed of the benefits and/or contraindications of that transfer.

(b) The transferring agency or staff shall take appropriate steps to implement the easy and immediate transfer of the client.

E. Substandard Facilities

The physical facilities of the Central Oahu Community Mental Health Center are generally appropraite to the functions and activities for which they are used. All facilities have adequate space and equipment and privacy of service delivery and are readily accessible. The new facilities in the Central Oahu Health Center, opened this year, are among the most modern in the State and provide appropriate space and equipment for the Center activities which are housed there.

F. Manpower Needs

Central Oahu Mental Health Center is fully utilizing the manpower resources available. In addition to the present positions, 21 new positions are being established in the grant application. These positions, their location in the Center, and their primary responsibilities are as follows:

Specific responsibilities area:

| Position Number | Responsible For |
|---|---|
| 9 (Acting Chief) | Director of the Center |
| 5 | Services to Children |
| 36 | Services to the Elderly |
| 6 | Consultation and Education (Alcoholism and Drug Abuse waived) |

These staff are organized by clinic location as well as by program.

Aiea Clinic

| (No.) | (Title) | (Program) |
|---|---|---|
| 1 | Psychiatrist I | Clinic head - Outpatient services |
| 7 | Clinical Psy. VI | Outpatient services |
| 15 | Reg. Prof. Nurse III | Outpatient services |
| 27 | Lic. Pract. Nurse II | Day Prog. A/PC |
| 23 | Secretary II | |

Pearl City Clinic

| (No.) | (Position) | (Program) |
|---|---|---|
| 2 | Psychiatrist II | Clinic head - Outpatient services |
| 16 | Reg. Prof. Nurse IV | Outpatient services |
| 17 | Reg. Prof. Nurse III | Outpatient/Day program |
| 28 | Lic. Prac. Nurse II | Day program |
| 33 | PMA III | Day program |
| 10 | Social Worker IV | Outpatient services |

Wahiawa Clinic

| (No.) | (Position) | (Program) |
|---|---|---|
| 18 | Reg. Prof. Nurse VI | Clinic head - Outpatient services |
| 3 | Psychiatrist I | Outpatient services |
| 11 | Social Worker IV | Outpatient services |
| 29 | Lic. Prac. Nurse II | Day program |
| 30 | Lic. Prac. Nurse II | Day program |
| 19 | Reg. Prof. Nurse III | Outpatient services/Day program |
| 31 | Lic. Prac. Nurse II | Outpatient services |
| 24 | Clerk-Steno III | |
| 8 | Clinical Psychologist VI | |

Waialua/Haleiwa Clinic

| | | |
|---|---|---|
| 4 | Psychiatrist II | Clinic head - Outpatient/Inpatient services |
| 20 | Reg. Prof. Nurse IV | Outpatient services |
| 32 | Lic. Prac. Nurse II | Day program |
| 35 | PMA III | Day program |
| 12 | Social Worker IV | Outpatient services, Inpatient services |
| 26 | Clerk-Typist II | |

Central Oahu Children's Mental Health Team

| (No.) | (Position) | (Physical Location) |
|---|---|---|
| 5 | Psychiatrist II | Team head - floating |
| 13 | Social Worker IV | Pearl City |
| 14 | Social Worker III | Aiea |
| 21 | Reg. Prof. Nurse IV | Waialua/Haleiwa |
| 25 | Clerk-Steno III | Pearl City |

Administrative Services and Technical Support Services

| (No.) | (Position) | (Program) |
|---|---|---|
| 9 | Social Worker V | Acting Chief director |
| 6 | Clinical Psychologist VI | Technical support |
| 22 | Occupational Therapist III | Technical support |
| | (clerical assistance provided by temporary staffing) | |

Proposed new staff will be assigned to programs and stationed at locations as follows:

Patient Advocate Team

| (No.) | (Position) | (Physical Location) |
|---|---|---|
| 40 | SW IV | Based at Pearl City. Work throughout the system. |
| 50 | Public Health Educator | |
| 36 | Psychiatrist II | |

Transitional Living Units

| | | |
|---|---|---|
| 45 | RPN III | Pearl City |
| 43 | SW IV | Wahiawa |
| 52 | House Manager | Pearl City |
| 53 | House Manager | Pearl City |

Learning and Skill Development

| | | |
|---|---|---|
| 46 | OT III | Wahiawa |
| 44 | RPN V | Pearl City |
| 42 | SW IV | Waialua/Haleiwa |

Senior Day Care

| | | |
|---|---|---|
| | Purchase of services | Wahiawa |

Mental Health Screening for Elderly

| | | |
|---|---|---|
| | (Same as Patient Advocate Team) | Throughout system |

Military Liaison Service

| | | |
|---|---|---|
| | (Patient Advocate Team) | Wahiawa |

Group Home for Youths

| | | |
|---|---|---|
| | Purchase of services | Pearl City |

Shelter for Abused Spouses

| | | |
|---|---|---|
| | Purchase of services | Kalihi Valley |

Adolescent Rap Center and Crash Pad

| | | |
|---|---|---|
| | Purchase of services | Waialua/Haleiwa |

Alternative Environments for Adolescent Counseling and Consultation

| (No.) | (Position) | (Physical Location) |
|---|---|---|
| 38 | Clinical Psychologist VI | Pearl City |
| 39 | Clinical Psychologist VI | Wahiawa |
| 41 | Social Worker IV | Pearl City |

Immigrant Services

| | | |
|---|---|---|
| | Purchase of services | Throughout system |

Administration

| | | |
|---|---|---|
| 37 | Clinical Psychologist VI (Evaluation Specialist) | Pearl City |
| 49 | Program Specialist: Contract Manager | Pearl City |
| 48 | Statistical Clerk | Pearl City |
| 51 | Clerk-Steno III | Pearl City |
| 47 | Accountant III | Pearl City |

# TABLE II

FIRST 12 MONTH GRANT PERIOD - ALL SERVICES

| (a) | PERSONNEL | | | SERVICES IN WHICH INDIVIDUAL WILL PARTICIPATE | | | | | | (g) | (h) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | (b) | (c) | | (d) | Check One | | (e) | (f) PREVIOUSLY PERFORMING THIS SERVICE | | | |
| POSITION NUMBER | POSITION TITLE EXISTING | Check One Full Time | Part Time | NAME OF SERVICE OR SERVICES | Old | New | PERCENT OF TIME SPENT IN 40 HOUR WORK WEEK EACH SERVICE | Yes | No | ANNUAL SALARY Current 8/1977 | QUALIFICATIONS FOR ACTUAL OR PROPOSED POSITION |
| 1 | Psychiatrist I | X | | Acting Chief, Aiea Clinic Outpatient | X | | 100 | X | | 33,514 | |
| 2 | Psychiatrist II | X | | Chief Pearl City, Outpatient services | X | | 100 | X | | 34,366 | |
| 3 | Psychiatrist I | X | | Outpatient services, Wahiawa | X | | 100 | X | | 30,492 | |
| 4 | Psychiatrist II | X | | Chief W/H clinic, Outpatient, Inpatient | X | | 75-25 | X | | 34,366 | |
| 5 | Psychiatrist II | X | | Chief Children's Team, Outpatient | X | | 50, 50 | X | | 34,366 | |
| 6 | Psychologist VI | X | | Technical Support Services C & E | X | | 100 | X | | 21,564 | |
| 7 | Psychologist VI (Vacant) | X | | Center director | | | | | | | |
| 8 | Psychologist VI | X | | Children's Team, Outpatient C & E | X | | 75, 25 | X | | 21,564 | |
| 9 | Social Worker V | X | | Acting Center Chief | X | | 100 | X | | 16,308 | |
| 10 | Social Worker IV | X | | Outpatient services, PC | X | | 100 | X | | 14,196 | |
| 11 | Social Worker IV | X | | Outpatient services, Wahiawa | X | | 100 | X | | 17,038 | |
| 12 | Social Worker IV | X | | Outpatient services, Inpatient, H/W | X | | 75, 25 | X | | 14,856 | |
| 13 | Social Worker IV | X | | Children's Team, Outpatient, PC | X | | 75, 25 | X | | 17,892 | |
| 14 | Social Worker III | X | | Children's Team, Outpatient, Aiea C & E | X | | 75, 25 | X | | 12,934 | |
| 15 | RPN III | X | | Outpatient, Aiea | X | | 100 | X | | 14,940 | |
| 16 | RPN IV | X | | Outpatient, PC | X | | 50, 50 | X | | 17,928 | |
| 17 | RPN III | X | | Day program | X | | 100 | X | | 13,368 | |
| 18 | RPN IV | X | | Chief, Wahiawa, Outpatient | X | | 100 | X | | 18,756 | |
| 19 | RPN III | X | | Outpatient/Day program, Wahiawa | X | | 50, 50 | X | | 17,136 | |
| 20 | RPN IV | X | | Outpatient, H/W | X | | 100 | X | | 17,136 | |
| 21 | RPN IV | X | | Children's Team, Outpatient C & E | X | | 75-25 | X | | 17,136 | |

Specific Instructions: Col. (a) Assign a number to each position and enter it in this column. Col. (b) Present [illegible]

FIRST 12 MONTH GRANT PERIOD - ALL SERVICES

| (a) | PERSONNEL | | | SERVICES IN WHICH INDIVIDUAL WILL PARTICIPATE | | | | | (g) | (h) |
|---|---|---|---|---|---|---|---|---|---|---|
| | (b) | (c) | | (d) | | | (e) | (f) | | |
| POSITION NUMBER | POSITION TITLE<br>EXISTING | Check One<br>Full Time | Part Time | NAME OF SERVICE OR SERVICES | Check One<br>Old | New | PERCENT OF TIME SPENT IN 40 HOUR WORK WEEK EACH SERVICE | PREVIOUSLY PERFORMING THIS SERVICE<br>Yes | No | ANNUAL SALARY | QUALIFICATIONS FOR ACTUAL OR PROPOSED POSITION |
| 22 | OT III | X | | Day programs, all | X | | 100 | X | | 12,444 | |
| 23 | Secretary II | X | | Aiea Clinic | X | | 100 | X | | 12,994 | |
| 24 | Clerk-Steno III | X | | Wahiawa Clinic | X | | 100 | X | | 12,444 | |
| 25 | Clerk-Steno III | X | | Children's Team | X | | 100 | X | | 12,444 | |
| 26 | Clerk-Typist | X | | W/H Clinic | X | | 100 | X | | 8,532 | |
| 27 | Lic. Prac. Nurse III | X | | Day program, A/PC | X | | 100 | X | | 12,060 | |
| 28 | Lic. Prac. Nurse II | X | | Day program, A/PC | X | | 100 | X | | 13,040 | |
| 29 | Lic. Prac. Nurse II | X | | Day program, Wahiawa | X | | 100 | X | | 13,040 | |
| 30 | Lic. Prac. Nurse II | X | | Day program, Wahiawa | X | | 100 | X | | 13,040 | |
| 31 | Lic. Prac. Nurse II | X | | Outpatient, Wahiawa | X | | 100 | X | | 11,173 | |
| 32 | Lic. Prac. Nurse II | X | | Day program, W/H | X | | 100 | X | | 13,040 | |
| 33 | PMA III | X | | Day program, A/PC | X | | 100 | X | | 12,060 | |
| 34 | PMA III | X | | Day program, Wahiawa | X | | 100 | X | | 11,460 | |
| 35 | PMA III | X | | Day program, H/W, In-patient | X | | 50-50 | X | | 12,060 | |
| | PROPOSED | | | | | | | | | (1978-1979 estimates) | |
| 36 | Psychiatrist II | X | | Patient Advocate Team | | X | 100 | | | 36,085 | |
| 37 | Clinical Psychol VI | X | | Evaluation Specialist | | X | 100 | | | 20,580 | |
| 38 | Clinical Psychol VI | X | | AECACS-Children-PC | | X | 100 | | | 20,580 | |
| 39 | Clinical Psychol VI | X | | AECACS-Children-Wahiawa | | X | 100 | | | 20,530 | |
| 40 | Social Worker IV | X | | Patient Advocate Team | | X | 100 | | | 16,308 | |
| 41 | Social Worker IV | X | | AECACS-Children's Team | | X | 100 | | | 16,308 | |
| 42 | Social Worker IV | X | | Learning and Skill Development | | X | 100 | | | 16,308 | |
| 43 | Social Worker IV | X | | TLU | | X | 100 | | | 16,308 | |
| 44 | Reg. Prof. Nurse V (clinical nurse spec.) | X | | Learning and Skill Development | | X | 100 | | | 18,736 | |
| 45 | Reg. Prof. Nurse III | X | | TLU | | X | 100 | | | 14,292 | |
| 46 | OT III | X | | Learning and Skill Development | | X | 100 | | | 14,196 | |
| 47 | Accountant III | X | | Administration | | X | 100 | | | 14,196 | |
| 48 | Statistical Clerk | X | | Administration | | X | 100 | | | 10,056 | |
| 49 | Public Health Admin Officer IV | X | | Administration | | X | 100 | | | 16,308 | |
| | | | | | | | | | | | |

Specific Instructions: Col. (a) Assign a number to each position and enter it in this column [illegible]

FIRST 12 MONTH GRANT PERIOD - ALL SERVICES

| (a) | PERSONNEL | | | SERVICES IN WHICH INDIVIDUAL WILL PARTICIPATE | | | | | (g) | (h) |
|---|---|---|---|---|---|---|---|---|---|---|
| | (b) | (c) | | (d) | | | (e) | (f) | | |
| POSITION NUMBER | POSITION TITLE | Check One | | NAME OF SERVICE OR SERVICES | Check One | | PERCENT OF TIME SPENT IN 40 HOUR WORK WEEK EACH SERVICE | PREVIOUSLY PERFORMING THIS SERVICE | ANNUAL SALARY | QUALIFICATIONS FOR ACTUAL OR PROPOSED POSITION |
| | | Full Time | Part Time | | Old | New | | Yes / No | | |
| 50 | Public Health Educator IV | X | | Patient Advocate | | X | 100 | | 16,303 | |
| 51 | Clerk-Steno III | X | | Administration | | X | 100 | | 10,483 | |
| 52 | House Manager | X | | TLU-Halfway House | | X | 100 | | 10,183 | |
| 53 | House Manager | X | | TLU-Halfway House | | X | 100 | | 10,183 | |

Specific Instructions: Col. (a) Assign a number to

The proportion of full-time equivalent staff engaged in direct services in relation to those engaged in administrative and clerical services is:

42 FTE Direct Service

9 FTE Administrative and Clerical

or a ratio of 20%.

G. Program Plans

For the past year the Central Oahu Community Mental Health Center has been conducting a complete needs assessment and planning cycle of which this plan, and the companion application for an initial operations grant, are a result. The planning process, described in detail in the Needs Assessment Report and in the Application for a Grant, has concluded that 14 new programs need to be developed to adequately address catchment area needs. For each of these a Program Profile follows. The Profiles provide:

I. Brief Description of the Service

II. Mental Health Needs Addressed

III. Goals and Objectives

IV. Target Population

V. Staffing Requirements

VI. Costs (detailed budget follows VII)

VII. Center Priority

VIII. Evaluation Plan

The 14 services and programs are integrated with the existing Center operations and the plan demonstrates the operation of the entire range of services as a system of treatment. Special attention has been given to matters of intake and referral, inter-program information exchange, community agency and Center linkages, and evaluation both by case and by program to insure coordinated service delivery.

The Center proposes to improve five existing service areas (Transitional Living, Partial Hospitalization, Services to the Elderly, Services to Children and Follow-up Care) and to establish four new services (Transportation, Services to the Military, Spouse-Abuse Shelter, and Services to Immigrants).

The Center proposes to improve community relations, understanding of the community and its problems by the Center and its staff, community input to programs and operations and community control of appropriate Center decisions and activities through the creation of new governance mechanisms and the provision of training and staff for the community board members as well as the addition to the Director's staff, a specialist with responsibility for community input.

The Center proposes to improve patient referral, tracking and follow-up through the establishment of improved record keeping systems, the monitoring by Center and lay committees of patient movement records, peer review of treatment plans and the monitoring, again by committees which include non-staff members, of patient follow-up including patient satisfaction indicators.

The Center proposes to improve staff capabilities and sensitivities through staff development activities including training and education.

The Center proposes to improve evaluation of services by establishing an evaluation design and procedures and by staffing this system with an evaluation specialist.

The Center proposes to respond to the assessed mental health needs of the community (as developed through extensive survey and other community input activities) with appropriate, well designed, manageable and carefully evaluated direct services and the necessary support services. Further, it is proposed to monitor the initial year's operations and to re-program to the degree necessary for the second and subsequent years.

To accomplish this, the Center is proposing 13 specific programs as outlined in the Program Profiles which follow. Each profile gives, for each program:

1. Treatment Philosophy and Service Description
2. Goals, Objectives and Criteria for Attainment
3. Staff (existing and new) for each program
4. Co-Ordination with affiliates and other agencies
5. Service Location
6. Expected Caseload

Analysis of special populations (children, elderly, immigrants, military) are provided in Special Population Profiles.

Existing and proposed staff are summarized on Table II and the dollar amount allocated to services to Children, to the Elderly and for Consultation and Education are given in the Financial Plan.

In addition to the Goals and Objectives stated in each Program Profile and overall Evaluation Plan is discussed in section 2.10(6) beginning on page 152.

The Center proposes an Inservice Training plan geared to the 13 Program Profiles and the skills needed to achieve excellence in the delivery of these services.

The administration of the Center and the role of the Governing Board are proposed as the necessary managerial and policy support needed to implement the proposed services. Where individual elements of service are provided by contract, copies of the contracts are included in section 2.10(11).

Plans for implementing assurances A,D,E,M and for meeting the other requirements of the law are proposed.

A long-range plan for program expansion, including estimates of increased costs and the financial support for proposed services where federal funding is reduced, is proposed and is elaborated in the financial plan on page 248.

## PRIORITIES AND TIMEFRAME

The setting of service priorities has been difficult due to the necessity of certain system-wide services that are of a support nature but which do not impact identifiably directly on any individual client. These services, such as evaluation or the simple provision of clerical support, are absolutely necessary to the functioning of the Center and any of the direct service programs but seldom receive high priority "ratings" by community groups, client advocates and others involved in setting priorities. It must be stated at the outset that while not a higher priority than any particular service, these general administrative services are a *sin qua non* for any of the prioritized services.

Among the various services, it has also been sometimes difficult to clearly identify priorities on which there could be some broad concensus. Practitioners, of course, tend to see their own discipline or service as a priority. Former and present clients and their families can be forgiven for having a built-in self-interest in seeing the service that they or their kin are receiving or have benefited from as the priority service. Community advocate groups for various special causes and interests (i.e., immigrants, youth, abused spouses) lobby hard to have the service that addresses their problem or population group declared a high priority.

In addition to all of these inputs and the overall community priorities indicated in the survey (see appendix D), the plan also includes managerial and structural considerations in establishing priorities. For example, while emergency services may not be a high priority with any client group or community interest group, it must be established early in a program simply because the consequences (both to the patient and to the Center) of not being able to respond to an emergency would be so drastic.

The "first priority" services are the existing basic community mental health services. Specifically:

Inpatient

Outpatient

Partial Treatment

Emergency

Transitional Intermediate Care

Follow-up

Screening for Early Identification

Consultation and Education

Services to Children

Services to the Elderly

Among the proposed improvements to service programs and new service programs, the priorities established by the planning team after consultation with the staff, the Governing Board and members of the community are:

1. Alternative Environment Counseling and Consultation Services for Children.
2. Transitional Living Units
3. Senior Day Care
4. Patient Advocate Follow-up Team
5. Shelter for Abused Spouses and Children
6. Group Homes for Youth
7. Rap Center/Crash Place
8. Learning and Skill Development Program
9. Immigrant Services Program
10. Transportation Assistance Services
11. Military Liaison Services
12. Mental Health Screening for the Elderly
13. Emergency Services Program

Services will be phased in over the first year of operations. The tentative timetable for the implementation of each service is:

IMPLEMENTATION SCHEDULE

| Program | Starts | Ends | Source of Alternative Funding Following Grant |
|---|---|---|---|
| 1. Admin | January 1979 | Continuous | State |
| 2. AECAS | January 1979 | Continuous | State |
| 3. TLUs (halfway house, 2 group homes | January 1979 | Continuous | State and 3rd Party, Client Payment |
| 4. SDC | January 1979 | Continuous | Client Payment Community Donations 3rd Party |
| 5. PAFT | January 1979 | Continuous | State |
| 6. Shelter | May 1979 | Continuous | State, Fed., Private |
| 7. GHY | May 1979 | Continuous | 3rd Party, State |
| 8. Rap Center/CP | May 1979 | Continuous | State |
| 9. LASD | May 1979 | Continuous | State |
| 10. ISP | September 1979 | Continuous | State |
| 11. TAS | September 1979 | Continuous | State |
| 12. MLS | September 1979 | Continuous | State |
| 13. MHSFE | September 1979 | Continuous | State |
| 14. ESP | September 1979 | Continuous | State |

Program Profiles of Proposed Programs

For each proposed new program, a Program Profile is presented. The proposed new programs are:

1. Alternative Environment Counseling and Consultation Services for Children
2. Transitional Living Units
3. Central Oahu Senior Day Care Center
4. Patient Advocate/Follow-up Team
5. Shelter for Abused Spouse and Children
6. Group Homes for Youth
7. Adolescent Rap Center/Crash Pad
8. Learning and Skill Development Program
9. Immigrant Services Program
10. Transportation Assistance Services
11. Military Liaison Services
12. Mental Health Screening for the Elderly
13. Emergency Services
14. Administrative Services

I. Title and Brief Description of Service

A. Title: Alternative Environment Counseling and Consultation Services for Children

B. Brief Description of Services:

1) Explore and utilize alternative environments other than the formal clinic environment in the treatment of children's problems. This has been recognized by the community as a major area of need. Such environments may include at home counseling involving both parents and children, in school activities such as rap groups or individual counseling, trips, or activities such as camping or field trips or counseling or outreach work at adolescent "hang outs".

2) Supplement clinic staff responsible for treatment of children. Increasing caseloads have made difficult the timely and appropriate treatment of children's problems, particularly at the Wahiawa and Pearl City clinics. With the rapidly increasing population of the central area, these difficulties can reasonably be expected to increase.

3) Expand consultation and coordination with other public service agencies serving children.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Increased availability of children's services.
2) Increased accessibility of children's services.
3) Comprehensiveness of children's services.
4) Interagency cooperation.

III. Goals and Objectives

A. Goals: To insure timely and appropriate treatment to children in environments which are compatible to their needs and conducive to more holistic treatment.

B. Objectives:

1) To utilize alternative environments in the treatment of children.

2) To insure timely and appropriate responses to children's services.

3) To involve various elements of the community in the treatment of children.

4) To accommodate the growing need for children's services within the area.

IV. Target Population

Children and adolescents.

V. Staff

A. Clinical Psychologists VI - 2 to be stationed at the Wahiawa and Pearl City clinics respectively.

60% consultation and education
40% case work or case finding

B. SW IV - to be utilized as a part of the children's team.

60% consultation and education
40% case work or case finding

VI. Costs

Recurring - 77,108
Nonrecurring - 1,825 Total - 78,933

VII. Priority: 1

A. Alternatives considered: No change - retain existing program as is.

B. Analysis of alternatives: Increasing caseloads and community recognition of increasing need for greater C & E and utilization of alternative environments make additional children's staffing a necessity.

| Category | Assigned to Project | | Assumed by Agency | |
|---|---|---|---|---|
| I. STAFF COSTS: | | | | |
| A. Clinical Psychologist VI (2) | 49,640 | | | |
| B. SW IV (1) | 19,668 | | | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent) | | | | |
| B. Equipment (3 desks @ 300 = 900; 2 bookcases, @ 100 = 200; cabinet, 125; 3 chairs @ 150 = 450; 3 int. chairs @ 50 = 150) | | 1,825 | | |
| C. Utilities | | | | |
| D. Supplies | 400 | | | |
| E. Travel (mileage) | 2,700 | | | |
| F. Communications (tel.) | 400 | | | |
| G. Training | 300 | | | |
| H. Activities (field trips, picnics, camping, etc.) | 3,000 | | | |
| I. Other Costs (educational supplies & materials) | 1,000 | | | |
| III. LOCATION: Wahiawa, PC and Children's Team | | | | |
| IV. PROBABLE CASELOAD: 200 - direct service increased consultation - 50% | | | | |
| V. LENGTH OF STAY: N/A | | | | |
| VI. TOTAL COST: | $77,108 | $1,825 | | |
| | $78,933 | | | |

VIII. Evaluation

| Objectives: | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| 1. To increase the utilization of environments other than the clinic in the treatment of children. | 1) Decrease of clinic caseload for crisis, remotivational and support care.*** | Sig | | 1) Utilization Record |
| | 2) Level of consumer satisfaction. | | | 2) Survey of Consumer/Family Satisfaction |
| 2. To insure timely and appropriate responses to children's services needs by providing adequate staffing to minimize waiting times and inconvenience. | 1) Staff-consumer ratio. | ? | | 1) Staffing Needs Assessment Data |
| 3. To accommodate the growing need for children's services in the catchment area. | 1) Congruence between needs identified & services provided. | Yes | | 1) Comparison of Needs Assessment Data and Service Plans/Objectives |
| | 2) Level of satisfaction with services. | VH | | 2) Survey of Consumer/Family Satisfaction |
| 4. To provide for greater numbers of consultation with the persons servicing or concerned with children. | 1) Increase in use of consultation services. | Sig | | 1) Utilization Record Before-After comparison |
| 5. In order to insure accountability, the Alternative Environment Counseling and Consultation Services for Children shall report annually regarding its activities to the Central Oahu governing board and be subject to review and evaluation by the COCMHC. | 1) Submittal of report to the board. | Yes | | 1) Board Record |
| | 2) Acceptance of report as satisfactory by board. | Yes | | 1) Board Record |

***Based on the principle that admission into the system shall be based on the determination of the disability and the inability of the folk support system to deal with the disability.

*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Brief Description of Service

A. Title: Transitional Living Units

B. Background: One of the goals of mental health services is to assist clients in achieving their potential by developing the capacity to live as independently as possible, requiring the minimum support of others. The COCMHC presently has no capability to provide temporary transitional residential treatment services other than through assistance to boarding and care homes in the area or by placing patients in transitional environments operated by other clinics or private agencies.

The Center has identified a number of patients who are currently residents of boarding or care homes or with their families who are considered to be capable of functioning more independently and who would benefit from a transitional living arrangement. For many such patients, custodial care is not necessary or may even be counter-productive.

C. Brief Description of Service: The Center will develop two independent group homes and a halfway house.

1) Independent group homes will be non-medical, residential facilities which provide room, board, supervised living, and other supportive or rehabilitative services to people with mental health problems and which facilitates needed treatment and rehabilitation services provided by mental health staff and other relevant community agencies.

The homes will be relatively unstructured, supportive environments which foster self-responsibility and growth in dealing with problems of daily living in the community through cooperative group living experiences. Such experiences may include: meal planning; shopping; preparations; household chores; budgeting; independency in self-care skills; use of leisure time; continued community familiarization; and participation in group meetings for management of daily living problems. Training and assistance in the development of the skills necessary to carry out the above mentioned program will be provided by the staff who oversee and supervise the home.

Staff will provide continuous monitoring of each patient's progress, prepare detailed objectives by which progress will be evaluated and serve as a link to Center and other community services which the patient may require.

2) A halfway house will provide temporary residential aftercare and rehabilitation services as an alternative to hospitalization and support and assist in the reintegration of clients into the community and eventually to independent living and their resumption of a useful, meaningful and productive life. 24 hour staff support will be provided by house managers and COCMHC staff will provide all necessary mental health services which patients may require.

II. Mental Health Needs Address

Mental health needs addressed include:

1) Comprehensiveness of service.
2) Reintegration and community involvement.
3) Continuity of service.
4) Individual treatment.
5) Interagency cooperation.
6) Alternatives to hospitalization.

III. Goals and Objectives

A. Goals: To provide a residential environment for adults which will facilitate the development of independent living skills among released mental patients and boarding and care home residents and serve as a transition for reintegration into the community.

B. Objectives:

1) To prevent inappropriate placement of released mental health patients or care and boarding home residents capable of supervised group living.
2) To provide group membership and peer support as a part of the reintegration process.
3) To equip patients with the practical skills necessary for independent living.
4) To provide continuous monitoring and staff supports to patients.
5) To balance the necessity of supervision, training and reassurance with the gradual assumption of responsibilities necessary for independent living and total reintegration.
6) To provide linkages with other supportive services provided by the Center and other community agencies.

IV. Target Population

A. Released patients.

B. Boarding and care home residents.

V. Staff

A. 2 house managers for halfway house.

B. RN III - develop and implement programs and monitor and control drug administration.

C. SW IV - develop and apply program, serve as community family liaison.

D. Professional staff will also assist day programs in the development and application of necessary programs.

VI. Costs

Recurring - 110,610
Nonrecurring - 9,000

Total - 119,610
(Total to be offset by 3rd party reimbursements)

VII. Priority: 2

A. Alternatives considered:

1) Leave clients in current residential arrangements.
2) Transfer client to transitional living units operated by another Mental Health Center or private resources.
3) Place clients requiring brief residential placement in hospitals.

B. Analysis of alternatives:

1) Leaving clients in care and boarding homes, when they do not need the level of care and supervision provided by the operators of these homes, is obviously paying for more than necessary, therefore, a waste of money and placement resource.

Leaving clients with their families denies them the opportunity to learn how to develop a more independent pattern of living, producing more severe problems within the family as the parents or other relatives grow older.

2) For the past several years, clients residing in the Central Oahu area who required placement in transitional living units have been provided such services by placement in such units which are operated by either the Mental Health Association or the Diamond Head Mental Health Services Branch. However, as the need for this type of service continues to increase, the capacity of the units referred to above will be exceeded.

In addition, these units operated by either the Mental Health Association or Diamond Head Mental Health Services Branch do not offer the services of providing brief placement and support for clients involved in crisis situation.

3) Placing clients who are involved in crisis situations requiring brief residential placement and mental health staff support in hospital settings is an inappropriate use of hospitalization. In some instances, however, hospitalization is used as a last resort simply because there are no suitable alternative community resources available. The transitional living unit helps fill this need.

| | | | | |
|---|---|---|---|---|
| I. STAFF COSTS: | | | | |
| A. House Manager (2) | 24,574 | | | |
| B. RPN III | 17,236 | | | |
| C. SW IV | 19,668 | | | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent): Halfway House @ 600 2 Group Homes @ 1,200 | 21,600 | | | |
| B. Equipment (building improvement and staff equipment) | | 9,000 | | |
| C. Utilities (water, elec, gas) | 5,664 | | | |
| D. Supplies (food-$4/day at 80% occupancy; household supplies, $720) | 17,116 | | | |
| E. Travel (mileage) | 3,000 | | | |
| F. Communications (tel.) | 1,152 | | | |
| G. Training | 300 | | | |
| H. Activities-N/A | | | | |
| I. Other Costs (office supplies, $300) | 300 | | | |
| III. LOCATION: Halfway house PC; Group Homes, PC and Wahiawa | | | | |
| IV. PROBABLE CASELOAD: Halfway house @ 30 days stay = 61 patients/year; Group homes @ 9 month stay = 11 patients/year. | | | | |
| V. LENGTH OF STAY: Halfway house = 30 days average; Group home = 9 month average. | | | | |
| VI. TOTAL COST: | $110,610 | $9,000 | | |
| | $119,610 | | | |

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>1. In order to insure & facilitate appropriate utilization of the group homes services, the COCMHC shall, with the approval of the governing board through the Community Advocacy Team | 1) % of Independent Group Homes listed in the COCMHC "Service Directory". | 100% | | 1) Analysis of data in "Service Directory" |
| | 2) Completion of Pilot-Testing Before Implem. | Yes | - | 2) Analysis of "Calendar of Developmental Activities" |
| | 3) Level of success of public education to enhance visibility of homes. | VH | | 3) a. Pilot-Test assessment by Evaluation Audit Team<br>b. Post-implementation period evaluation on Before-After comparison of Consumer/Public Knowledge of services. |
| a. develop, test and implement informational and educational services to potential clients and referral sources to enhance visibility of the services within the first year; | 1) Presence of criteria for screening, etc. | Yes | - | 1) Analysis of CAT Status Report to the Board |
| | 2) Completion of pilot-test before implementation. | Yes | - | 2) Analysis of Calendar of Developmental Activities |
| b. develop, test and implement criteria for the screening, placement, discharge and readmission to the group home within the first year; | 3) % of Planning-Linking conferences applying the criteria. | 100% | | 3) Analysis of "Service Record" |
| c. require, on an annual basis, each group home in the catchment area to provide a description of the medical, psychiatric, supportive, and rehabilitative/habilitative services to be made available to residents in the group homes. | % of group homes in CO with a clear description of the said characteristics lodged with the COCMHC. | 100% | | Analysis of the data in the "Servic Directory" |

*Op - Optimum
**Acc - Acceptable
[illegible] - Significant

VIII. Evaluation (continued)

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives: | | | | |
| 2. In order to equip patients with practical skills necessary for independent living and those needed for reintegration into the community, the COCMHC shall, on an on-going basis | 1) % of group homes which submitted the said written specification to the Board. | 100% | | 1) a. Availability of "Procedures Manual"<br>b. Analysis of Board Records |
| | 2) % of group home specifications approved by the Board. | 100% | | 2) Analysis of Board Records |
| a. prepare written specifications of methods by which the residents' needs will be met by the group home staff, Center and/or clinic staff, other community resources, annually; | 1) % of consumers with designated staff facilitation upon admission. | 100% | | 1) Analysis of "Service Record" |
| | 2) % of consumers placed in error in a group home. | 0% | | 2) Analysis of "Service Record" |
| b. assign a specific staff person to facilitate the clients obtaining needed services on a timely basis and for ensuring liaison and coordination of services upon admission of consumer to the group home. | 3) % of linkages carried out by assigned staff. | 100% | | 3) Analysis of "Service Record" |
| 3. In order to insure quality of care, the COCMHC, through the Patient Advocate, within the first six months of operation | 1) Presence of a program to monitor the quality of group home care. | Yes | | 1) Analysis of Patient Advocate Status Report to the Board |
| a. develop a program to monitor the quality of group home progress. | 2) Approval of program by the Board. | Yes | | 2) Analysis of Board meeting minutes |
| | 3) Level of satisfaction with care. | VH | | 3) Survey of Consumer Satisfaction |
| 4. In order to insure accountability, the Independent Group Homes shall report annually regarding its activities to the Central Oahu governing board and be subject to review and evaluation by the COCMHC. | 1) % of group homes which submitted annual report to the Board. | 100% | | 1) Analysis of Board Records |
| | 2) % of reports returned by the Board as unsatisfactory. | 0% | | 2) Analysis of Board Records |

*Op - Optimum
**Acc - Acceptable

I. Title and Brief Description

A. Title: Central Oahu Senior Day Care Center

B. Background: There are currently no senior day care programs in the Central Oahu catchment area and only 3 such centers on Oahu. In hopes of filling this gap in services, a number of concerned citizens have initiated planning efforts toward the development of such a program in Wahiawa. The COCMHC has provided technical assistance to these efforts and supports the development of such a program.

Despite the general satisfaction expressed by the elderly in recent needs assessment surveys and the relatively large number of recreational programs available to the elderly in the area, there exists a demonstrable need for a protective environment to service those elderly who are either incapacitated or who cannot otherwise effectively utilize existing services.

C. Brief Description of Service: Services at the day care center would include providing a protective environment, personal care and supervision and opportunities for social/psychological stimulation to retard the processes of physical and mental deterioration. Specific services include:

1) day supervision for those who, if not for day care, would be placed in care, nursing, or boarding homes;
2) individualized services to elderly released from inpatient facilities who are in need of outpatient services and continuity of care;
3) rehabilitative services to elderly who can attain a more independent level of functioning and subsequently be referred to existing senior citizen programs;
4) recreational and social activities for disabled or isolated elderly including residents of boarding homes who are capable of benefiting from such activities;
5) provide linkages to other existing elderly services;
6) individualized needs assessment and service delivery;

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Continuity of service inpatient transition.
2) Individualization of services.
3) Comprehensiveness of service.
4) Alternatives to institutionalization.

III, Goals and Objectives

A. Goals:

1) Prevent or postpone institutionalization of the elderly by providing a protective and therapeutic day environment and encouraging the maintenance of the family as a unit.
2) Insure continuity and integration of the range of services available to the elderly within the community.
3) Provide a recreational and therapeutic environment for elderly not otherwise equipped or able to effectively utilize existing community resources.

B. Objectives:

1) To provide a supportive and protective environment for elderly who cannot participate or benefit from existing programs.
2) To provide new opportunities for social and intellectual interaction for elderly who are physically or emotionally isolated or disabled.
3) To provide transitional rehabilitative services to elderly for active participation in other programs and environments.
4) To provide new opportunities for meaningful and productive activities.

IV. Target Group

Elderly.

V. Staff

Staff requirements have been developed by Central Oahu Senior Day Care Inc. with the technical assistance of COCMHC. They were based upon the staffing of similar existing programs and the opinions of numerous professionals within the field.

1) RN with psychiatric experience - 1
2) Psychiatric SW - ½
3) OT - ½
4) Nurses Aide - 1
5) PMA - 2

VI. Cost

$106,549

VII. Priority: 3

A. Alternatives considered:

1) Utilize existing services.
2) COCMHC independent establishment of senior day center.
3) Leave clients in current settings or have them placed in boarding or care homes.

B. Analysis of alternatives:

1) Only 3 such centers on Oahu, none in catchment area, existing centers fully utilized.

2) Existence community based organization would be both more cost effective and lead to greater community acceptance and utilization.

3) Leaving clients in their current environment or placing them in care homes deprives them of the opportunity to fully develop their potentials.

| | | | | |
|---|---|---|---|---|
| I. STAFF COSTS: | | | | |
| A. RN (1) | | | 17,878 | |
| B. Psychiatric SW (½) | | | 8,268 | |
| C. Occupational Therapist (½) | | | 7,516 | |
| D. Nurses Aide (1) | | | 9,020 | |
| E. Para-Medical Assistant (2) | | | 15,042 | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent & Renovation) | | | | 6,500 |
| B. Equipment (see following) | | | | 12,200 |
| C. Utilities | | | 7,500 | |
| D. Supplies (see following) | | | 9,120 | 5,525 |
| E. Travel | | | 2,400 | |
| F. Communications | | | 360 | |
| G. Training | | | 1,020 | |
| H. Activities | | | 1,800 | |
| I. Other Costs (see following) | | | 2,400 | |
| III. LOCATION: Wahiawa | | | | |
| IV. PROBABLE CASELOAD: 30 at any one time. | | | | |
| V. LENGTH OF STAY: | | | | |
| VI. TOTAL COST: | | | $82,324 | $24,225 |
| | | | $106,549 | |

B. Equipment:

| | | |
|---|---|---|
| 1. | 40 chairs @ 100 | $4,000 |
| 2. | 1 wheelchair | 350 |
| 3. | 6 folding tables @ 200 | 1,200 |
| 4. | 15 cots @ 100 | 1,500 |
| 5. | 1 desk and chair | 500 |
| 6. | 1 typewriter | 800 |
| 7. | 1 filing cabinet | 225 |
| 8. | Mimeograph machine and supplies | 400 |
| 9. | Dishwasher | 800 |
| 10. | Phonograph | 350 |
| 11. | 2 TVs @ 550 | 1,100 |
| 12. | Projector and screen | 975 |
| | Total | $12,200 |

D. Supplies:

| | | |
|---|---|---|
| 1. | Educational, kitchen, medical, etc | $5,000 - NR |
| 2. | Office | 1,200 - R |
| 3. | Food | 7,920 - R |
| 4. | Linen | 525 - NR |
| | | $9,120 - R |
| | Totals | $5,525 - NR |

1. Other Costs:

| | | |
|---|---|---|
| 1. | Fee for Service Secretary @ 100/mo. | $1,200 |
| 2. | Sanitorial services @ 100/mo. | 1,200 |
| | Total | $2,400 |

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>1. Within three months, the Central Oahu Senior Day Care Center shall develop coordinative linkages between itself and existing agencies serving senior citizens within the catchment area in order to insure: | % of referral with complete | 100% | | Analysis of Service Record |
| a. adequate and appropriate referral mechanisms, and<br>b. knowledge, availability and usage of appropriate support services. | 1) Increase of DC staff knowledge and usage of support services.<br>2) Error in usage. | Sig<br>0% | | 1) Before-After comparison of knowledge and usage<br>2) Utilization Record |
| 2. In order to insure appropriate screening and individualized services, the Central Oahu Senior Day Care Center shall, within 3 months, develop and begin implementation of the findings of a comprehensive screening program for its clients which identify: | | | | |
| a. social training necessary to enhance interpersonal skills;<br>b. task and skill training necessary to enhance non-employment related instrumental skills;<br>c. home training necessary to enhance interpersonal; and<br>d. other forms of training or therapy necessary to retard deterioration or enhance independence or reintegration. | 1) % consumers with Service Records that include identification of a through d.<br>2) Level of consumer/family satisfaction with screening.<br>3) % of skills achieved. | 100%<br>VH | | 1) Service Record<br>2) Survey of Consumer Satisfacti<br>3) Service Record |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

VIII. Evaluation (continued)

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Informatio |
|---|---|---|---|---|
| Objectives:<br>3. Within six months, the Central Oahu Senior Day Care Center shall develop and begin implementation of a plan to provide the services required by its clients, the components of which shall include:<br><br>a. staff utilization;<br>b. community linkages;<br>c. programs and implementation schedules; and<br>d. evaluation. | 1) Completion of the plan for a-d.<br>2) Level of consumer satisfaction with a-d services. | Yes<br>FH | | 1) Status Report to the Board<br>2) Survey of Consumer Satisfactic |
| 4. In order to insure accountability, the Central Oahu Senior Day Care Center shall report annually regarding its activities to the Central Oahu governing board and be subject to review and evaluation by the COCMHC. | 1) Completion and submission of report.<br>2) Acceptance of Report. | Yes<br>Yes | | 1) Board Records<br>2) Board Records |



*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Brief Description of Service

A. Title: Patient Advocate/Follow-up Team

B. Background: Under the Community Mental Health Centers Act, patient care has shifted from hospital and long-term custodial care to a more decentralized, short-term, treatment-oriented, community based system of mental health services. Analysis of the COCMHC and its implementation of this type of health care delivery system has found the following shortcomings:

1) Related to continuity of care:

The COCMHC currently provides 1½ full time equivalent professional positions to the Hawaii State Hospital for assistance in treatment of and discharge preparation for patients admitted from the catchment area.

A number of problems exist with this arrangement:

a) The absence of clearly delineated lines of authority regarding treatment in and discharge from Hawaii State Hospital.
b) The inability of COCMHC staff to provide crisis care and monitoring services at Hawaii State Hospital.
c) The current arrangement leaves the Haleiwa-Waialua clinic (the most rural of the four Central Oahu clinics) without continuous professional staffing.
d) Patients are sometimes "lost", i.e., appropriate interagency contacts and follow-up does not occur due to unclear lines of responsibility and inefficient interagency cooperation.
e) Inappropriate placement following discharge sometimes occur because of lack of patient screening and unclear delineations of responsibility.
f) There are overlaps and duplications of effort which may lead to confusion in treatment and follow-up.

This suggests that an alternative program which emphasizes continuity of care following release from the hospital and the development of individualized post-hospital treatment plans would better serve patient needs.

In addition, there is a lack of alternative transitional living environments in the catchment area resulting in little movement once initial post-hospitalization placement occurs. The Center has no defined mechanism for the initiation and coordination of such movement.

2) Related to comprehensiveness of services:

The Center, in order to provide a comprehensive range of patient services, is required to maintain a complex set of interrelationships with many administratively distinct agencies. In theory, the Center should be able to establish linkages with the Department of Social

Services and Housing, Department of Vocational Rehabilitation, Department of Education and other administrative units within the Department of Health.

While hospital admissions have been deemphasized, an effective community-based coordinative system has not been developed between the Center, its satellite clinics and other support services to ensure continuity of care for all patients. Currently, any coordinative activities must be initiated by the staff treating a particular patient, based upon their knowledge of where and how to obtain other services. This non-systematic and random approach to service coordination makes questionable the quality and comprehensiveness of care between patients.

3) Related to the ability to monitor the movement of patients within the system:

The Federal concerns on this topic can best be summarized as:

a) How is a client identified?
b) How does the client enter the system?
c) What happens to the client while in the system?
d) How does the client move within the system?
e) How does the client get out of the system?
f) How is the individual followed after leaving the system?

The COCMHC does not have, at the present time, an individual or group vested with the responsibility to monitor clients on a case-by-case basis, in terms of these questions. Nor is there an individual or group with the authority to take actions to remedy any problems encountered in the delivery of services.

C. Brief description of services

The Patient Advocate/Follow-up Team will be an interdisciplinary response team which can assure appropriate placement and continuity of care for former institutionalized patients taking up residence in the Central Oahu catchment area; plan and coordinate the resources which may be necessary to resolve or initiate resolution of an individual's problems; and act as principal agent of the patient in the continuing assessment of the appropriateness and efficacy of clinical and support services. Major services components would include:

1) Activities related to insuring continuity of care:

a) Continuous case-by-case monitoring of patient treatment and discharge status to insure continuity of care at COCMHC upon transfer to the catchment area.

b) Consultation with HSH/Queen's and DSSH discharge personnel regarding placement, treatment and follow-up requirements of each patient.

c) Assistance in processing all documents necessary for discharge, including documents for timely payment and support.

d) Inspection of recommended placement site to insure physical and psychological appropriateness of the environment.

2) Activities related to the provision of comprehensive services:

a) Assist the patient or representatives of the patient, COCMHC treatment staff, and representatives of other agencies involved in the case, develop a mutually acceptable treatment and services plan including specific behavioral objectives and the sequence in which objectives are to be met.

b) Assist the COCMHC treatment staff in obtaining support services necessary to augment the clinical services of the Center.

c) Provide continuous monitoring and coordination of services between COCMHC staff, operators of transitional living units, and other relevant personnel from public or private agencies involved in the case.

d) Develop and apply the mental health screening for the elderly program (see Program Profile 12).

3) Activities related to the monitoring of patient movement:

a) The PAFT will convene and act as the patient's representative in monthly treatment plan reviews with all necessary contacts, including patient family members, care and boarding home operators, COCMHC personnel, and relevant personnel from other public and private agencies involved in the case.

b) The PAFT will act as the patient's representative in all instances where change in the treatment plan is proposed; any changes must be aggreeable to all parties involved.

c) The PAFT will report to the Quality Assurance Committee (QAC) and/or the Peer Review Committee (PRC) instances of systematic deviation from the standards of patient care and service delivery established by the Division, Center and/or the Governing Board and report recommendations from these bodies to the Center Chief for disposition.

d) Upon termination of services by the COCMHC, the PAFT will follow-up each patient for not less than 3 months and report to the original treatment staff any findings which may indicate the need for readmission of the client.

4) The PAFT will also have principle responsibility for the operations of the Military Liaison Services and the Mental Health Screening for the Elderly program.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Continuity of service: Inpatient transition.
2) Comprehensiveness of service: Planning and inter and intra-departmental linkages.
3) Screening.
4) Individualization of services.
5) Ensuring and maintaining the quality of care.

III. Goals and Objectives

A. Goals:

1) Prevent inappropriate placement of patients following discharge from inpatient facilities.
2) Minimize confusion and duplication in treatment and placement of patients.

3) Provide adequate screening and service planning following release from an inpatient facility.

4) Insure coordination and continuity among the various supportive services available within the community to released patients.

5) Provide the necessary planning, liaison and follow-up services to clients moving within the system of transitional living units or admitted directly into such environments.

B. Objectives:

1) To provide comprehensive and individualized discharge planning and follow-up services to released patients.

2) To coordinate services available within the community to released patients.

3) To reduce duplication and confusion among agencies and personnel responsible for discharge placement and follow-up.

4) To insure that "red tape" and other sources of delay are minimized.

5) To insure appropriate placement.

6) To provide necessary information and planning to various elements of the patient's social and medical environment upon release.

7) To insure appropriate linkages and patient planning within the available range of environments when necessary.

IV. Target

A. Released patients.

B. Boarding and care home residents.

C. TLU residents.

V. Staff

During the first year of opeartion, the PAFT will consist of a Psychiatrist II, Social Worker IV and a Public Health Educator. The Psychiatrist will be team coordinator and have the specific responsibility for discharge planning and development of a patient services plan. The PHE and SW IV will have responsibility for obtaining and coordinating support services as well as necessary case conferences and follow-up work. All individuals will be responsible for monitoring and reviewing the implementation of the patient services plan; and individuals will act as patient advocates in the service plan reviews, the QAC and/or the PRC.

VI. Cost

$89,276 (see attached sheet for budget breakdown)

VII. Priority: 4

Alternatives considered: The alternative approach considered was a purchase of service arrangement with either Mental Health Association of Hawaii or Health and Community Services Council of Hawaii for the Community Advocacy program. Subsequent discussions with Division and Center personnel indicated this arrangement led to problems of future program accountability and loss of identity of the advocacy program.

| Category | Assigned to Center | | Assigned to Affiliate | |
|---|---|---|---|---|
| I. STAFF COSTS: | | | | |
| A. SW IV | 19,668 | | | |
| B. Public Health Educator | 19,668 | | | |
| C. Psychiatrist II | 43,519 | | | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent) - Provided by Center. | | | | |
| B. Equipment (3 desks @ 300 = 900; 3 chairs @ 150 = 450; 2 bkcases = 100; 3 int. chairs = 250; 1 file cab. = 125) | | 1,825 | | |
| C. Utilities - N/A | | | | |
| D. Supplies (office) | 500 | | | |
| E. Travel (mileage) | 2,520 | | | |
| F. Communications (tel.) | 576 | | | |
| G. Training | 500 | | | |
| H. Activities - N/A | | | | |
| I. Other Costs (educ. material; form devel.; Xeroxing) | 500 | | | |
| III. LOCATION: COCMHC | | | | |
| IV. PROBABLE CASELOAD: Approximately 200 clients/ year. | | | | |
| V. LENGTH OF STAY: N/A | | | | |
| VI. TOTAL COST: | $87,451 | $1,825 | | |
| | $89,276 | | | |

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives: | | | | |
| 1. Comprehensive individualized pre-discharge planning and follow-up for released patients. | 1) % discharges with plan. | 100 | | 1) Hospital Records |
| | 2) % dischargees followed up in 90 days | | 80 | 2) Patient Records |
| | in 180 days | | 100 | Patient Records |
| 2. Coordination of community services. | 1) % dischargees with multi-agency plan. | | 60 | 1) Patient Records |
| | 2) Existence action of agency council. | In existence by 3rd month | | 2) Council Minutes |
| 3. Reduce duplication. | % of agency cases receiving duplicate services. | 0 | | Comparison of agency records |
| 4. Reduce delay in receiving services. | % of users making complaints. | 5 | | Surveys of clients. |
| 5. Appropriate placement of releasees. | % placements deemed appropriate. | 100 | | Peer Review Records |
| 6. Provide necessary information to elements in patient's social and medical environment. | 1) % professionals with proper data on patient. | 100 | | 1) Comparison of records |
| | 2) % other helpers with proper information. | 85 | | 2) Surveys of other helpers |
| 7. Create appropriate service linkages. | 1) Number of new links between formerly unlinked services. | 1/mo. | | 1) Survey of Services |
| | 2) Re-use rate and duration of new links. | 5/mo. 1 yr. | | 2) Survey of Services |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Brief Description of Service

A. Title: Shelter for Abused Spouse and Children

B. Background: The Shelter for Abused Spouses and Children opened on June 9, 1975 and provides temporary emergency relief and shelter to abused parents and children. Abuse of either a child alone or of a spouse alone may qualify the family. Abuse could vary from sexual to physical to mental abuse.

The shelter is the only such facility in the State and has provided services for over 300 families, averaging 4.5 members per family, since its opening in 1975. Expanded public awareness of the service has greatly increased the number of clients utilizing the service and additional funding and support services are required to meet the expanding needs of the community.

Recent needs assessment surveys have indicated a high degree of concern for abused spouses and children. There are, however, no residential facilities and few programs designed to accommodate the needs of abused persons within the area.

C. Brief description of service: The COCMHC will enter a purchase of services agreement with the Shelter for Abused Spouses and Children so as to assure the availability of space within the shelter for residents of Central Oahu. In addition, shelter staff will assist COCMHC in developing programs and counseling for abused persons and families. Specific services provided will include:

1) An emergency residential facility where abused spouses or children can seek temporary shelter and relief.
2) Referrals and assistance in utilizing other social services available.
3) Assistance in assessing their situation and making decisions regarding possible alternatives.
4) Assistance to COCMHC in establishing programs and counseling services to assist abused persons.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Emergency services.
2) Comprehensiveness of services.
3) Interagency cooperation.
4) Public education.

III. Goals and Objectives

A. Goals: To insure the availability of a temporary residential facility and services for abused spouses and children of the Central Oahu catchment area.

B. Objectives:

1) To ensure the availability of a temporary residential facility for abused spouses and children.
2) To coordinate services available to abused spouses and children.
3) To maintain an environment in which abused spouses and children can have assistance in examining their alternatives and assistance in pursuing their chosen course of action.
4) To increase public awareness regarding the plight of abused spouses and children.
5) To develop mental health programs to further assist those abused spouses and children in need.

IV. Target Group

Abused spouses and children.

V. Staff

This is a purchase of service contract with the Shelter for Abused Spouses and Children and is based on assumption of 30% of total operating budget given average client caseload from Central Oahu Catchment Area.

VI. Cost

$16,500 (see attached budget)

Analysis of alternatives: All data indicated a high priority for this type of service but not the need for development of a specific unit in the catchment area. Unanimous support was given toward establishing a formal relationship with the existing shelter program as it is well established and has proven to be very effective in responding to client needs.

VII. Priority: 5

| Category | Assigned to Center | | Assigned to Affiliate | |
|---|---|---|---|---|
| I. STAFF COSTS: | | | | |
| 30% of existing operating costs - 2 paid staff at $20,142 | | | 6,043 | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent) | | | | |
| B. Equipment | | | | |
| C. Utilities | | | | |
| D. Supplies | | | | |
| E. Travel | | | | |
| F. Communications | | | | |
| G. Training | | | | |
| H. Activities | | | | |
| I. Other Costs - | | | | |
| 30% of Operating budget: | | | 8,957 | |
| 30% of Administration: | | | 1,500 | |
| III. LOCATION: Kalihi Valley | | | | |
| IV. PROBABLE CASELOAD: | | | | |
| V. LENGTH OF STAY: Avg. 5 days | | | | |
| VI. TOTAL COST: | | | $16,500 | |

NOTE: Purchase costs based on % use of shelter by central Oahu residents, approximately 30% of current caseload.

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>1. In order to insure the availability of a temporary residential facility for abused spouses and children from the Central Oahu catchment area, the SASAC shall provide on a continuous basis, space for no less than one such family at all times. | Availability of space for one family or more. | Yes | | Services Directory |
| 2. In order to increase public awareness and education regarding the problems of abused spouses and children, the SASAC shall, with the assistance and cooperation of COCMHC develop and begin implementation within the 2nd year of a pilot public education program. | 1) Availability of completed education program plans.<br>2) Pilot test of program before implementation.<br>3) Increase of public awareness of problems of SASAC. | Yes<br>Yes<br>Sig | | 1) Status Report to the Board<br>2) Calendar of Developmental Activities<br>3) Before-After program comparison<br>a. Post-Pilot<br>b. Post-Implementation |
| 3. In order to provide appropriate inter-agency assistance, the SASAC shall continue to utilize maximum referral and support services and shall provide assistance to COCMHC clients and staff requiring knowledge or contact with existing resources. | 1) % of identified referral/support linkages carried out for consumer.<br>2) Increase in knowledge.<br>3) % of relevant services with identifiable contact person. | 100%<br>Sig | | 1) Service Record<br>2) Before-After comparison of staf knowledge of existing resources.<br>3) Relevant Services Directory |
| 4. In order to insure accountability, the Shelter for Abused Spouses and Children shall report annually regarding its activities to the Central Oahu governing board and be subject to review and evaluation by the COCMHC. | 1) Completion/Submission of report to the Board.<br>2) Acceptance of report as satisfactory by the Board. | Yes<br>Yes | | 1) Board Record<br>2) Board Record |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Brief Description of Service

A. Title: Group Homes for Youth

B. Background: There does not exist within the catchment area any transitional living environments to respond to the needs of youth and adolescents, especially in cases of severe family disruption.

C. Brief description of service: This project is designed to provide a temporary living environment for high school youth who, due to family problems, unstable living conditions and associated interpersonal problems, have left home.

The homes are to be staffed by "houseparents" whose responsibilities include maintenance of an informal, home-like atmosphere; personal counseling; and facilitation of professional counseling. The project director will recruit, train, supervise and counsel house parents and other staff. The group homes social worker will provide treatment services and act as liaison between home and COCMHC.

Consultation services will be provided by the staff of the COCMHC clinic providing services in the area the home is located. An individualized treatment plan will be developed jointly by the group home social worker and COCMHC clinic staff.

Admission to the group homes is voluntary, but based on appropriate screening procedures. Application is made by referral from various community agencies.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Availability of temporary or transitional living environments for runaways.
2) Expand the range of environments available for the treatment of problems arising in the adolescent population.
3) Involvement of parents in the resolution of their children's problems.
4) Increase communication, coordination and referral capability among social agencies servicing children in the area.

III. Goals and Objectives

A. Goals: To provide a stable living environment coupled with appropriate counseling and support services which will enable residents to complete their schooling; solve personal and family problems; return home or find alternative living situations; and make plans for the future.

B. Objectives:

1) To ensure the availability of an alternative residential facility for adolescents.
2) To coordinate community resources for the resolution of problems.
3) To establish an environment in which adolescents and their families can obtain assistance in examining alternative avenues of problem resolution.
4) To develop mental health programs to further assist runaway adolescents in need.

IV. Target

High school youth in crisis situations requiring alternative living situations.

V. Staff

Personnel requirements were developed jointly by planners and purchasing agency based upon existing practices in the field. In the case of the Group Homes for Youth, counseling and treatment staff were eliminated because these services can be provided through regular clinic staff or the Children's Team of COCMHC.

VI. Cost

$62,285 (see attached budget breakdown)

VII. Priority: 6

Alternatives: Development of a Group Home for Youth by COCMHC was considered. Utilization of existing expertise in the operation, and maintenance of such an environment was considered a better option because:

1) Start-up time would be quicker.
2) Problems in philosophy and concept had already been resolved.
3) Administrative and logistical structures were in place.

Major decision was whether home should be short or long-term. Center staff felt a long-term facility would better meet the needs of the clientele.

| Category | | | | |
|---|---|---|---|---|
| I. STAFF COSTS:* | | | | |
| A. House Manager | | | 8,813 | |
| B. Child Care Worker (2) @ $4,320 | | | 10,575 | |
| C. Social Worker (½ FTE) | | | 7,344 | |
| D. Director (¼ FTE) | | | 5,649 | |
| E. Bookkeeper (8 hrs/week) | | | 2,479 | |
| F. Secretary (9 hrs/week) | | | 1,439 | |
| *(Includes 22.4% fringe) | | | | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent) @ 550/month | | | 6,600 | |
| B. Equipment Van lease | | | 3,500 | |
| C. Utilities | | | 1,870 | |
| D. Supplies (see following) | | | 2,700 | |
| E. Travel | | | 1,000 | |
| F. Communications | | | 655 | |
| G. Training | | | 605 | |
| H. Activities | | | 1,084 | |
| I. Other Costs (see following) | | | 7,983 | |
| III. LOCATION: Pearl City | | | | |
| IV. PROBABLE CASELOAD: Average caseload, assuming 8 month length of stay equals 9. | | | | |
| V. LENGTH OF STAY: Average length of stay = 8 months. | | | | |
| VI. TOTAL COST: | | | $62,286 | |

D. Supplies:

| | | |
|---|---|---|
| 1. | Education | $165 |
| 2. | Office | 200 |
| 3. | Recreation | 120 |
| 4. | Medical | 165 |
| 5. | Janitorial | 450 |
| 6. | Vehicle | 1,275 |
| 7. | Household | 325 |
| | Total | $2,700 |

I. Other Costs:

| | | |
|---|---|---|
| 1. | House repairs and maintenance @ 50/month | $600 |
| 2. | Printing | 65 |
| 3. | Insurance | 778 |
| 4. | Contractual services | 740 |
| 5. | Professional dues | 585 |
| 6. | Administrative overhead | 4,500 |
| 7. | Miscellaneous | 715 |
| | Total | $7,983 |

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>1. In order to insure and facilitate appropriate utilization of services provided through the group homes for youth, the COCMHC shall, with the approval of the governing board, and via the Community Advocacy Team: | | | | |
| a. develop, test and implement information and educational services to potential clients and referral sources to enhance visibility of services the first year; | 1) % of homes listed with the COCMHC.<br>2) Completion of pilot testing before implementation<br>3) Level of success of public education to enhance visibility of homes. | 100%<br>Yes<br>VH | | 1) COCMHC Services Directory<br>2) Calendar of Developmental Activities<br>3) Post-implementation on Before-After comparison of Public/Consume knowledge |
| b. develop, implement and test criteria for the screening, placement, discharge and readmission to the group homes for youth within the first year; | 1) Availability of criteria for screening, etc.<br>2) Completion of pilot test before implementation.<br>3) % of Planning-Linking Conferences applying the criteria. | Yes<br>Yes | | 1) CAT Status Report to the Board<br>2) Calendar of Developmental Activities<br>3) Service Record |
| c. require, on an annual basis, each group home for youth in the catchment area to provide a description of the medical, psychiatric, supportive, and rehabilitative/habilitative services to be made available to residents in the homes. | 1) % of group homes in CO with a clear description of said characteristics lodged with the COCMHC. | 100% | | 1) Service Directory |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Informatic |
|---|---|---|---|---|
| Objectives:<br>2. In order to equip residents with the ability to solve their problems and make plans for the future, the COCMHC shall, on an ongoing basis: | | | | |
| a. require written specification of methods by which resident needs will be met by the group home staff, Center and/or clinic staff, and other community resources annually; | 1) % of group homes which submitted written specification to the Board. | 100% | | 1) a. Procedures Manual<br>b. Board Records |
| | 2) % of group home records approved by the Board. | 100% | | 2) Board Records |
| b. require the assignment of a specific staff person to facilitate the clients obtaining needed services on a timely basis and for ensuring liaison and coordination of services upon admission of consumer to the group home. | 1) % of consumers with designated staff facilitator upon admission. | 100% | | 1) Service Record |
| | 2) % of consumers placed in, or discharged from, home in error. | 0% | | 2) Service Record |
| | 3) % of linkages carried out by staff. | 100% | | 3) Service Record |
| 3. In order to insure the quality of care, the COCMHC, via the Patient Advocate, within the first six months of operation, will develop, implement and test a program to monitor the quality of care provided residents of the home. | 1) Presence of program to monitor the quality of care. | Yes | | 1) Patient Advocate Status Repor to the Board |
| | 2) Pilot test of program before implementation. | Yes | | 2) Calendar of Developmental Activities |
| | 3) Level of satisfaction with care. | VH | | 3) Survey of Consumer Satisfacti |
| 4. In order to insure accountability, the Group Homes for Youths shall report annually regarding its activities to the Central Oahu governing board and be subject to review and evaluation by the COCMHC. | 1) % of homes which submitted annual report to the Board. | 100% | | 1) Board Records |
| | 2) % of reports accepted as satisfactory or % of reports returned as unsatisfactory. | 100%<br>0% | | 2) Board Records |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Description of Service

A. Title: Adolescent Rap Center/Crash Pad

B. Background:

1) Estimate of need: The 1970 Census indicated that persons under 18 years of age represented approximately 36% of the catchment area's total population. Application of State Department of Education estimators to this population results in an estimated 4,500 children with emotional and mental impairment of sufficient magnitude to require counseling and other forms of therapeutic intervention.

As of December, 1976, the Center reported providing services to a total of 413 children and 218 families. As can be seen, there is a substantial difference between current caseload and the COE estimate of the number of children in need of services.

2) Problems in the delivery of services to children: Act 211-74, Section 321-176, mandates the provision of mental health services to children. This act does not provide for direct case identification within the schools. Currently, identification and referral functions are vested with the school counselors. The Children's Mental Health Team is called in only after a case is identified and parental permission for treatment has been obtained. At the present time, the Children's Team does not have any basis for a continuous and permanent presence on school campus. Thus, its activities take on a reactive, rather than preventive, function.

Because the Center and the Children's Team must work through referral intermediaries, it has no control over the nature and appropriateness of referrals being made. Specifically, the school itself represents a source of emotional stress to children. The possibility exists that cases identified through the schools may represent children who are reacting to the school environment. In this sense, the Center may, in effect, be involved in aiding the schools "process" its "products", rather than identifying and treating children with major emotional problems.

It appears that some children will not voluntarily use the counseling centers because of the stigma associated with the terms "mental health" and "counseling". Additionally, local children do not appear to respond effectively to traditional one-to-one counseling methods. They appear to be more responsive in group, or peer counseling situations. Finally, there is a lack of "places in the Central Oahu catchment area where children can congregate and just "hang out".

C. Brief description of services: This program attempts to provide an unstructured, non-therapeutic environment for youth and adolescents who for a variety of reasons, such as extreme family tension, potential school failure, lack of socialization skills, drug and/or alcohol involvement, are finding it difficult to function successfully within community norms and expectations. The target population is youth and adolescents in the 12 to 18 year age group.

The Rap Center/Crash Pad provides a place where youth can come to talk with one another, or receive help in crisis situations. They are able to stay overnight while avenues of problem resolution are developed by Center and/or clinic staff.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Comprehensiveness: Expanded capability to provide services to youth and adolescents.
2) Screening and identification: More direct means of identifying children in need of assistance.
3) Acceptability: Creation of a counseling environment more acceptable to children in the community.
4) Emergency service: Provision of crisis care.

III. Goals and Objectives

A. Goals:

1) Insure more effective case identification and screening processes.
2) Insure that mental health services are acceptable to children and adolescents.
3) Increase the awareness among children and youth of resources available to them.
4) Reduce the stigma associated with mental health.

B. Objectives:

1) To develop a mechanism for more direct and responsive case identification.
2) To develop an unstructured environment which is more conducive to problem resolution.
3) To provide a better relationship between mental health professionals and children.
4) To provide the means for determining the problems and needs among children and youth.

IV. Target

Youth and adolescents, aged 12 to 18 years.

V. Staff

Staffing based on information provided by individuals involved in the provision of services to children and youth and the operators of the Waianae-Nanakuli Rap Center.

VI. Cost

$87,094

VII. Priority: 7

Alternatives: Preliminary approaches involved exploring the possibility of using school facilities in the catchment area. Problems with obtaining a site during day hours and security problems after hours mitigated against this approach. Currently negotiating with individuals from John Howard Assoc., YMCA and the Storefront School to determine exact scope of program. The ultimate implementation of this program will remain difficult because of the lack of strong community organizations which can support this type of program.

| Category | Assigned to Center | | Assigned to Affiliate | |
|---|---|---|---|---|
| I. STAFF COSTS: | | | | |
| A. Project Director | | | 14,030 | |
| B. Day Counselor | | | 17,784 | |
| C. Night Counselor | | | 17,784 | |
| D. Night House Manager | | | 12,287 | |
| E. Clerical (½) | | | 6,325 | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent)- 3 bedroom house | | | 6,000 | |
| B. Equipment (see following) | | | | 2,670 |
| C. Utilities | | | 500 | |
| D. Supplies (see following) | | | 2,937 | |
| E. Travel | | | 480 | |
| F. Communications | | | 355 | |
| G. Training | | | 300 | |
| H. Activities | | | 1,142 | |
| I. Other Costs (see following) | | | 3,000 | 1,500 |
| III. LOCATION: Waialua/Haleiwa | | | | |
| IV. PROBABLE CASELOAD: 250 annually | | | | |
| V. LENGTH OF STAY: Variable, short term | | | | |
| VI. TOTAL COST: | | | $82,924 | $4,170 |
| | | | $87,094 | |

B. Equipment:

| | | |
|---|---|---|
| 1. Desk | | $150 |
| 2. 2 Chairs @ $30 | | 60 |
| 3. File cabinet | | 125 |
| 4. 4 beds @ $135 | | 540 |
| 5. Linen | | 50 |
| 6. 10 chairs @ $10 | | 100 |
| 7. 10 cushions @ $5 | | 50 |
| 8. Television | | 600 |
| 9. Pool table | | 995 |
| | Total | $2,670 |

D. Supplies:

| | | |
|---|---|---|
| 1. Food | | $2,500 |
| 2. Household | | 437 |
| | Total | $2,937 |

I. Other Costs:

| | | |
|---|---|---|
| 1. Education | | $500 - R |
| 2. Insurance | | 2,000 - R |
| 3. Medical care | | 500 - R |
| 4. House decorations (draperies, paint) | | 1,500 - NR |
| | | $3,000 - R |
| | Total | $1,500 - NR |

VIII. Evaluation

| Objectives: | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| 1. In order to insure more effective case identification and screening processes for children, the ARC/CP staff shall develop a process for more direct and responsive case identification within the first six months of operation. | 1) Availability of identification process. | Yes | | 1) Procedures Manual |
| | 2) % of consumer caseload identified and screened using process. | 100% | | 2) Utilization Record |
| | 3) % of errors in identification placement. | 0% | | 3) Service Record |
| 2. In order to insure that mental health services are acceptable to children and adolescents, the ARC/CP staff will develop and provide an unstructured environment conducive to problem resolution within the first six months of operation. | 1) Pilot test of acceptability of services. | Yes | | 1) Comparison of alternative concitions by random assignments of clients to conditions/Calendar of Developmental Activities |
| | 2) Level of satisfaction of consumer. | VH | | 2) Survey of Consumer Satisfaction |
| 3. In order to increase awareness among children and youth of resources available to them, the ARC/CP staff will develop public education programs, e.g., seminars, lectures etc., to children and adolescents in the community within the first six months of operation. | 1) Availability of public education programs. | Yes | | 1) Services Directory/Status Repor to the Board/Calendar of Developmental Activities |
| | 2) Increase of awareness of services. | Sig | | 2) Before-After comparison of awareness |
| | 3) Increase of use of services. | | | 3) Before-After Utilization Recorc Data comparison |
| 4. In order to reduce the stigma associated with mental health and improve the treatment environment between mental health professionals and youth, the ARC/CP will develop and provide the means for assessing the problems and needs of children and adolescents within the first year of operations. | 1) Completion of needs assessment. | Yes | | 1) Status Report to the Board |
| | 2) Decrease in stigma associated with mental health. | Sig | | 2) Survey of Consumer Attitude: Before-After comparison |
| | 3) Improvement of treatment environment. | Sig | | 3) Before-After observations by Evaluation Audit Team |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>5. In order to insure accountability, the Adolescent Center/Crash Pad shall report annually regarding its activities to the Central Oahu governing board and be subject to review and evaluation by the COCMHC. | 1) Submittal of report to the Board.<br>2) Acceptance of report by the Board as satisfactory. | Yes<br>Yes | | 1) Board Record<br>2) Board Record |



*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Brief Description of Service

A. Title: Learning and Skill Development Program

B. Background: The adult education division of the Department of Education provides classes in the following areas:

1) Basic elementary education
2) Advanced elementary education
3) Secondary education
4) Homemaking and parent education
5) Civic training
6) Naturalization training
7) Cultural opportunities

Among their mandates is to provide remedial education services for disabled and handicapped. Insofar as the day program of the COCMHC, the boarding and care homes servicing released patients and many of the other services provided by the Center are designed to serve as steps in the re-integration of clients into the community and the programs offered by adult education can serve as excellent resources in the development of educational and practice skills, a program coordinating these resources toward the ends of educational and vocational rehabilitation, as well as public education, would be advisable.

Such a program would require appropriate training, liaison, follow-up, and coordination in order to assure that the individual needs of each client is met.

C. Brief description of the service: The Learning and Skill Development Program will be a cooperative effort involving the COCMHC and the adult education division of the Department of Education. The program will include:

1) Comprehensive individual screening of COCMHC day program clients and boarding and care home residents to determine learning and skill development needs and the development of treatment plans to accommodate these needs.
2) Development by COCMHC and adult education of courses and programs based upon the treatment plans.
3) Selection and training of teachers for classes and placement of students in appropriate classes.
4) Consultation between COCMHC staff and boarding or care home operators or family members (as applies) to review treatment plan and intent of classes to ensure conformity within the domestic environment.
5) Ongoing review of classes, including teachers, environments and materials, to ensure appropriateness and efficiency.
6) Development of cooperative public education and information programs and classes to be included as part of the adult education curriculum.
7) Development of programs within the COCMHC day programs to supplement adult education classes and address needs not fulfilled thereby.

8) Patient input and agreement throughout each element of the program.

9) Case conferences and linkages with the Department of Vocational Rehabilitation to prepare clients to assume jobs.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Comprehensiveness of service: Interdepartmental linkages and cooperation.
2) Screening.
3) Individualization of service.
4) Skill development.
5) Public education.

III. Goals and Objectives

A. Goals:

1) Provide individual assessment of the learning and skill development needs of COCMHC day program patients.
2) Utilize existing community resources to satisfy identified learning and skill development needs.
3) Provide clients with the skills necessary for advancement to vocational education and other forms of advancement toward independence of greater community involvement.
4) To educate the public regarding services available through the COCMHC.
5) Provide public education regarding mental health of the community.

B. Objectives:

1) To provide COCMHC day patients with the necessary practical and learning skills for reintegration into the community.
2) To assess the learning and skill development needs of clients.
3) To expand avenues of interagency cooperation and public awareness regarding the services available to COCMHC.

IV. Target

1) COCMHC day program clients.
2) Boarding and care home residents.
3) Public at large in need of information regarding services of COCMHC.

V. Staff

COCMHC day programs currently operate without the benefit of full time professional staffing other than LPN's. Application of comprehensive screening and individualized behavioral training as well as teacher training class evaluation and interdepartmental conferences and liaison will

require the supplementing of the program with a significant increase in staffing, particularly insofar as many clients are under medication or require detailed individualized assistance.

1) OT III - assigned to Wahiawa
2) RPN V with Master's in Clinical Nurse Specialist - Pearl City
3) SW IV - Haleiwa-Waialua

VI. Cost

Nonrecurring - $2,225
Recurring - 65,629 - Total - $67,854

VII. Priority: 8

A. Alternatives considered:

1) Linkage to DOE with no additional staff.
2) Establish learning and skill development within existing day programs rather than linking.
3) No change.

B. Analysis of alternatives:

1) Existing day program staff are not equipped to implement the above mentioned program.
2) Existing resources within the community do not justify individual establishment of a program.

| Category | Assigned to Center | | Assigned to Affiliate | |
|---|---|---|---|---|
| I. STAFF COSTS: | | | | |
| A. OT III | 17,121 | | | |
| B. RPN V | 22,620 | | | |
| C. SW IV | 19,668 | | | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent) - Provided by COCMHC | | | | |
| B. Equipment (3 desks @ 300 = 900; 2 bkcases = 100; cabinet = 125; 3 chairs @ 150 = 450; 3 int. chairs = 150) | | 1,725 | | |
| C. Utilities - N/A | | | | |
| D. Supplies (office) | 600 | | | |
| E. Travel (mileage) | 1,080 | | | |
| F. Communications (tel.) | 255 | | | |
| G. Training | 500 | 500 | | |
| H. Activities (see following) | 3,285 | | | |
| I. Other Costs | 500 | | | |
| III. LOCATION: OT - Wahiawa, RPN V - PC, RPN III - Wahiawa | | | | |
| IV. PROBABLE CASELOAD: Screening & program development for no less than 100 day patients annually. Public information forms to no less than 250 individuals annually. | | | | |
| V. LENGTH OF STAY: N/A | | | | |
| VI. TOTAL COST: | $65,629 | $2,225 | | |
| | $67,854 | | | |

H. Activities:

| | | |
|---|---|---|
| 1. Field trips | | $2,000 |
| 2. Books | | 1,000 |
| 3. Materials | | 785 |
| | Total | $3,785 |

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives: | | | | |
| 1. In order to assess the learning and skill development needs of COCMHC day patients, within three months, the COCMHC day program staff shall develop, test and implement a comprehensive screening for day program clients which identify: | | | | |
| a. social training skills necessary to enhance interpersonal skills; b. task and skill training necessary to enhance daily living skills; c. home training necessary to increase interpersonal and daily living skills; and d. pre-vocational training necessary to enhance opportunities for employment. | 1) % of consumers with Service Record that include identification of a,b,c,&d. | 100% | | 1) Analysis of Service Record |
| | 2) Level of consumer/family satisfaction with skills acquisition/maintenance. | VH | | 2) Survey of Consumer Satisfaction Before and After Implementation |
| | 3) % of skills achieved. | 100% | | 3) Analysis of Service Record |
| 2. In order to provide clients with skill development opportunities, the COCMHC day program shall | | | | |
| a. within the first six months: 1) submit the results of its needs assessment to the Adult Basic Education Director for review and comment; | 1) Level of satisfactory conduct of needs assessment. | VH | | 1) Evaluation Audit Team's Report o Needs Assessment Effectiveness and Efficiency submitted to the Board |
| | 2) Report is submitted to the ABED for review. | Yes | | 2) Status Report to Board Record |
| 2) review existing programs offered by adult education and develop, with local adult education staff, programs meeting the needs of COCMHC day activity clients. | 1) Completion of review of adult education programs. | Yes | | 1) Analysis of Board Record |
| | 2) Completion of development of needed programs or % of needed programs developed. | Yes 100% | | 2) Status Report to the Board |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

VIII. Evaluation (continued)

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives: b. on an ongoing basis: 1) assist the Adult Education program in selection and training of teachers servicing COCMHC day activity clients; | 1) Availability of in-service training program for teachers. | Yes | | 1) Program Procedures Manual Statu Report to the Board |
| | 2) Level of satisfaction of teachers for in-service. | VH | | 2) Post-In-service Evaluation by Teachers |
| 2) regularly provide consultation services to adult education teachers servicing COCMHC clients; | 1) Availability of regular consultation services. | Yes | | 1) Program Procedures Manual |
| | 2) % of consultation requests answered. | 100% | | 2) Utilization Record |
| 3) provide consultation services to boarding and care home operators or family members (as applies) to insure understanding and appropriate reinforcement in the domestic environment of the client. | 1) Availability of consultation services. | Yes | | 1) Program Procedures Manual |
| | 2) % of consultation requests answered. | 100% | | 2) Utilization Records |
| | 3) Level of satisfaction with consultation services. | VH | | 3) Survey of Consumer Satisfactio |
| 3. In order to provide public education services to the public, the COCMHC, via the Community Advocacy Team, shall on an ongoing basis, contact local adult education staff for the purposes of developing program planning of public education programs, lectures and forums. | 1) % of local adult education staffs contacted. | 100% | | 1) CAT Status Report to the Board |
| | 2) % of proposed public education programs developed by CAT. | 100% | | 2) CAT Status Report to the Board |
| 4. In order to insure accountability, the Learning and Skill Development Program shall report annually regarding its activities to the Central Oahu governing board and be subject to review and evaluation by the COCMHC. | 1) Completion and submission of annual report to the Board. | Yes | | 1) Board Records |
| | 2) Acceptance of Report. | Yes | | 2) Board Records |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Description of Service

A. Title: Immigrant Services Program

B. Background:

Estimate of need: The 1965 amendments to the U.S. Immigration and Nationality Act abolished national origins quota system which had been in operation since 1929. The national quota system provided for immigration in direct proportion to the ethnic composition of the U.S. population reflected in the 1920 census. This system allocated a greater quota to the northern European countries and a smaller number to other areas, especially Asian countries. Congress abolished the national origins quota system and placed immigration from all countries on an equal footing.

Hawaii, because of its multi-ethnic population and location, serves as the gateway for a substantial number of immigrants from Asian and Pacific countries. Although the State of Hawaii ranks 40th in the nation in total population, it ranks 12th for the number of immigrants admitted.

Needs assessment data indicated that foreign born residents of the catchment area represent approximately 16% of the total population. The data suggests that the immigrant population of Central Oahu is not composed of recent arrivals since the majority of this population has lived in Hawaii for at least 5 years. Filipinos, the major immigrant group, are principally located in Wahiawa and Waialua-Haleiwa. Samoan immigrants are found more frequently in Aiea and Pearl City.

The Center does currently employ a professional with bilingual/bicultural capability to provide direct services to the immigrant population of the community.

The Center lacks a systematic program for gaining data that would define problems and needs in the immigrant community.

C. Brief description of service: The Immigrant Services Program will consist of purchase of services of the Kalihi-Palama Immigrant Services Center. Basic services of the program will consist of the following components:

1) Direct services:

a) Personal counseling and translation services.
b) Assist in the preparation of forms pertaining to the receipt of services.
c) Other services which are identified as being crucial to the immigrant family.

2) Information and referral:

a) Development of a system of liaison, contact and referral to appropriate agencies and programs.
b) Provide guidance and follow-up for immigrants referred to various agencies.
c) Maintain an up-to-date listing of services available in the area.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Bilingual/bicultural mental health services capability.
2) Increased awareness of State health and social services.
3) Problems and needs identification.

III. Goals and Objectives

A. Goals:

1) Insure the acceptability of State mental health services to the foreign born population.
2) Continuous needs assessment and case finding.
3) Development of systematic linkages to existing community resources.

B. Objectives:

1) Establish a process whereby needs of the immigrant population can be determined and assessed.
2) Development of an effective outreach program.
3) Development of an effective referral system so as to direct this population to the most appropriate source of services.

IV. Target

Immigrants.

V. Staff

This is a purchase of service contract based upon the current staff capability of the Kalihi-Palama Immigrant Services Center.

VI. Cost

$13,000 (see budget for detailed breakdown)

VII. Priority: 9

Analysis of alternatives: Federal legislation requires bilingual capability in those instances where a substantial population of the catchment population is non-English speaking. Present estimates suggest that approximately 16% of the Central Oahu population is foreign born. Original plan was to hire a full time bilingual professional and bilingual aide. Staff input indicated that the immigrant caseload would not justify the addition of such a specialized capability. However, in order to insure minimal capability and to provide training to the staff, this formal link to the well established Kalihi-Palama Immigrant Services program is recommended.

| Category | Assigned to Center | | Assigned to Affiliate | |
|---|---|---|---|---|
| I. STAFF COSTS: | | | | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent) | | | | |
| B. Equipment | | | | |
| C. Utilities | | | | |
| D. Supplies | | | | |
| E. Travel | | | | |
| F. Communications | | | | |
| G. Training | | | | |
| H. Activities | | | | |
| I. Other Costs (see following) | | | | $13,000 |
| III. LOCATION: Kalihi-Palama | | | | |
| IV. PROBABLE CASELOAD: 200 per year | | | | |
| V. LENGTH OF STAY: | | | | |
| VI. TOTAL COST: | | | | $13,000 |

NOTE: Unexpended funds will be returned to COCMHC.

*Estimated client caseload 200/yr; 121 hrly cost $6/hr, treatment duration [illegible] (5 sessions)

I. Other Costs:

| | | |
|---|---|---|
| 1. | Direct services payment estimated 200 clients/year at average treatment duration 10 hrs/client at $6/hour. | $12,000 |
| 2. | Training consultation and admin. | 1,000 |
| | Total | $13,000 |

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>1. In order to insure the acceptability of State mental health services to the foreign born population, the ISP will establish a process whereby the needs of the immigrant population can be determined and assessed - within the first year of operations. | 1) Availability of approved needs assessment process. | Yes | | 1) Status Report to the Board/ Calendar of Developmental Activiti |
| 2. In order to insure continuous needs assessment and case finding among the foreign born, the ISP will develop an outreach program within the first six months of operation. | 1) Availability of approved outreach program.<br>2) Increase in caseload identified through outreach. | Yes<br>Sig | | 1) Status Report to the Board/ Calendar of Developmental Activiti<br>2) Before-After Outreach comparisc |
| 3. In order to develop systematic linkages relevant to existing community resources, the ISP shall establish an intra-agency referral system which would guide the foreign born to the most appropriate source of service. The referral system should be established within the first year of operation. Once established, the referral system would be ongoing. | 1) % of relevant referral contacts established out of identified possible mechanisms.<br>2) % of identified linkages carried out for consumer. | 100%<br>100% | | 1) Directory of Services<br>2) Service Record |
| 4. In order to insure accountability, the Immigrant Services Program shall report annually regarding its activities to the Central Oahu governing board and be subject to review and evaluation by the COCMHC. | 1) Submittal of report to the Board.<br>2) Acceptance of report as satisfactory by the Board. | Yes<br>Yes | | 1) Board Records<br>2) Board Records |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Brief Description of Service

A. Title: Transportation Assistance Services

B. Background: Geographically, Central Oahu is the largest of Oahu's catchment areas. As such, difficulties arise in transporting clients to potentially beneficial activities or environments, particularly when such transportation involves the movement of relatively large groups.

Although rental services are available, the cost and difficulty of arranging such services has inhibited such activities as the traveling to alternative social or recreational envoronments on a regular basis. Such activities would obviously be beneficial for a range of target populations in need of exposure, training or the use of alternative environments for treatment.

In addition, transportation difficulties have been experienced by patients and boarding and care home operators who sometimes have difficulty in simply reaching Center services as well as offering the services they would like to offer such as picnics and trips.

Center plans for the centralization of specific services which could be more efficiently and beneficially carried out as a centralized service is naturally contingent upon the insurance of an adequate transportation capability for isolated or distant areas.

A bus, which belongs to Hale Mohalu may become available for Center use. However, a driver is necessary and a more moderate scale form of transportation would also be desirable. The Center currently has one van.

C. Brief description of service: Principal services will include:

1) Assistance to day programs and boarding and care home operators and in transporting groups to various recreational and social environments.
2) Assistance to non-ambulatory or isolated clients in reaching Center services.
3) Assistance to other groups, as designated or developed by Center staff, to alternative environments which may facilitate treatment.
4) Contact and coordination with other agencies offering transportation assistance to disabled or elderly persons.
5) 1-4 above will be carried out through the hiring of a PMA IV to provide and coordinate transportation services and the purchase of 2 twelve passenger vans to be stationed at the Pearl City and Waialua-Haleiwa clinics.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Accessibility.
2) Facilitate the utilization of alternative environment for treatment and exposure.
3) Reintegration.

III. Goals and Objectives

A. Goals: To maximize the use of non-clinic based environments in the treatment of clients and to increase the accessibility of Center services to non-ambulatory and otherwise isolated clients through the providing of transportation services.

B. Objectives:

1) To facilitate the use of the community in the treatment of Center clients by providing transportation services.
2) To assist isolated and non-ambulatory clients in reaching Center services.

IV. Target Population

A. Day program clients.
B. Boarding and care home residents.
C. Non-ambulatory or isolated.
D. Elderly.
E. Children.

V. Staff (existing)

VI. Costs

Nonrecurring - $25,075
Recurring - 7,000 - Total - $32,075

VII. Priority: 10

A. Alternatives considered:

1) Utilize existing transportation services.
2) Contract with existing agency.
3) Do nothing.

B. Analysis of alternatives: As the largest of Oahu's catchment areas, adequate transportation services are a necessity if COCMHC is to make itself accessible and if it is to fully utilize existing community resources. Contractual services and the existing transportation system do not provide the flexibility or reliability of Center based transportation services.

| Category | Assigned to Center | | Assigned to Affiliate | |
|---|---|---|---|---|
| I. STAFF COSTS: | | | | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent)- To be provided by Center | | | | |
| B. Equipment (12 pas. van = 10,000; 12 pas. van w/lift = 15,075) | | 25,075 | | |
| C. Utilities N/A | | | | |
| D. Supplies | | | | |
| E. Travel | | | | |
| F. Communications | | | | |
| G. Training | | | | |
| H. Activities N/A | | | | |
| I. Other Costs (Insurance = 2,000; vehicle maintenance, gas = 5,000) | 7,000 | | | |
| III. LOCATION: Pearl City, Waialua-Haleiwa | | | | |
| IV. PROBABLE CASELOAD: | | | | |
| V. LENGTH OF STAY: N/A | | | | |
| VI. TOTAL COST: | $7,000 | $25,075 | | |
| | $32,075 | | | |

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>1. In order to maximize the use of non-clinic based environments in the treatment of clients, the TAS shall transport or arrange for the transport of clients to and from non-clinic based environments. | % of consumers needing transportation provided with the service. | 100% | | Analysis of Utilization Records |
| 2. In order to increase the accessibility of COCMHC services to non-ambulatory and isolated clients, the TAS shall transport or arrange for the transport, of clients to and from the COCMHC. | 1) % of consumers needing transport provided with service.<br>2) Increase in number/% of consumers served. | 100% | | 1) Analysis of Utilization Records<br>2) Analysis of Utilization Records |



*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Brief Description of Service

A. Title: Military Liaison Services

B. Brief description of service: Military Liaison Services would include:

1) Coordination of mental health services available to active duty personnel and their dependents.

The military is not without mental health resources. However, the nature and availability of these resources vary within each branch and the public services necessary to supplement them similarly vary. The function of COCMHC's military liaison service would be to contact and coordinate services with relevant military personnel and programs so as to assure the availability of a range of services to active duty personnel and dependents.

2) Formation and implementation of groups and programs to address military specific mental health problems.

Specific identifiable groups such as wives of low ranking enlisted men may suffer from problems of hardships which are unique to their situation and which require the development of a special program. It will be the responsibility of military liaison services personnel to clearly define these groups and work with the military establishment in developing services to meet their needs.

3) Development of resource sharing programs with the military and other programs designed to enhance understanding and alleviate tensions between military and civilian sectors.

4) Data gathering and sharing to provide a basis for future planning in both military and civilian sectors.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Comprehensiveness of services.
2) Interagency cooperation.
3) Continuity of services.

III. Goals and Objectives

A. Goals: To insure the provision of a comprehensive range of services to active duty military and their dependents in the catchment area and to develop programs aimed at creating greater community understanding and alleviating the difficulties experienced by military personnel.

B. Objectives:

1) To facilitate the coordination of resources and services to military personnel.
2) To identify and develop programs for specific target groups within the military in need of such programs.
3) To develop programs designed to enhance understanding and alleviate tensions between the military and civilian sectors.
4) To gather data to provide a basis for future planning.

IV. Target Group

Military personnel and their dependents.

V. Staff

Community Specialist of the PAFT.

VI. Cost

(Accounted within PAFT cost.)

VII. Priority: 11

Analysis of Alternatives: Military and military dependents represent approximately 30% of the catchment area's total population. There does not currently exist any mechanism for coordinating and exploring opportunities for mutual cooperation between COCMHC and the military mental health programs. Initial concept involved establishing a formal outreach program for the military; however, there exists no avenue for the implementation of this type of program. Development of special programs was discarded because of the lack of definition of military problems. The liaison program appeared to be the best approach to establish an initial avenue for closer cooperation.

## VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>1. In order to insure the provision of a comprehensive range of services to active duty military and their dependents, the COCMHC shall: | | | | |
| a. on an ongoing basis, contact the relevant military personnel and programs to inform them of COCMHC services; and | % of relevant military personnel and programs contacted | 100% | | Directory of Relevant Providers and Status Report to the Board |
| b. within the first six months, develop, test and implement service programs for specific target groups within the military which shall include but not be limited to enlisted men's wives. | 1) Availability of developed programs. | Yes | | 1) Status Report to the Board |
| | 2) Completion of Pilot Test before implementation. | Yes | | 2) Calendar of Developmental Activities |
| | 3) Level of satisfaction with programs. | VH | | 3) Post-program Evaluation by Consumer |
| 2. In order to create a positive community attitude toward the military personnel and their families, thereby alleviating tension, the COCMHC shall, with agreement from the relevant military authorities | 1) Availability of developed programs. | Yes | | 1) Status Report to the Board |
| | 2) Completion of Pilot Test. | Yes | | 2) Calendar of Developmental Activities |
| | 3) Decrease in military-civilian tensions. | Sig | | 3) Before-After comparison of perceived military-civilian tensic |
| a. within the first year, develop, test and implement civilian-military interaction programs. | | | | |
| 3. In order to insure accountability, the Military Liaison Services shall report annually regarding its activities to the Central Oahu governing board and be subject to review and evaluation by the COCMHC. | 1) Availability of completed report submitted to the Board. | Yes | | 1) Board Records |
| | 2) Satisfaction level on report. | VH | | 2) Board Records |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Brief Description of Service

A. Title: Mental Health Screening for the Elderly

B. Background: The COCMHC currently has no formal mechanism for either case finding or needs assessment among the elderly. However, the community has indicated through various needs assessment survey that mental health services for the elderly are a very high priority, but have not been able to clearly define the nature or extent of their mental health problems.

The Honolulu Area Office on Aging is currently conducting health screening for elderly throughout the State, including the central catchment area, but do not include as a part of their program, mental health screening services. A number of sources, including the Hawaii State legislature, have expressed a desire for the inclusion of mental health screening as a part of the health screening program, but have not provided the mechanism or manpower for such a program.

Given the absence of any clear definition of the problems of the elderly in the central area, coupled with the tendency for their problems to be linked with physical degeneration, a program linking mental health screening in the central catchment area with the existing health screening program would facilitate maximum utilization of existing resources and contribute to the comprehensiveness of both agencies.

C. Brief description of service: Principal services provided by the Mental Health Screening for the Elderly program include:

1) COCMHC participation in the Honolulu Office on Aging health screening program by development and application of a mental health screening component.
2) COCMHC case identification of the elderly interviewed through the screening process.
3) Development of a screening process to be applied in the central catchment area as a pilot for statewide implementation.
4) Public education regarding mental health services available through the COCMHC.
5) Data gathering on the elderly to provide a basis for future program development.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Screening and case finding.
2) Interagency cooperation.
3) Public education.
4) Comprehensiveness of service.

III. Goals and Objectives

A. Goals:

1) Develop a comprehensive mental health screening for the elderly to be applied as a part of the county elderly health screening program.
2) Educate the elderly regarding services available through the COCMHC.
3) Identify and gather data on the mental health needs of the elderly within the area.

B. Objectives:

1) To establish and refine linkages between various health services available to the elderly.
2) To identify and treat elderly within the catchment area who would genefit from COCMHC services.
3) To promote greater community awareness of mental health services available.
4) To individually screen elderly throughout the catchment area in order to identify cases and trends among the elderly population.
5) To develop a basis for further program development for the elderly.

IV. Target Group

Elderly.

V. Staff

N/A (patient advocate function)

VI. Cost

N/A (part of PA budget)

VII. Priority: 12

A. Alternatives considered:

1) Establish geriatrics team.
2) Establish independent screening program.
3) Do nothing.

B. Analysis of alternatives:

1) Caseload and difficulty in identifying and defining problems of the elderly does not justify establishment of an independent team.
2) Tie in with existing program would be most cost efficient and provide insights into physical and other difficulties experienced by the elderly.

## VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>1. In order to develop a comprehensive mental health screening process, the MHSE will: | | | | |
| a. establish linkages between the relevant health services available to elderly within the first year of operations; | % of linkages established with relevant health services through contact with relevant personnel. | 100% | | Directory of Relevant Providers |
| b. develop a screening process to be included as a part of the existing City and County elderly health screening program and to systematically identify elderly within the catchment area who would benefit from COCMHC services within the first six months of operation; | 1) Presence of evidence of contractual or collaborative agreement with the City and County. | Yes | | 1) Board Records |
| | 2) Level of success of case finding effort. | VH | | 2) Evaluation Audit Team assessme |
| | 3) Increase in caseload. | Sig | | 3) Before-After comparison, Servi Record |
| c. identify and provide appropriate treatment to elderly who would benefit from COCMHC services as an ongoing activity; | % of identified consumers given services on ongoing basis. | 100% | | Service Record |
| d. develop specific programs for the elderly based on mental health screening findings within the first year of operation. | Congruence of programs developed with screening findings. | VH | | Content comparison of programs ar findings by Evaluation Audity Tea |
| 2. In order to educate the elderly regarding the availability of services, the MHSE will develop a public education program designed to promote and increase community awareness of mental health services available within the first six months of operation. | 1) Availability of public education program. | Yes | | 1) Directory of Services and Stat Report to the Board |
| | 2) Increase in community awareness of services. | Sig | | 2) Before-After comparison of cor munity awareness survey results |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives: | | | | |
| 3. In order to identify and gather data on mental health needs of the elderly, the MHSE will individually screen elderly throughout the catchment area as an ongoing process as a part of the City and County health screening program. | (Same as Obj. 1.b indicators 2) and 3)) | | | (Same as Obj. 1.b Sources of Indicator Information 2) and 3)) |
| 4. In order to insure accountability, the Mental Health Screening for the Elderly Program shall report annually regarding its activities to the Central Oahu governing board and be subject to review and evaluation by the COCMHC.. | 1) Completion and submission of report to the Board. | Yes | | 1) Board Records |
| | 2) Board satisfaction level with report. | VH | | 2) Board Records |



*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Brief Description of Service

A. Title: Emergency Services

B. Brief Description of Services

On Monday through Friday, between 7:45 a.m. to 4:30 p.m., emergency services for Central Oahu residents, including children and youth, adults, elderly and substance abusers are provided by the Central Oahu Community Mental Health Center Branch through the Aiea, Pearl City, Wahiawa and Waialua-Haleiwa Mental Health Clinics. Staff provide immediate telephone response and face-to-face crisis intervention.

After 4:30 p.m., each clinic will have an automatic answering device connected to the telephone. A pre-recorded message will instruct the caller to call the Suicide and Crisis Center in the event of an emergency.

From 4:30 p.m. to 7:30 a.m. and for 24 hours on weekends and holidays, the services of five psychiatrists from the Central Oahu Community Mental Health Center Branch are to be available on rotational on-call basis. The on-call psychiatrist will provide consultation to the Suicide and Crisis Center telephone specialist, crisis workers and the patient as needed. The psychiatrist will go to the scene of the crisis if necessary.

II. Mental Health Needs Addressed

Mental health needs addressed include:

1) Availability of emergency psychiatric consultation during non-clinic hours, weekends and holidays.

2) Improve the quality and continuity of care to residents in the area of emergency services.

3) Provide more effective case identification and screening processes.

III. Goals and Objectives

A. Goals: To insure the availability, quality and continuity of care in the area of emergency mental health services.

B. Objectives:

1. To provide for individual problem assessment.

2. To provide for referral, when appropriate, to an agency which can offer assistance.

3. To provide, when appropriate, telephone psychiatric consultation and conferencing.

4. To provide for the dispatching of either the on-call psychiatrist or the crisis team for on-site, face-to-face crisis response.

5. To provide for post-emergency follow-up.

IV. Target Group

Children and youth, adults, elderly and substance abusers in emergency or crisis situations.

V. Staff

To be staffed by COCMHC psychiatrists participating in the on-call emergency mental health services program.

VI. Cost

47,291 (see attached budget)

Analysis of alternatives:

At the present time, except for the Kalihi-Palama Mental Health Catchment Area, on-call psychiatric emergency services are provided through the Suicide and Crisis Center, on an Island-wide basis. With the addition of several new Center programs, four affiliate programs, and the strengthening of Center-Community identification, greater awareness of the COCMHC and its services will occur, increasing the need for after-hours crisis response. These factors point to the need for the development of a separate psychiatric emergency roster for the COCMHC catchment area.

| Category | Assigned to Center | | Assigned to Affiliate | |
|---|---|---|---|---|
| I. STAFF COSTS: Psychiatrist on-call all hours during which Center is closed. 16 hrs/working day @ $5/hr; 24 hrs/weekend & holiday @ $5/hr | 42,741 | | | |
| II. OPERATING COST: | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent) | | | | |
| B. Equipment (see following) | | 2,850 | | |
| C. Utilities | | | | |
| D. Supplies (see following) | | | | |
| E. Travel | | | | |
| F. Communications | 250 | | | |
| G. Training | | | | |
| H. Activities | | | | |
| I. Other Costs (see following) | 1,450 | | | |
| III. LOCATION: | | | | |
| IV. PROBABLE CASELOAD: | | | | |
| V. LENGTH OF STAY: | | | | |
| VI. TOTAL COST: | $44,441 | $2,850 | | |
| | $47,291 | | | |

B. Equipment:

| | | |
|---|---|---|
| 1. | Answering machines, 4 @ $650 | $2,600 - NR |
| 2. | Multiline converter | 250 - NR |
| | Total | $2,850 - NR |

I. Other Costs:

| | | |
|---|---|---|
| 1. | Equipment maintenance | $250 - R |
| 2. | Pager ("beepers"), 5 @ $20/month | 1,200 - R |
| | Total | $1,450 - R |

VIII. Evaluation

| | Indicator | Standard *Op | **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>1. In order to increase awareness and utilization of the 24-hour emergency services, within the first three months, the COCMHC shall provide publicity for this telephone service to all community agencies, community groups and schools in the catchment area; and a minimum of one (1) news article a month regarding the phone service in a community newspaper. | 1) Number of agencies, community groups and schools notified. | VH | | Activity report of community specialist |
| | 2) Number of media sources contacted. | VH | | |
| | 3) Number of articles appearing with information on telephone service. | VH | | |
| 2. In order to provide more effective case identification and screening, the COCMHC and the Suicide and Crisis Center shall, within the first six months, develop procedures for: | | | | |
| a. Problem assessment<br>b. Referrals to non-Center resources, when appropriate<br>c. Referrals for telephone psychiatric consultation<br>d. Dispatching of on-site, face-to-face crisis assistance<br>e. Post emergency follow-up services | 1) % of client work sheets lacking problem assessment. | 100 | | Client work sheets (Suicide and Crisis Center) |
| | 2) % of clients referred to other agencies. | Sig | | |
| | 3) % of calls requiring telephone psychiatric consultation. | VH | | |
| | 4) % of calls requiring on-site intervention. | VH | | |
| | 5) % of clients contacted after emergency and/or % of clients seen in clinic after emergency. | | | |

*Op - Optimum
**Acc - Acceptable
Sig - Significant

VIII. Evaluation

| | Indicator | Standard *Op | Standard **Acc | Source of Indicator Information |
|---|---|---|---|---|
| Objectives:<br>3. In order to insure accountability, the COCMHC shall report quarterly on the activities of the emergency services program to the Central Oahu governing board and be subject to review by the COCMHC. | 1) Total phone usage.<br>2) Number of Central Oahu residents using phone service.<br>3) Reason for call.<br>4) Disposition of calls (info crisis, referrals). | VH<br>VH<br><br>100%<br>VH | | Suicide and Crisis Center Client Work Sheets (provided all federal and state requirements to protect confidentiality of such information is maintained). |



*Op - Optimum
**Acc - Acceptable
Sig - Significant

I. Title and Brief Description of Service

A. Title: Administrative Services

B. Brief description of services:

1) Administrative Assistant/Contracts Manager (PHOA IV)

a) Monitor affiliate contracts, maintain linkages with relevant community agencies.
b) Develop formal interagency agreements with other social service agencies.
c) Develop community contacts including arrangements with local employers to facilitate re-entry into the community.
d) Assist Center director in insuring Center compliance with all Federal requirements regarding federally assisted programs.
e) Coordinate consultation and education programs throughout the community.

2) Evaluation Specialist (Clinical Psy VI)

a) Principal responsibility for quality assurance and peer review program (see quality assurance for detailed job description in this area).
b) Develop and implement inservice training program (see inservice training).

3) Statistical Clerk

Maintain necessary records and statistics as required by Center director, evaluation specialist or governing board in order to insure appropriate accountability and evaluation.

4) Accountant III

Maintain all necessary fiscal accounts and assist in the evaluation of contracts and preparation of the Center's biannual budget.

5) Clerk-steno III

Provide necessary clerical assistance.

Coordination of the above mentioned support services as well as overall coordination of all new and existing programs will be the responsibility of existing support services staff.

Inservice training consultants and training for governing board (see Narrative on Training).

| Category | Assigned to Center | | Assigned to Affiliate | |
|---|---|---|---|---|
| **I. STAFF COSTS:** | | | | |
| A. Evaluation Specialist (Clinical Psychologist VI) | 24,820 | | | |
| B. Administrative Assistant/ Contracts Manager (PHAO IV) | 19,668 | | | |
| C. Statistical Clerk | 12,123 | | | |
| D. Clerk-steno III | 12,649 | | | |
| E. Accountant III | 17,121 | | | |
| **II. OPERATING COST:** | Recurring | Nonrecurring | Recurring | Nonrecurring |
| A. Space (Rent) | | | | |
| B. Equipment (see following) | | 10,370 | | |
| C. Utilities | | | | |
| D. Supplies | 1,200 | | | |
| E. Travel (staff mileage) | 2,880 | | | |
| F. Communications | 840 | | | |
| G. Training (see following) | 5,750 | | | |
| H. Activities | 1,000 | | | |
| I. Other Costs (see following) | 8,250 | | | |
| **III. LOCATION:** COCMHC | | | | |
| **IV. PROBABLE CASELOAD:** N/A | | | | |
| **V. LENGTH OF STAY:** N/A | | | | |
| **VI. TOTAL COST:** | $106,306 | $10,370 | | |
| | $116,676 | | | |

B. Equipment:

| | | |
|---|---|---|
| 1. | 5 desks @ $300 | $1,500 |
| 2. | Chairs: 3 executive @ $150 | 450 |
| | 2 secretarial @ $60 | 120 |
| | 6 interviewing @ $100 | 600 |
| 3. | Bookcases: 3 @ $100 | 300 |
| 4. | Filing cabinets: 3 @ $150 | 450 |
| 5. | Typewriter | 800 |
| 6. | Typewriter stand | 50 |
| 7. | Microprocessor | 1,500 |
| 8. | Calculator with paper tape capability | 600 |
| 9. | Video equipment and recorder (in-service training) | 4,000 |
| | Total | $10,370 |

G. Training:

| | | |
|---|---|---|
| 1. | Consultant/Trainer fees for In-Service Training, 35 days @ $100/day | $3,500 |
| 2. | Consultant/Trainer fees for Governing Board Training, 15 days @ $100/day | 1,500 |
| 3. | Materials & supplies for training | 750 |
| | Total | $5,750 |

I. Other Costs:

| | | |
|---|---|---|
| 1. | Consultant fees for evaluation, 30 days @ $100/day | $3,000 |
| 2. | Governing Board Member mileage, 20 members x 1,000 miles/year @ 18¢/mile | 3,600 |
| 3. | Xeroxing and printing | 250 |
| 4. | Equipment maintenance | 400 |
| 5. | Liability Insurance, Governing Board | 1,000 |
| | Total | $8,250 |

H. Community Input

The year long planning process has emphasized community input in both the planning of the Center and in the on-going and continuing operations of the Center.

Needs were assessed through three major inputs. A comprehensive survey of 1,200 households asking 247 items related to mental health was conducted under contract to MPAC, Inc. in 1977*. Its results were compared with the data derived from an earlier survey of Knowledgeable Resources conducted by Dr. Anthony J. Marsella of the University of Hawaii and a study by the Center's Psychologist, Dr. David Bremer.

The total needs picture generated from these sources was discussed with a variety of community groups, both mental health specific such as the Center board, and more general groups of citizens. These groups worked from the full survey reports and from a summary of the data which indicated:

1. Respondents were only somewhat aware of the social services surveyed. Only 53% of the respondents indicated knowledge of the 12 services. Community counseling centers was one of the services. Only 40% indicated knowledge of the centers and only 6% reported use. The services which were most known and used were State/City Recreation Facilities, Welfare/Food Stamps/Medicaid, Veterans Benefits and Unemployment Insurance.

In general, more females than males reported that they knew about and used the social services surveyed with the exception of Veterans Benefits. The association of age, income and location with knowledge and use varied from one service to another. With regard to counseling centers, more females and younger respondents reported knowledge and more low income and residents of Kunia and Waipio reported use.

2. Respondents rated the 30 counseling and therapeutic services surveyed as somewhat necessary. Services to the victim and source of children abuse, drugs, alcohol and rape, and services for disturbed children were rated as very necessary. Counseling for smokers, those with difficulty sleeping and for other personal improvement problems were rated as necessary by as many individuals who indicated that the service should be provided privately or not at all.

More females than males reported that they considered the services important. Services to meet chronic and serious needs were given high endorsements by a greater percentage of the young. Low income groups tended to give high endorsements of importance. Residents of Wahiawa tended to give low endorsements of importance.

3. About 1/3 (30%) of the respondents indicated that they would feel uncomfortable or very uncomfortable in going to a DOH counseling center. However, only 2% reported that they do not see a need for a center. About 90% preferred the center to be located in an accessible location but not too close to their houses.

Females, older and lower income group respondents had higher percentages reporting that they would feel comfortable in going to a DOH counseling center. More females than males and older respondents

*See survey report.

endorse the location of the center close to their homes. The percentage of those who saw no need for the center was greater among males, and greatest among the oldest age group. Residents of Pearl City and Aiea and Wahiawa were in least agreement to the location of the center close to their homes. In general, residents of an area preferred to see the mental health facilities including boarding homes, halfway houses and partial day care and hospitalization located in an adjacent neighborhood.

4. Family doctors ranked first among professionals and lay persons whom respondents felt comfortable should they need help. Psychiatrists and psychologists were next while lay workers and community volunteers were last. However, when confronted by personal or family problems which cause stress, individuals rarely seek professional help from psychologists, psychiatrists or counselors. Instead, they seek help first from immediate family members, than friends, relatives and, again, their family doctors.

Comfortableness with both professional and lay mental health practitioners increased with age. More low income respondents reported that they would feel very comfortable with counselors.

5. Emergency services were rated as important by 92% and professional help on call were rated similarly by 36-51%.

Females gave more importance to the availability of 24-hour services than males. Low income groups gave higher importance ratings to talking with someone on the phone on a 24-hour basis.

6. Transition, day care and boarding home care were considered important by 50-53% of the respondents.

More females than males and lower income groups rated boarding and care homes, halfway houses, and day care/partial hospitalization programs as important.

7. Psychiatric services from Kaneohe Hospital received poor ratings of confidence while those from Queen's Hospital received high ratings. Emergency services provided by counselinf centers, particularly in a home visitation mode, received high confidence ratings while phone-in services did not.

Residents within the area surrounding Tripler and Wahiawa hospital facilities tended to give higher ratings of confidence with the services provided by these hospitals. High income respondents showed greater confidence in Queen's Hospital, and low income respondents with Leeward and Wahiawa general hospitals. Low income groups also showed greater confidence in emergency services delivered through hospitals than middle and high income groups.

8. Problems related to money, job pressures, unemployment and children behavior and intrafamily relations caused more stress in more families than drugs, drinking and other problems. In general, the problems surveyed caused stress to only 6% of those surveyed.

Males, younger and low income and Pearl City/Aiea respondents tended to report that specific problems caused family stress. More males, older and low income respondents tended to use alcohol as a diversion from problems causing stress.

9. Although 15% reported that they work longer than they would like to, only 4% reported dissatisfaction with their work situation.

While 46% of respondents reported having less time actually spent than desired for leisure, only 6% indicated that they were dissatisfied with their leisure and recreation activities.

Younger and lower income respondents tended to report lower satisfaction ratings toward aspects of their work situation and leisure/recreation.

10. The respondents perceived themselves as physically healthy in general.

Younger and higher income respondents reported higher percentages of "healthy" responses in terms of feeling of general well-being.

11. They also reported satisfaction with their contacts with family and friends, and satisfaction with estimation of personal worth.

Less than 5% of respondents reported that they did not feel they belong to the community, felt insecure for their physical safety or felt "bad" toward the community. However, 24% indicated community involvement of low or no importance.

Importance of and actual participation in community activities were greater among female and younger respondents. However, positive attitudes toward the community and sense of community belonging increased with age. This was also true with feelings of security and trust in the neighborhood which might be indicative that Central Oahu does not have the problems of physical abuse of the elderly which exist in big urban centers in the U.S. Mainland.

The planning implications of this data were worked out by the survey and planning team. A summary of the implications, used in working with the Center Board and staff in developing programs, looked first simply at the demographic data.

An important finding in the demographic data is the education level of the population. While this data is available in the census, the survey provided a replication and updating of this basic source of demographic data. With almost 40% high school graduates and 24% having had some college, it is quite apparent that this community can take advantage of those therapeutic modes which require a high level of verbal interaction. Traditional counseling therapies and verbal group processes should both find available populations. The education level also supports the use of printed media for informing the population about the

clinics and the services. In targeting both publicity and service actions, however, the inter-relation of ethnicity and education level should be attended to (see Chapter 4 for the specific breakdown by ethnic group).

The fact that only 3.2% of the population lives alone indicates that those problems associated with isolation are not as likely to be major problems in this community. Some of the mental health services and delivery models developed in inner city areas which tend to have higher numbers of people living in isolation are not indicated for this community. Results of the survey indicate that the Samoan population of Central Oahu tend to live in multiple-unit dwellings. This has strong implications for the use of outreach workers. A worker assigned to a building or group of buildings can, if he/she uses the structure of the community property, handle three or four times the client load of a worker covering a large area of single family dwellings with no natural groupings.

A number of items about the accessibility of the military counseling services and the high number of persons who are eligible indicate a definite need for close interaction between the military sources of mental health services and the Center. Perhaps no other single organization affects so large a percentage of the total catchment area population as the military services do.

On the awareness of Social Services Scale (Scale 1), it was found that with the exception of the Samoan sample, ethnicity did not affect awareness drastically. Income and military status was not particularly interrelated with degrees of awareness taken as a whole. The overall awareness rate of 40% means that if 10 out of every 100 people could benefit from counseling services at any given time, the odds are that 6 out of the 10 do not know that the service is available. The Center's public information and community relations programs can use this figure as a baseline. It seems reasonable to target a 60% awareness goal for a one-year publicity effort with a 70% final goal after three years. Geographic location did not seem to affect overall awareness nor did there appear to be any urban/rural split on this matter. Thus, any public information effort can be mounted at the catchment-wide level without the necessity for individually community-targeted campaigns as have been necessary in some less homogeneous communities.

Scale 2 looks at the importance of counseling services to the population. The finding that 95% consider the service to be either important or very important should give some confidence to the planning and programming effort. Of more interest is the differentiation between types of services. What emerges from Table 4, which ranks the 30 types of service, is a definite bias in favor of those services which treat the chronic, the victim and the seriously disturbed. Of much less interest are those services which the layman puts in the category of self-improvement. Thus, services for narcotic drug addicts, for the victims of rape, for the very depressed, elderly, and for alcohol

abusers are all considered very high priorities by the community. Programs, however, aimed at helping people to stop smoking or to sleep more easily or to have a better marriage receive the least support. These unsupported items are in most instances indicated as properly in the domain of the private practitioner.

In the setting up of services, attention should be given to these indications of community priorities. It would be wise to establish first those services which the community supports and feels its tax dollars ought to be going to. Even though good mental health theory would stress the establishment of preventative types of services, the community has a strong preference for "treatment."

Another clear implication of this ranking is the creation of an active education program. Many of the responses, such as the one on rape (where victims rated 4th priority but perpetrators are 14th), can best be dealth with through education of the public to the logic of prevention as well as the necessity of treatment.

The respondents had preferences not only for the type of services to be offered but for the method of delivery. Counseling services should be offered on regular schedules rather than on an irregular basis; would be preferred in an individual rather than a group mode, but, surprisingly, would be more to the preference of more individuals if conducted informally (Table 5). The single most highly ranked mode of counseling service was the "sympathetic listener" type.

With regard to the location of counseling services, the findings can best be summed up as "near but not too close." Most people want the counseling clinics in their own community, but only 7% wanted it actually near their house. Most people indicated they would feel most comfortable if the clinic were in their own community (Scale 3). This argues for a dispersed, decentralized delivery system. The present arrangement, or even a more diffused pattern employing the time-sharing of facilities with other agencies (e.g., conducting counseling in DOE classrooms or offices after school hours or in other government and semi-public agencies on weekends) is indicated here.

In the fact of the demand for evening and weekend hours (Table 7), it would be hard to justify the continuation of the clinic's present schedules. Although it will require serious negotiation with the department and the unions, the finding that over 60% of the residents find the present hours of oepration inconvenient cannot be set aside lightly.

With respect to the types of mental health professionals that the community would like to see staffing these decentralized, evening and weekend treatment-focused clinics, the usual finding that the family doctor would be the ideal deliverer of mental health services is again supported. No other professional comes close to the doctor's rating wherein 82% of the respondents would fee comfortable with him/her as the source of mental health services. Unfortunately, most doctors practice in a specialty other than psychiatry out of choice, an understanding of their own temperament, and a life-long investment in

specialized training. Although a few doctors do "re-tool" from a surgical or other specialty to psychiatry, it is unlikely that the community's preference for the family doctor to become the family mental health professional is going to be met. Among the cluster of psychologists, psychiatrists, professional counselors, social workers and nurses, the variation of preference is not great. However, strong disapproval of lay counselors and volunteers is indicated (see Table 11).

For program planning, several strategies are suggested. The high score given the family doctor can be capitalized on not by converting him or her to a mental health worker but by recruiting these people into the network or front-line diagnosticians and referral makers. Through the medical association, and especially through the family practice physicians who presently work with the Center, an effort can be launched to encourage family practitioners to be on the look-out for possible symptoms of mental health problems among their patients and their patients' families. Most doctors are relatively trained at this. What may be most necessary is simply to let the community's doctors know that the clinics exist, that they are professionally staffed and will provide excellent service to the doctors' referrals and will provide the doctor and his/her office staff with the information needed to make good referrals.

The strong negative rating given to the lay workers/community volunteers may require some deeper analysis. No major effort to train and use lay volunteers should be started unless this item is answered satisfactorily.

Ethnic preferences among the various helping professionals are shown in Table 10. These can be useful in the establishment of staffing patterns at clinics located in various ethnic enclaves.

Of the possible 24-hour emergency services, a hospital emergency room was considered the most important. However, only 42% of the people expressed confidence in emergency rooms, compared to 61-63% confidence in counselors on house calls or at the clinic. Psychiatrists and psychologists on call, however, were relatively lowly rated. Given the expense of maintaining these professionals on call 24 hours a day, alternative coverage should be explored by the planners. Not only was the preference for an emergency room high, but a particular hospital, Queen's, got a very high rating in comparison to other hospitals that were closer. Apparently, Queen's has established a very positive reputation. If services are to be centered in other area hospitals, an intensive community information and trust-building effort is needed. At the other end of the spectrum, Kaneohe State received the lowest confidence rating. Its image as the hospital of last resort for the seriously disturbed, for court referrals, etc., has given it a definite stigma. Programs and personnel should eschew identifying themselves with this institution or else whould be aware of the negative connotation and take steps to counteract it.

Several items give information of direct relevance to service planning in that they describe characteristics of the population associated with mental health problems. A detailed reading of these tables is recommended. Some of the highlights include the finding that money and job problems rate high as sources of family stress. Services tied to the client's work place, possibly offered in conjunction with his/her union, seem to be indicated. The lowest ranking stress sources were items that recently were very much a part of the literature of mental health, drug abuse and inter-cultural differences. The data do not support these as high stress sources in this community. The expected correlation between family stress and family income holds up with the lower income brackets experiencing proportionately more stress. There is also some indication that the urban and suburban communities, which are not necessarily low income, have higher incidences of family stress than the rural areas.

The various coping strategies are employed by the population. In rank order, the following are turned to most often for the solution of personal problems: family members, friends, relatives, family doctor, minister, professional in a public clinic, psychiatrist. The order is an exact inverse function of the degree of training possessed by the potential helper. Those with the most expertise are turned to last and least, and those with no formal training at all are the front-line "workers" of mental health. Two programs are strongly suggested here: A public education and training program to help the average citizen become equipped to handle, at least by appropriate referral, the problems of his/her family and friends and efforts to make the professional helpers better known, more accessible to and more useful to the community. Although this finding of an inverse proportion of ability to use is not unique to this community, it is somewhat peculiar to the mental health field. For broken bones, no one goes first to this family, then to his friends and only last to an orthopedist. Although the possible responses to this finding can get overwhelming, and while the information itself has been repreated so much that many are blase about it, this final ranking is perhaps the most significant of all the tables in the survey. It has implications for planning that go far beyond the simple location and delivery of services. On these "how do you cope" items, also the ethnic and military/civilian cross-tabulations are significant and must be included in the creation of service patterns in different communities. The Filipino, Chinese and Cosmopolitan groups all showed a lower propensity to utilize any of the coping strategies included in the scale. The civilians showed a slightly higher propensity than the military. What this means is that since we have already recommended that services be decentralized, it is important to decentralize the right community. The different ways that different communities (ethnic, military, etc.) think one "ought" to cope with a problem indicate which type of therapeutic strategy is called for.

The problems of the Center's services are also examined. The outside planning team and the lay board find that although no Center service is in any serious trouble, none was entirely without problems. The findings, which are already being used to make changes in Center services are summarized by service category.

Community Input Interviews

Interviews were conducted with various community members to gather initial input, to obtain reactions to tentative conclusions and program alternatives under consideration, and to achieve community-wide concurrance on the final plan.

Interviews with Social Service Providers

A. Interviews averaged 1½-2 hours.

B. Contacts were selected for their familiarity with the catchment area, consequently they tended to be direct providers or middle level bureaucrats rather than program, department or division heads.

C. Information sought:

1. overview of existing MH related services provided by agency,
2. overview of existing relationship with MH,
   a. nature of relationship, and
   b. gaps in comm., services, etc.
3. view of role of COCMHC in social service provision,
4. needs of catchment area for social services in general and MH in particular,
5. recommendations for program development, and
6. willingness to work with COCMHC in program development.

General Community Contacts

A. Interviews averaged 1-1½ hours.

B. Contacts were key advisory board members and key recommended contacts.

C. Information sought:

1. overview of problems in community,
2. specific difficulties experienced,
3. program recommendations,
4. review/confirmation of survey data, and
5. recommended further contacts.

Contacts in development of program profile and plan drafts:

| Dates | Mental Health Services Providers |
|---|---|
| 5/20 | 1) Helen Yoshimi, SHPDA; Gladys Park, SHPDA |
| 6/8 | 2) Pat Watanabe, MHD, program support services |
| 6/17 | 3) Shirley Hayashi, MHD, program support services |
| continuous | 4) Sunao Murata, chief COCMHC |
| continuous | 5) David Bremer, supp. serv. COCMHC |
| 6/14 | 6) Dr. Hannum, PC clinic head |
| 6/20 | 7) Dr. Chun and staff Aiea clinic |
| 6/20 | 8) Dr. Paltin, head, children's team |
| 7/7 | 9) Ms. Kozai and staff, Wahiawa ch. clinic |
| 7/7 | 10) Dr. Abbot and staff, Haleiwa-Waialua and inpatient team |
| 6/29 | 11) Dr. Dennis McLaughlin, MHD |
| 6/27 | 12)*Needs priority presentation and workshop w/G. Warfel |
| 8/3 | 13) Cmdr Ferguson, M.D. - P.H. medical services, head |
| 8/4 | 14) Cmdr Hazlett, M.D. - P.H. mental health clinic |
| 8/12 | 15) Carol Eblem - dir., Hawaii Mental Health Assoc. |

| Dates | Social Service Providers |
|---|---|
| 7/14 | 1) Ms. Ono - N. Central Div. PH Nurses |
| 6/2 | 2) Mr. Phil Baltch, Wahiawa Hosp. |
| 7/9 | 3) Ms. Florence Lau, Continuing Education for Women |
| 7/14 | 4) Mr. Isa, DSSH N. Central Division |
| 7/13 | 5) Mr. Itokazu, DVR |
| 7/13 | 6) Mr. VanLopeck, Suicide and Crisis Center |
| 7/12 | 7) Ms. Lundstrum, Child and Family Services |
| 7/12 | 8) Mr. Honnaka, Adult Education, Aiea |
| 7/14 | 9) Mr. Charles Roylo, Exec. office on Aging |
| 7/18 | 10) Mr. Harold Hashimoto, DOE Special Ed. - Central Dist. |
| 6/28 | 11) Mr. David Yanigasako, KP, neighborhood specialist |
| 6/6 | 12) Ms. Helen Muller, HCSCH |
| 6/10 | 13) Mr. Michael McElroy, Hawaii housing authority |
| 8/18 | 14) Mr. Ted Sakai, Dir., John Howard Assoc. |
| 8/9 | 15) Rev. Joris Watlin, Kokua Kalihi Valley |

| | Consumer Community Contacts |
|---|---|
| | *1) Needs prioritization and workshop w/adv. board |
| continuing | 2) Sherry Montgomery, Pres. Adv. Brd, active in children's prog/Wahiawa |
| continuing | 3) Jan Mosier, sec. Adv. Brd, CHAMPUS counselor/Aiea |
| 6/22 | 4) Don Domondon, V.P. Adv. Brd, Med. research/Pearl City |
| 6/2 | 5) Comm. group div. Wahiawa Day Prog. |
| 6/1 | 6) Ira Vanterpool, Pres. Central subarea hlth. council |
| 7/11 | 7) State Sen. Patsy K. Young |
| 5/19 | 8) Rev. Nagao, Wahiawa Honganji |
| 7/15 | 9) Rev. Matsushita, Wahiawa Methodist Church |
| 7/22 | 10) Joe Leong, Area wide horizons, Haleiwa-Waialua |
| 7/15 | 11) Rev. Acosta, P.C., former pres. P.C. Comm. Assoc., former member Adv. Brd. |
| 7/21 | 12) P.C./Aiea Care and Boarding Home Operators org. |
| 6/2 | 13) Eleanor Florendo, Adv. Brd. mem. Care Home Operator P.C. |
| 8/15 | 14) Mr. Edward Tonaki, Wahiawa Storefront School |

## Plan Processing

A general outline of plan development and processing is appended. It is envisioned that during the second week of August, major community review and modification of draft program and population profiles will commence. A direct appeal to the MH Advisory Board has been made to gain their assistance in recruiting individuals and groups interested in participating in these activities. Additionally, major efforts will be made to utilize the COSAC in the review process. Preliminary discussions with Mr. Ira Vanterpool, president of COSAC, have been very fruitful in this regard.

Plan Development

A three step procedure was used to develop the program plans.

STEP 1: This consists of two sections which describe and establish criteria for the delivery of services in a specific environment. Responsibility for Section 1, the Introduction, rests with the MPAC staff; initial responsibility for Section 2, Criteria for the Analysis and Development of Program Profiles, rests with the MPAC staff, with major input, modification and final acceptance by community groups and the Central Oahu Mental Health Board.

SECTION 1: Introduction

A. Purpose and Scope: Limitations on mental health services within specific environments for purposes of planning.

B. Definitions: Intended to provide a common definition for all users of the profile.

C. Historical Information

D. Trends: What is occurring now; what is apt to occur in the future.

1. By target populations.
2. By target disability groups.

E. Utilization: How much and the way services are used.

1. Caseload by disability groups.
2. Caseload by target populations.

SECTION 2: Criteria for the Analysis and Development of Program Profiles

A. Accessibility: A measure of the geographic proximity between a potential user of the program and the site where the service is located.

B. Availability: The amount of service as measured by manpower, equipment and facilities currently available and projected to meet the needs of persons requiring the services of a particular service environment; also includes office hours, waiting time and the ability of client to pay.

C. Acceptability: The general acceptance of a service by the public; the extent to which providers have taken into account cultural, ethnic, language and other differences of their patients.

D. Comprehensiveness: The full range of services that are available by a single provider or an arrangement among providers.

E. Continuity: The character of the relationships between services and service agencies; referral mechanisms; relationship to other programs.

F. Cost: The arrangements that exist so that patients can use services regardless of ability to pay.

G. Quality of Care: Generally accepted methods as peer review, PSRO, accreditation and certification of both professional staff and the institution, plans for continuing education.

STEP 2: This consists of three sections which describe the current delivery system within a specific environment; projection of estimated disability prevalence and required program capacity; and analysis of the delivery system in terms of the criteria for program development. Responsibility for Section 1, Description of Current System, and Section 2, Projection of Estimated Disability Prevalence and Required Program Capacity are the responsibility of MPAC: Section 3, Analysis of the Delivery System, initial draft will be made by MPAC with final input, modification and acceptance by community groups and the Central Oahu Mental Health Advisory Board.

SECTION 1: Description of Current System

A. Accessibility

B. Availability

C. Acceptability

D. Comprehensiveness

E. Continuity

F. Cost

G. Quality of Care

SECTION 2: Projection of Estimated Disability Prevalence and Required Program Capacity

A. Projected Total Community Caseload

B. Projected Caseload by Target Disabilities

C. Projected Caseload by Target Populations

SECTION 3: Analysis of the Delivery System

A. Problems and Concerns

1. Accessibility
2. Availability
3. Acceptability
4. Comprehensiveness
5. Continuity
6. Cost
7. Quality of Care

B. Gaps and Overlaps

STEP 3: This is the final step in the development of program profiles. It consists of two sections. Section 1, Recommendation, and Section 2, Program and Services Plans. Initial draft statements for each section will be developed by the MPAC staff; however, major input for program objectives and recommendations will be developed by community groups after review of MPAC staff drafts. It is hoped that this recommendation can be prioritized on a year-by-year basis for grant application purposes. Additionally, recommendations will be of two types. The first are those recommendations which are internal to the Center and can be accomplished without major funding requirements. The second are those that require operations funding.

SECTION 1: Objectives and Recommendations

A. Objectives pertaining to Accessibility:

1. Recommendations not requiring funding.
2. Recommendations for operations funding.

B. Objectives pertaining to Availability:

1. Recommendations not requiring funding.
2. Recommendations for operations funding.

C. Objectives pertaining to Acceptability:

1. Recommendations not requiring funding.
2. Recommendations for operations funding.

D. Objectives pertaining to Comprehensiveness:

1. Recommendations not requiring funding.
2. Recommendations for operations funding.

E. Objectives pertaining to Continuity:

1. Recommendations not requiring funding.
2. Recommendations for operations funding.

F. Objectives pertaining to Cost:

1. Recommendations not requiring funding.
2. Recommendations for operations funding.

G. Objectives pertaining to Quality of Care:

1. Recommendations not requiring funding.
2. Recommendations for operations funding.

SECTION 2: Program and Services Plans

The necessary actions to be taken to implement the objectives and recommendations developed in Section 1 includes time sequence for implementation.

Personnel policies of the Center and of each of the proposed affiliates are attached in appendix G.

Governance of the Center

In addition to creating maximum opportunities for community input, the planning team developed a Center governance structure and process. The heart of the process is the provision for community board member access to needed information, the creation of channels for board member reactions. Comments and input to be made to the Center operational staff, and the sharing, where appropriate, of the governance of the Center by the staff and board.

Under the structure, the Governing Board shall:

1. be composed, where practicable, of individuals who reside in the catchment area and who, as a group, represent the residents of the area taking into consideration their employment, age, sex and place of residence, and other demographic characteristics of the area; and

2. meet at least once a month; and

3. a. establish general policies for the Center (including a schedule of hours during which services will be provided),

b. approve the Center's annual budget, and

c. approve the selection of the director; and

4. at least one half of the body shall be individuals who are not providers of health care.

In addition, the plan addresses the following:

1. the general and specific functions and responsibilities of the board;

2. the processes by which a representative board will be selected and maintained;

3. the processes by which appropriate training will be made available to board members so as to enhance their effectiveness;

4. the organizational and administrative relationships between the governing board and the Center director, the professional advisory committee and any superordinate governing structure;

5. the procedures the board will utilize to review the CMHC program, the quality of its services and the results of CMHC evaluation data;

6. the procedures in reporting and disseminating information to the public on the Center's programs and services; and

7. the procedures for ensuring that the governing body will have adequate administrative support and capacity to carry out its functions.

I. Functions and Responsibilities of the Governing Board:

Establishment of general policies for the Center.

1. Establish policy: Within the constraints of State and federal laws and rules governing personnel and the operations of CMHC, the decision of the governing board regarding the establishment of policy will be binding on actions to be taken by the Central Oahu Community Mental Health Center. The framework for these decisions will be

established through an annual written report by the board identifying target groups, gaps in service and priorities for the coming year. For each recognized group or goal, the board will establish operation goals towards which the Center is to aim during that year. The Center will thereafter justify all recommended changes in policy in terms of these recognized goals.

2. Committee structure: In order to insure maximum representation and thoroughness in the review and establishment of Center policy, the board will establish a committee structure which will delegate responsibility for examination of recommended policy to committees representing a broad spectrum of those interested in a particular issue or group. These committees, e.g., child and youth services committee, elderly committee, discharge and follow-up care committee, will report their findings to the board for final disposition.

3. Powers: Final authority over all policy decisions currently held by the Center director or his staff will be delegated to the board. Similarly, recommendations to the Department of Health regarding changes in State policy will be the prerogative of the board.

The clinical and administrative functions and powers of the director and staff shall be retained by them. These functions shall include those powers relating to treatment, confidentiality, personnel (other than the director or staff to the board), and other administrative details necessary for the day-to-day operations of the Center and to ensure consistency with State administrative procedures.

However, the board may, whenever necessary review administrative decisions of the Center in order to insure conformity with its established policy provided that the decision of the board does not violate existing State or federal laws, rules or procedures.

4. Professional advisory committee: The professional advisory committee will be composed of the director of the Center and representatives of each mental health discipline employed by the CMHC and selected by the director so as to ensure geographic representation and interest in working with the governing board. The professional advisory committee will perform the following functions for the governing board:

a. provide ongoing training at governing board meetings on a topic selected by the governing board under advisement from the professional advisory committee;

b. present policy positions complete with rationale and explanations of the positions recommended and of alternative positions that are not recommended;

c. research issues or topics on which the governing board wants further information in order to facilitate decision making.

5. Evaluation: In addition to the above mentioned professional assistance, the Center will be required to assign an evaluation specialist (proposed plans call for this to be among the positions requested in

the federal initial operations grant) to assist, train and direct the activities of the board regarding the evaluation of the operations of the Center. Such evaluation will emphasize a continuing review of the appropriateness of services provided by the Center to the community. A detailed report of the board's participation in the evaluation process will be a part of the evaluation component of the plan and grant application.

Approval of the annual CMHC budget.

1. Budget process: The Hawaii State legislature meets in budget sessions biennually. The process of approval of the CMHC's budget involves the Center's submission of its proposed budgets for the biennual period to the Department of Health's Mental Health Division for review and approval followed by a similar review by the Department of Budget and Finance for review and inclusion in the governor's budget which is submitted to the legislature for final disposition. Through either State rule or statute, each ascending level of government retains the authority to alter the budget which is submitted by a lower level.

2. Board authority: Barring massive realignment of the State's budgetary processes, it is therefore unlikely that the governing board will be able to approve any version of the Center's budget other than that which is submitted by the Center to the Mental Health Division. Such a process could involve the submission of the budget proposed by the Center's staff to the governing board no less than four months prior to the submission deadline of the Mental Health Division. With the assistance of the professional advisory committee and other Center staff, the board would then examine the submissions and approve or require change in part or all of the budget provided that, deletion or changes requested are consistent with Center policy and all relevant laws or regulations. The decisions of the board would represent the Center's submissions to the Mental Health Division. If required by the board, supplementary budget requests will undergo a similar process.

In order for this to be a meaningful exercise, the board must be equipped with adequate assistance and expertise in fully examining the document. It will therefore be required that the Center's proposal be presented to the board in lay terms and in such a way as to clearly represent the priorities of the Center staff regarding new and existing budgetary requests. The proposed budget would be presented to the board by the Center director and the professional advisory committee who would also be responsible for providing the board with additional information as requested.

3. Committee structure: The board will establish through its bylaws an appropriate committee structure to examine the budget in terms of relevant target groups, disability groups and to insure continuity of services. Following presentation of the budget portions of it which are relevant to the activities of the various committees will be referred to those committees for consideration. The recommendations will then be resubmitted to the board for final action.

Approve the selection of the Center director.

1. Selection process: The director of the Central Oahu Community Mental Health Center is currently selected by the director of health either through appointment of qualified DOH personnel or from among candidates recruited by the Department of Personnel Services either through inter-departmental or public advertising. The procedures are prescribed by State law and preference is given to candidates in accordance with State civil service procedures. The role of the governing board in this procedure will be to screen candidates or nominees for local acceptability.

2. Board preparation: In order to insure that the board is appropriately equipped to make a proper decision, the professional advisory committee will provide the following assistance:

a. a written summary of the responsibilities of the director,
b. a summary of the criteria used by DPS in screening applicants,
c. a recommended criteria for screening on the Center level, and
d. whatever other forms of assistance the board or personnel committee may require or request.

Following the submission of this data, the board will then prepare a set of detailed, written evaluation criteria and procedures which will be used in assessing the qualifications of the nominees for the position.

3. Board decision: DOH appointment. Subsequent to the director of health's nomination of qualified DOH personnel for appointment to the Center director's position, the names and qualifications of nominees will be forwarded to the governing board via the acting Center director. A duly elected personnel committee will then, using the criteria established by the board, review the qualifications of the applicants. Included among the possible elements of review will be personal interviews. The personnel committee will submit its recommendations to the board which will then vote to approve or disapprove of each nominee. In the event of disapproval of any nominee, the board will prepare a sufficient written justification for its actions stating in detail its reasons for rejecting the nominee. This report will be forwarded to the director of health.

4. DPS recruitment: A similar procedure will take place for candidates submitted to the board through Department of Personnel Services recruitment. In this event, the personnel committee will recommend approval or disapproval of each of the names submitted to it and a written justification will be required on each candidate disapproved. Following this procedure, the list of acceptable candidates will be resubmitted to the director of health for final disposition.

In the event that all of the applicants are disapproved by the board for sufficient specified reasons, the board may request DOH to submit another list of eligibles.

5. Removal: Subject to the laws and regulations governing State civil service positions, the board may petition the director of health for removal of the Center director. Its petition will clearly state and document the reasons for its request.

II. Representativeness of the Board and Linkages to Community (Selection and continued representation.)

Governing board composition.

1. Geographic representation: The Central Oahu CMHC currently provides services to the approximate 152,000 people living within the catchment area; services are provided through four local clinics located in Aiea, Pearl City, Wahiawa and Haleiwa-Waialua. In order to facilitate administration and to insure adequate support services and representation, two regional advisory committees will be established along recognized social and geographic lines within the catchment area. One will represent those areas serviced by the Aiea and Pearl City clinics, the other, those areas serviced by the Wahiawa and Haleiwa-Waialua clinics. Previous difficulties with the development of clinic specific advisory committees suggests that the establishment of these regional committees would better accommodate organization and administration as well as ensure appropriate geographic and interest group representation.

To insure geographic representation on the governing board, each regional committee will elect a number of members to the board proportional to their population in the catchment area. All members of the regional committees will be associate members of the governing board and will be able to participate in all board activities and meetings other than voting, making motions or reviewing confidential material. In addition, each regional advisory committee will be a standing committee of the governing board and report to the board regularly with its recommendations and activities.

2. Recruitment of regional advisory committees: In order to insure maximum representation in the recruitment of regional advisory committees, each local clinic will be held responsible for contact and recruitment among the following groups:

a. major community organizations within the area,
b. groups or individuals representing identifiable target groups for the area,
c. groups or individuals representing other health services or social services providers within the area, and
d. general recruitment through area-wide advertising through newsletters, newspapers, etc.

3. Functions of regional advisory committees: The principal responsibilities of the regional advisory committees will be:

a. in conjunction with clinic staff, reporting and disseminating information to the public on the Center's programs and activities (this process will hopefully be enhanced through the systematic use of community organizations and social service outlets, members from which will be actively recruited to serve on the advisory committees),
b. review Center programs to insure local acceptability,
c. identify community needs and target groups,

d. participate in the production of the governing board's annual program including the setting of operational goals for the area and the review of policy as it affects the area, and
e. elect members to the governing board.

4. State government representative: A seat on the governing board will be held by the director of health, or a representative of his office. Membership on the governing board by a representative of the department would assure representation on the governing board of the interests of State administered mental health services and planning. The special problems of creating a governing board in a traditionally State administered mental health program undoubtedly qualify as a special circumstance that would enable the board to allow some non-catchment area residents to participate on the board.

Currently, the newly established Central Oahu subarea health council is responsible for citizen participation in health planning for the catchment area. Among other responsibilities, the council must review and approve any requests for facility expansion among State health services within the catchment area. In order to facilitate coordination between these two citizen health planning agencies, the chairman of the subarea council or his representative will also hold a seat on the board.

In addition, representation will be sought from neighborhood boards established by the Charter of the City and County of Honolulu and elected by local communities. Representation from these boards will serve as a link to city government and services as well as enhance neighborhood representation.

5. Target group representation: Once the governing board members have been selected by the local advisory committees, the director of the Center will determine what target groups lack representation on the board. The existing members of the board will invite residents of the catchment area who would be appropriate representatives of the target groups to participate as full members of the governing board. In addition, the committee structure of the board will be organized around target groups relevant to the area. Non-board members will be recruited as committee members and enrolled as associate governing board members. Such associate members will be allowed full participation in all committee processes except voting. If associate members are outvoted in committee decisions, they will be allowed time at board meetings to present their recommendations to the board as a whole.

6. Training of the governing board: The principal responsibility for the training of the governing board will fall upon the professional advisory committee. However, in order to ensure that the board receives a number of perspectives, training will be required and sought from professional sources. For example, the evaluation specialist and community advocates who will be a part of the initial operations grant currently being applied for, will be held responsible for training the board in their areas of expertise. This training will be apart from that which

is received from the professional advisory committee and one or both these people may be required to take a critical perspective of the procedures and services of the Center in order to present the alternatives of evaluation and analysis available.

Another major element of training will come from the community itself. The recruitment process of the board will emphasize maximum utilization of the expertise available in the community. It is expected that such personnel will also be available in providing the board with methods of analysis and information from their respective areas.

7. Organizational and administrative relationships: The governing board of the Central Oahu Community Mental Health Center will function as the final authority for policy and budgetary decisions affecting the Center on the local level. As a part of the State of Hawaii health service system, powers and prerogatives invested in the Department of Health or in the Mental Health Division of the Department of Health by statute or rule will remain with those bodies except when through negotiation they agree to include the governing board in the process.

Policy and budgetary powers previously held by the Center director will be invested in the board and the Center director will be expected to serve as the administrative arm of the board except when otherwise required by State rule or law.

Formal agreements and procedures to ensure the appropriate legal status and formalization of relationships will be established with the Department of Health and other branches of the Hawaii State government as necessary.

8. Administrative support: The Center will provide whatever necessary and reasonable administrative support services the board will require including data collection, and the preparation and dissemination of reports and minutes.

Table 39

State Structure

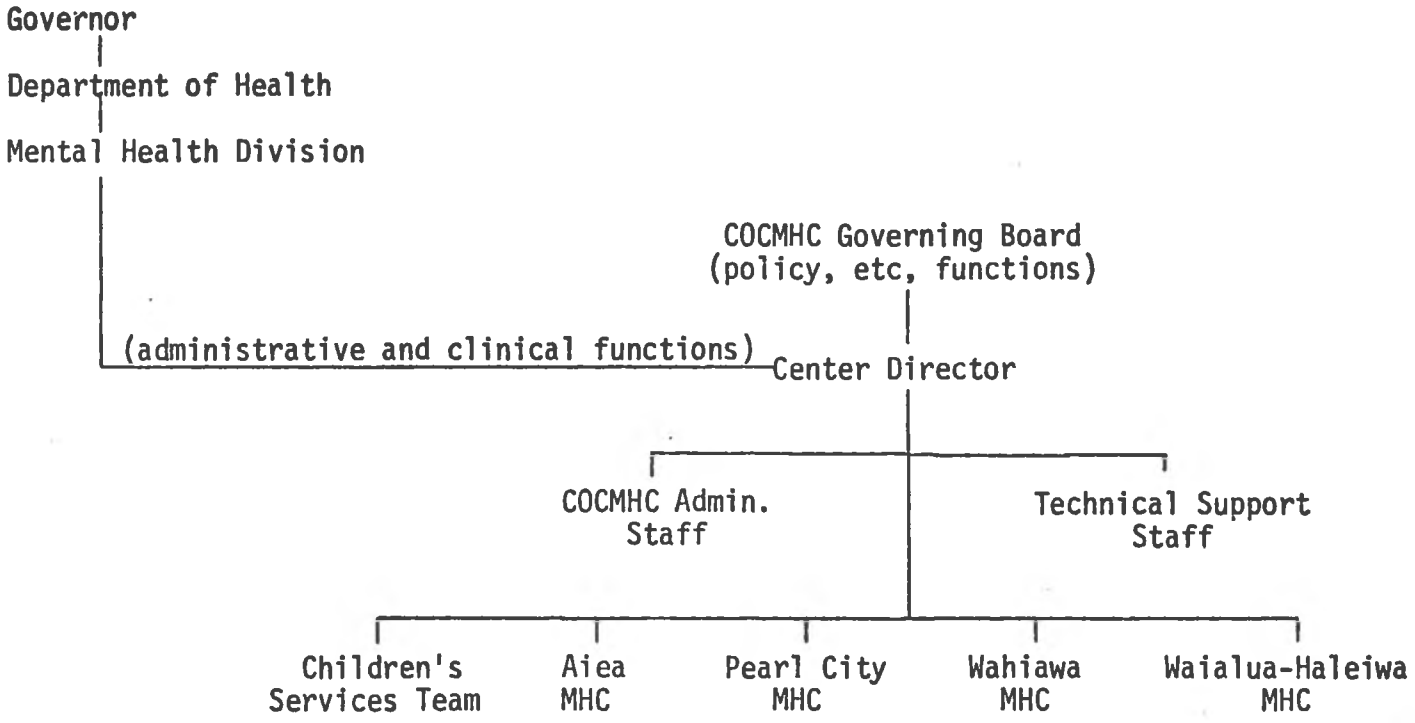


Table 40

Governing Board Structure

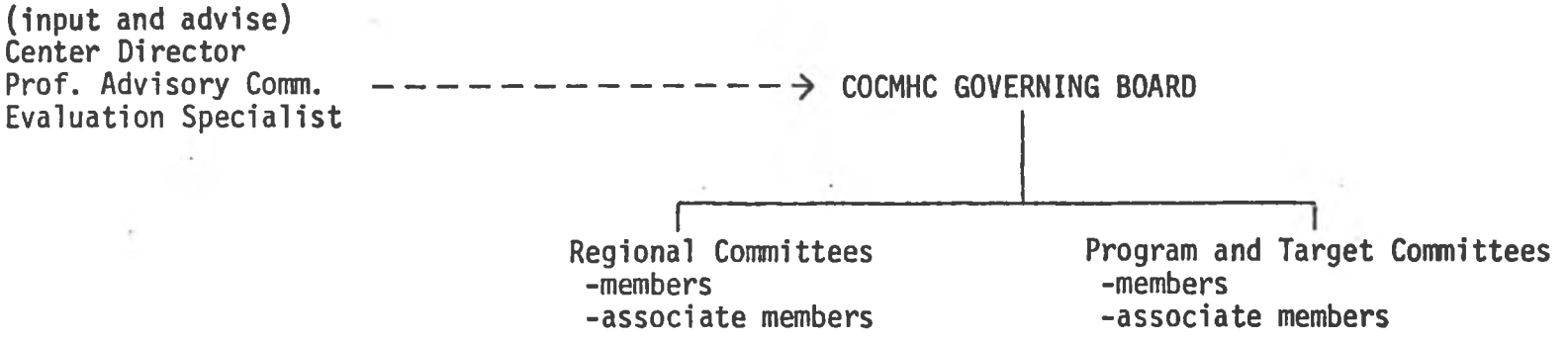


Table 41

Membership Selection

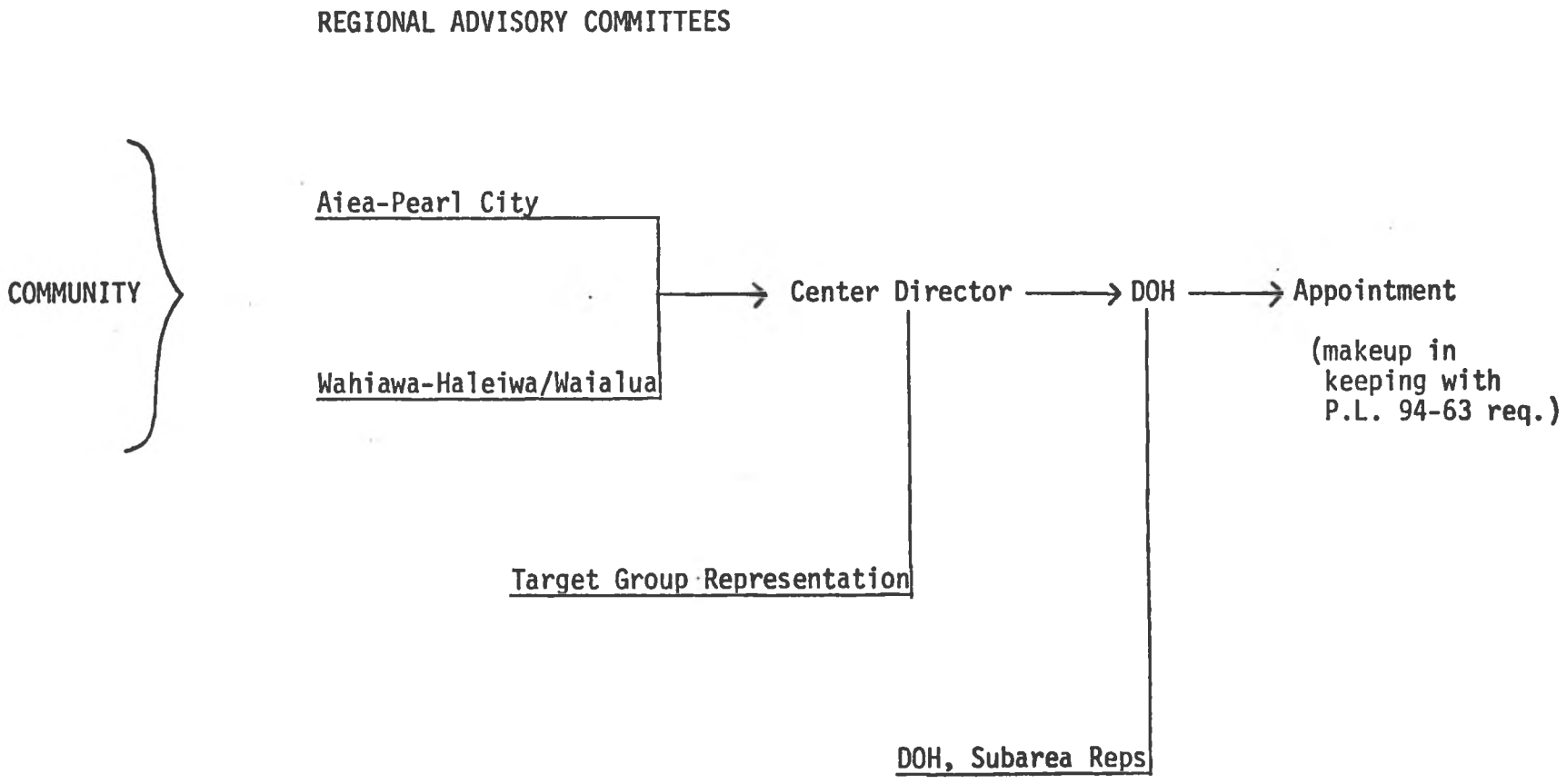


Table 42

Policy Establishment and Review Structure
(Policy control overall all powers currently held by Center Director)

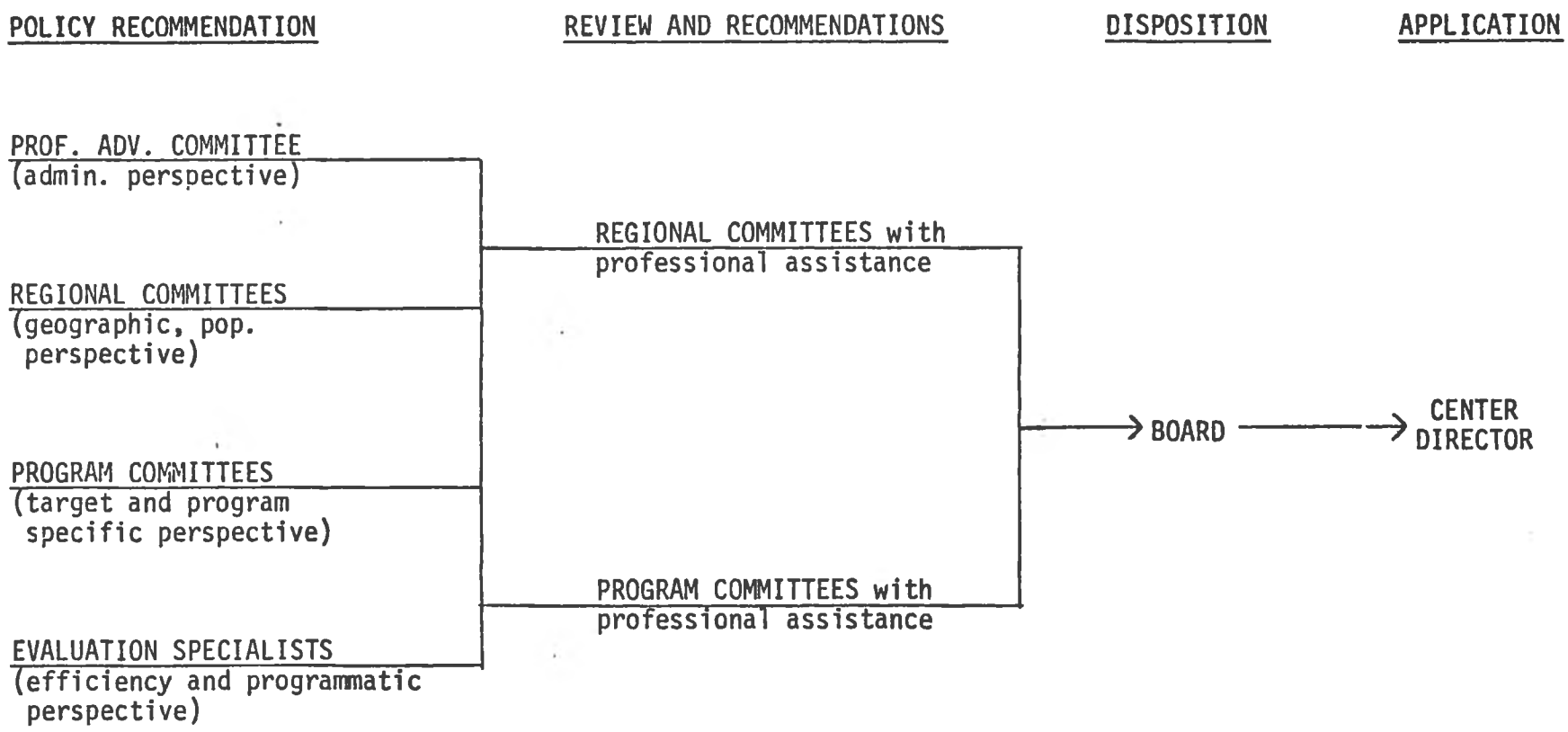


Table 43

Budget Review Process

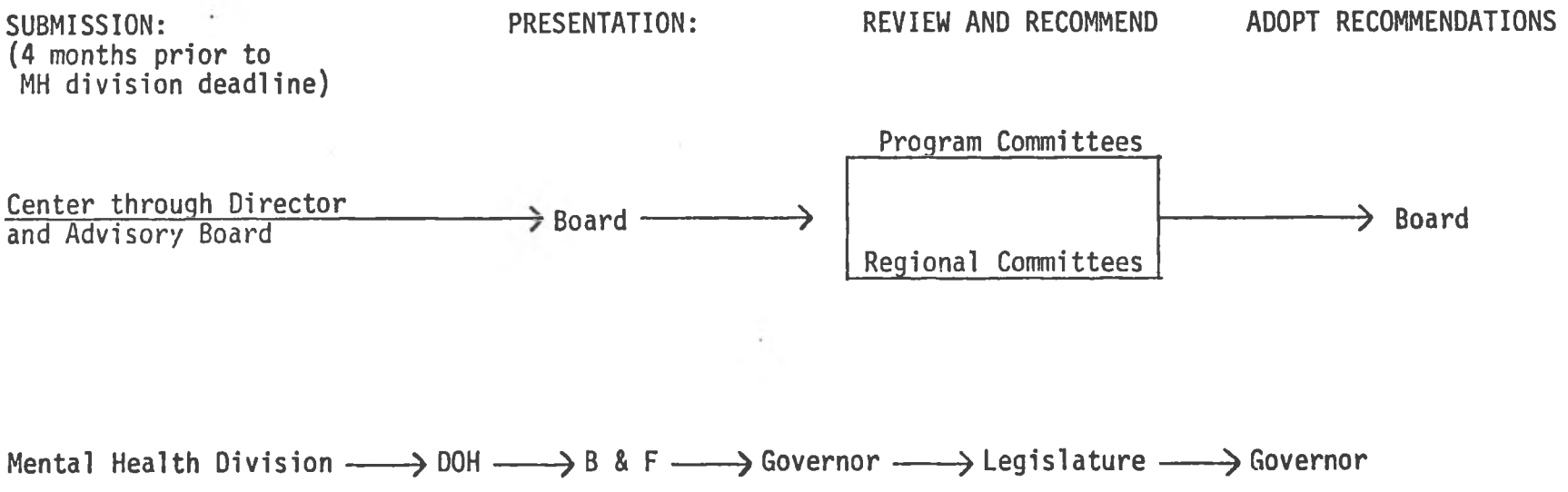
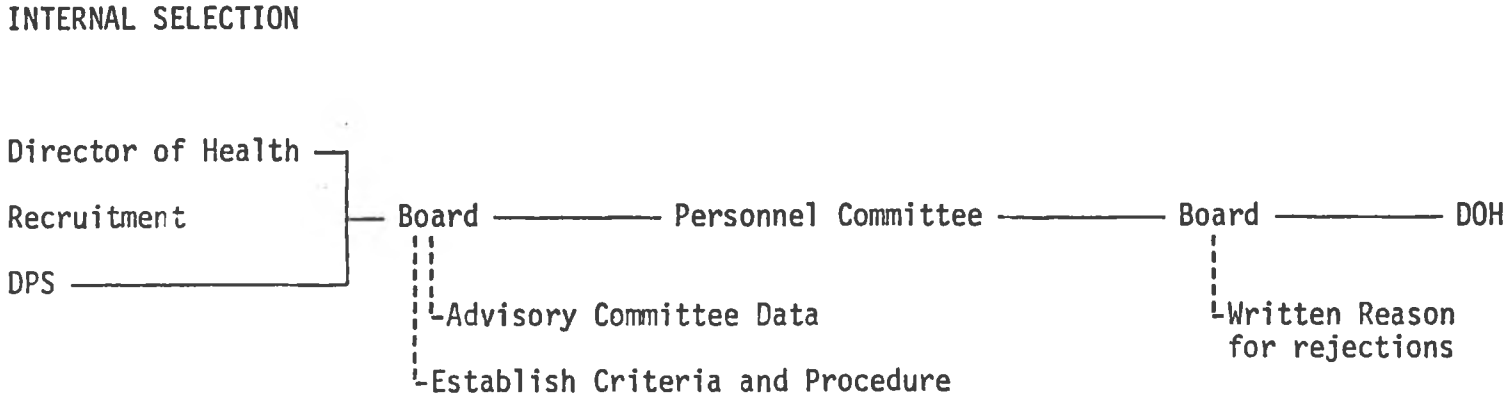


Table 44

Director Approval Process



# CENTRAL OAHU COMMUNITY MENTAL HEALTH ADVISORY BOARD MEMBERSHIP

President.....Sherry Montgomery
Vice President.....Don Domondon
Secretary.....Jan Mosier
Treasurer.....Joseph Leong

| | | |
|---|---|---|
| **Aiea area** | | |
| Pat Kowal | 1048 Kaonohi Street, Aiea 96701 | 488-0101 |
| Jan Mosier | 1328 Anapa Street, Honolulu 96818 | 422-2825 (hm)<br>471-9364 (wk) |
| Maggie Musselman | 98-1089B Komo Mai Drive, Aiea 96701 | 487-1735 (hm)<br>946-1438 (wk) |
| **Pearl City area** | | |
| Don Domondon | 2218 Auhuhu St, Pearl City 96782 | 455-7884 |
| Eleanor Florendo | 971 Hoomoanu St, Pearl City, 96782 | 455-7473 |
| Mila Medallon | 1639 Komo Mai Drive, Pearl City 96782 | |
| Robert Nakamura | 2169 Awikiwiki Street, Pearl City 96782 | 456-9768 (hm)<br>946-8691 (wk) |
| **Wahiawa area** | | |
| David Hagino | 30 Cypress Avenue, Wahiawa 96786 | |
| Reiko Kimura | 2625 California Ave, Wahiawa 96786 | 621-0223 (hm)<br>621-9008 (wk) |
| Augustine Momiyama | 717 Duncan, Schofield Barracks | 433-6606 (wk) |
| Sherry Montgomery | 3807-D Collier St, Schofield Barracks | 624-4035 |
| Norito Nagao | PO Bo x 265, Wahiawa 96786 | 622-4320 |
| **Waialua/Haliewa area** | | |
| Joseph Leong | 66-332 Paalaa Rd, Haleiwa 96712 | 637-4284 |
| Shirley Matutino | PO Box 263, Waialua 96791 | 637-9787 |

---

Sunao Murata -- Director, Central Oahu Mental Health Center 455-1035

David Bremer, PHD -- Central Oahu Mental Health Center 455-1035

## I. Conclusion

This plan, based on an intensive and thorough planning process involving the Center staff, the Advisory Board, members of state agencies and other service providers, members of the catchment area community and federal officials, has been conducted under the direction of the Center Chief and the Advisory Board with the professional assistance of the consultant, MPAC, Inc. It is felt that it represents the most comprehensive and workable plan for a mental health center that has yet been developed for use in Hawaii. In its techniques of needs assessment, in the total involvement of staff and community in the planning process, in the detailed specifications of each Center program, position and service and in the emphasis on formative evaluation processes, the plan attempts to bring the most current state of the art of health services planning to the provision of community mental health in the Central Oahu catchment area.