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Mental Health Transformation State Incentive Grant
Comprehensive Mental Health Plan for the State of Hawaii

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Preface

In every part of the world where man has lived and lives, he has made for himself a lei, necklace, a crown of various materials to adorn his body, to ward off evil spirits, to bring good fortune, to please his gods, to denote rank among men, to give as tokens of love, and for pure and simple enjoyment.

In Hawai'i, ...in the fields with the farmer when he invoked the blessing of the gods upon his fields and crops, as a necessary ornament for the hula dance, as part of the healing rites of the kahuna lapa`au, the healing priest, as a mark of chiefly rank, as an offering to the gods, lei was a symbol of love. It belonged to the festivals and brightened up the routine of daily life as well.

Children made them. Men and women made them. Gods and goddesses favored them.

Some were of a permanent nature while others were made only to endure a short period of time. The beauty of each type was no less beautiful than the other. They were valued more for what they represented.

Excerpts from Marie McDonald, Ka Lei: The Leis of Hawaii.

In Hawaii, the custom of giving someone a lei or garland on a special occasion is part of our local culture. Beautiful lei fashioned in unusual styles or color may be made for the head (*lei po`o*), the neck (*lei `a`i*) or the wrist and ankles (*kupe`e*). Today, they may be easily purchased from a florist, lei stand or even a super market, but the effort in taking the time to make someone a lei is a truly a labor of love.

The making of this First Year Comprehensive Mental Health Plan can be compared to the making of a precious *lei po`o* for our people throughout our island chain. In the Hawaiian culture, a person's head and shoulders are considered sacred parts of the body to be respected by others. How fitting that this plan should fashion a special *lei po`o*—or lei to be worn on one's head—done in the *haku* or arranged or braided style.

In making a haku lei, materials are gathered and prepared to be arranged using a braid method. Flowers, leaves and fruits with stems cut to two to three inches are added to a three-strand plait of ferns, dried banana stalk skin, hau bast or ti leaves. Materials with supple, tough stems were best suited for this technique, since they too, became a part of the braid.

Excerpts from Marie McDonald, Ka Lei: The Leis of Hawaii

Just as a lei maker gathers flowers for his special lei, gathering people for this plan was important. Through fourteen Town Hall meetings in communities across our state, we invited people to participate in developing this plan. More than 200 individuals signed up to work in Sub-Working Groups.

A lei maker takes time to consider his resources and develops a plan or vision for how the flowers will be assembled before the lei can be made. Similarly, members of the Sub-Working Groups and Transformation Working Groups also looked at community resources taking time to consider what should be assembled in the first Year's Comprehensive Mental Health Plan.

We are now ready to assemble the *lei*-- a *lei* that will require a strong base of support. Like the three-strand plait of ferns, our state agencies will need to braid their resources, so that the flowers or services provided through the various agencies may be a interwoven into the *lei po`o* that will be honored and cherished by our people.

As we continue to weave this lei, our labor of love, let our pledge be to:

*“E ala! E alu! E kuilima!
Up! Together! Join hands!
A call to come together to tackle a given task.”*

Mary Kawena Pukui, Olelo No`eau #258

Governor's Message:

March 28, 2008

Substance Abuse & Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

When I first introduced the Transformation Grant to the community, I spoke of this as a “chance of a generation” to improve mental health care for all of Hawaii’s citizens. When I selected the leaders for this effort, I directed them to assure a meaningful process so real changes would benefit all communities and cultures.

Numerous Town Hall Meetings were held and members of the community were invited to participate on Sub-Working Groups. Community leaders, family members and consumer, together with key members of my Cabinet, have participated in the Transformation Working Group. Through these combined efforts, the Transformation Working Group and community Sub-Working Groups have developed a Plan for Hawaii.

This Comprehensive Mental Health Plan provides the guidance for the next stage of transforming mental health for our residents. Together with the Needs Assessment and Resource Inventory, it is our first Transformation Grant product to be delivered to you, the federal funding authority. Thank you for this five year opportunity.

For transformation to be truly effective, this plan must now be refined and work must begin to implement what is possible. We will keep you informed as the recommendations in this plan are modified and updated through the implementation phase. My Administration and I are committed to the process.

I look forward to our continued collaboration to help meet the goals of the New Freedom Commission and Hawaii’s citizens.

Sincerely,

Linda Lingle

Acknowledgements:

This Comprehensive Mental Health Plan draws its strength from the participation of many who deserve our deepest thanks for their drive, dedication, patience and willingness to go the extra mile. To honor the collaboration that was ultimately achieved, we wish to highlight groups critical to this effort:

- The Governor of the State of Hawai`i, her staff and members of her Cabinet for supporting this opportunity.
- The Director of Health and Deputy Director for Behavioral Health and their staffs. They spearheaded the interim Steering Committee until grant leadership could be appointed.
- The skilled writers of Hawai`i's grant application. Without them we would not have this opportunity.
- The Sub-Working Group (SWG) members, coming from all walks of life, all regions and cultures; the co-chairs of these groups who gave extra time and effort needed, including meetings and technical writing.
- The MHSRET Evaluation Team who worked hard to link the NA/RI with the efforts of our SWGs.
- Lending their wisdom and guidance to the whole process were the members of the Transformation Working Group.
- Numerous partners, both in Hawai`i and nationally: The State Council on Mental Health, the Hawai`i Communities of Practice, Leaders from concurrent grants, such as the COSIG, numerous consumer, youth and family representative organizations, as well as professional organizations and agencies; National experts including members of WICHE, the GAINS Center and organizations like NTAC, who supported them.
- SAMHSA support, and in particular our Federal Grant Officers and consultants.

Finally, on a personal note, we offer our deepest gratitude to Tercia Ku, Carol Medina, Judge Marcia Waldorf (ret.), Janet Iraha, Diane Lee, Gaylyn Kauleinamoku, and Gayle Matsumoto. Our MHTSIG Staff worked long and hard hours, supporting others with whatever was needed, be it late-night copying or expert facilitation at meetings.

Together, all of these partners have stepped up to the challenge and made this plan truly comprehensive. *Mahalo nui loa* (thank you)!

Executive Summary:

In 1999, the U.S. Surgeon General published a report on Mental Health in America, declaring that mental health is part of overall health, mental illnesses are real, are as treatable as physical health disorders and to focus on recovery (citation: US DHHS). In 2003, the President's New Freedom Commission on Mental Health (NFC), in researching whether mental health care across the nation conforms to what we know, found that major problems exist (citation: NFC). Fragmentation and serious gaps in care, as well as high unemployment and disability for persons with mental illness were widespread.

Prompted by the goals set by this Commission, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced the opportunity for Mental Health Transformation State Incentive Grants (MHTSIG) to help states better meet the Commission's goals, improving mental health care outcomes. The methodology prescribed included a Needs Assessment and Resource Inventory (NA/RI) and a Transformation Working Group (TWG) process to develop and implement a state-wide Comprehensive Mental Health Plan (CMHP). Forty-four states submitted MHTSIG applications in 2005; only seven states were granted an award.

Hawai'i was well positioned to benefit from the opportunity, having recently been released from two major court cases (one for adults and the other for children). As Governor Linda Lingle noted, it was "an opportunity of a generation" to have the funds to examine and improve the infrastructure of our Mental Health system of care and make a real difference for all citizens of Hawai'i including in rural and underserved areas. With guidance from the New Freedom Commission Goals and input from a broad spectrum of stakeholders, Hawai'i could now chart an independent way forward from Federal Court oversight to address the particular needs of our multicultural citizens in our unique island mix of urban and rural settings.

An Interim Steering Committee chaired by the Department of Health Deputy Director Michelle Hill oversaw the grant while the search for a MHTSIG leader was conducted. In Summer 2007, Governor Lingle appointed two leaders, a director and chief operations officer, to lead the grant. While the official Kickoff Event was held at the State Capitol on O`ahu, it was important to demonstrate a commitment to the people of Hawai'i on all islands. Thirteen more town hall meetings were held soon after, to begin in a grassroots fashion, first engaging the communities, then pulling together the Sub-Working Groups (SWG) and finally constituting the Transformation Working Group (TWG) for the grant.

Based on the NFC Goals and Hawaii's particular needs, seven SWGs were formed. Five of the groups are directly charged with considering one of the NFC Goals (1 and 2, as well as 4-6). Executive direction at the start of the grant emphasized the development of a meaningful process that includes all communities and cultures. This theme is addressed by NFC Goal 3, so all SWGs were charged with attending to "access that was geographically and culturally relevant". In addition, workforce

development and community supports were major themes for all stakeholders, giving charge to SWG 6. Linking the NA/RI and evaluation information with the Plan resulted in creating SWG 7, centered on evaluation.

An Evaluation Team, part of the University of Hawaii's Mental Health Services Research and Evaluation Team Project (MHSRET) began work on the NA/RI and supported the work of the SWGs through participation and the development of relevant reports.

The volunteers recruited from the fourteen Town Hall meetings began their work in the SWGs, in September 2007, with monthly (or more frequent) meetings following. Focus was on developing three to five recommendations each to be considered as part of the CMHP. The SWGs brought together representatives from a full range of communities. This included rural and urban, multiple cultures and many roles. MHTSIG Staff attended each SWG meeting to provide support to the overall process. Evaluation Team members also served on each SWG to provide information and technical assistance in the form of responses to queries.

Hawai'i also had national assistance. The Western Interstate Commission on Higher Education (WICHE), the National GAINS Center and Hawaii's (children's) Communities of Practice (CoP) provided additional consultation on workforce development, criminal justice and children's issues, respectively. WICHE supported the work of the SWG 6 (Workforce) with a technical report and meeting; the GAINS Center and the CoP each helped start specific MHTSIG efforts we considered Task Groups (TG).

Following the grass roots design, the TWG was convened by the Governor in November of 2007. It brought together relevant Department Directors, community leaders in mental health, consumers and family members, as well as SWG Co-Chairs. As steering committee, the TWG was first briefed on the grant process and in January of 2008 received draft recommendations from each SWG for feedback. A second round of Town Hall Meetings in January and February allowed MHTSIG staff, SWG members and State Council for Mental Health members to present these recommendations to their communities for additional feedback.

Based on this input and with format guidance from MHTSIG staff, the SWGs updated their recommendations, each of which can be found in full in the Appendix of this CMHP. Staff drafted the CMHP framework and used all feedback to collect into a new chapter overarching and priority recommendations. This was placed at the end of the SWG/TG chapters. As a quasi Editorial Board, the TWG helped refine this chapter and considered the implications for Governance. Together, these two chapters represent "the big picture" of this CMHP. Final edits were made and presented back to the TWG and SWGs and the CMHP was submitted to the Governor in March.

At the heart of this CMHP are thus the recommendations developed by the SWGs, informed by the NA/RI and expert input and refined by the TWG. A total of 28 recommendations were made (including those of the two TGs). These recommendations were clustered with TWG guidance and with attention to specific

overlap, conceptual similarity and implementation. A set of five overarching themes emerged:

- Educating the Public
- Systems Integration
- Consumer and Professional Workforce Development and Training
- Research, Evaluation and Dissemination
- Financing and Sustainability

These allowed us to consider all of the recommendations together and re-map them into new TGs charged with implementation. From this same exercise, a list of **Values** emerged that each TG was to uphold:

1. **Inclusive of consumer input and direction**
2. **Respectful of cultural and community protocols**
3. **Building capacity of consumers and family as well as providers to ensure sustainability, and**
4. **Encouraging collaboration and innovation.**

Drawing on the whole experience of this first year, a **Common Vision** has emerged and will guide us into the next stage:

Hawaii's transformed mental health system will focus on prevention, effective intervention and recovery across the life span, providing coordinated, culturally sensitive services state wide that are sustainable and consumer-driven.

As we move from planning to implementation, the role of the SWGs will become even more essential. They spent significant time thinking through complex issues and narrowing the focus. They will have to help us and the TGs maintain fidelity to their effort and to our grass-roots process.

This CMHP is clearly a work in progress. Due to the short timeline, SWGs had little time to fully digest the enormous amount of NA/RI information. They also had little time to coordinate their thoughts and recommendations. Thus, this first plan is a collaboration of SWGs, TGs, MHTSIG staff and the TWG and places initial priorities on the table. There are many pockets of excellence we have yet to uncover. Clearly, making transformational progress a reality will only be possible with a concerted, cross-agency effort, guided by consumer, family and youth input.

In the coming years, we will refine the recommendations and working quickly to begin implementation. We will seek opportunities work on difficult, but important long-term changes as well as seize opportunities for rapid changes and small implementation pilots. We have little doubt that the coming year (to the next September Plan deadline) will be as busy and productive as the first!

Introduction:

Development of Hawaii's Mental Health System

As we look forward together with this Comprehensive Mental Health Plan (CMHP), it seems vital to first look back to learn from our past and honor those who helped us achieve what we have now. Surprisingly little has been published about the history of Hawaii's mental health system. A brief, but important exception is the history offered by psychiatrist William Cody, who makes several of the following points (citation: Cody).

Much was lost with modern immigration following Captain Cook's explorations in 1778, including elements of the host Hawaiian culture, its wisdom and also the wisdom of those other peoples drawn from their homes in their cultures, all of which now make up the mingled present of our island state.

For example, in her book, *Nana I Ke Kumu* (Look to the Source), the late Mary Kawena Pukui, respected "*kupuna*" (elder), discussed the ancient practice of "*ho'oponopono* (to put to right)," a family therapy (citation: Pukui). Each successive layer of trouble (*mahiki*) is dealt with resulting in full and complete forgiveness (*mihī*), which frees all involved completely (*kala*). Thus, Hawai'i itself provides us with an example of family therapy that reaches back significantly beyond what we might otherwise have considered the beginning of such a treatment modality. Much work remains to recapture what we can of the frequently oral tradition and knowledge.

So, we leap ahead to 1850, when King Kamehameha III established the Board of Health. It was only a relatively short time afterwards that the 1862 Legislature authorized the construction of what was to be known as the "Oahu Insane Asylum". Built in 1866, it seems prophetic that the first six patients were transferred from the Honolulu Jail. When the new Territorial Hospital in Kaneohe was finished in 1930, 549 patients were transferred there. By 1960, the census had risen to beyond 1,200.

The origins of community mental health in Hawai'i also offer us one of those coincidences that seem prophetic. While Philadelphia Child Guidance Clinic's Frederick Allen's visit was dismissed in 1939, it was National Alliance on Mental Illness's (NAMI) founding director Clifford Beers' 1931 speech at McKinley High School that helped lead to the formation of Governor Lawrence Judd's Advisory Council on Mental Hygiene a year later. (NAMI would later play an important role in noting the status of mental health care in Hawai'i.) In 1937 University of Hawaii's consultant Franklin Ebaugh performed a comprehensive mental health survey that two years later led to the Hawai'i Mental Health Clinic, the success of which led to the 1939 formation of a Bureau of Mental Hygiene under the Board of Health. Regional mental health centers followed and still remain.

If we fast-forward to the more recent past, we note that some of the forces most strongly affecting mental health services were the results of legal challenges. From the litigation that revolutionized involuntary civil commitments and measurably changed Hawaii State

Hospital admissions (citation: Gudeman), to the recent conclusion of two major federal reform cases, litigation has changed the current landscape of Hawaii's mental health services.

In 1989, the US Department of Justice (DOJ) launched its investigation into the conditions at the Hawaii State Hospital, largely because in the late 1980's NAMI's E. Fuller Torrey ranked Hawai'i 51st behind all the other states and the District of Columbia in quality of mental health services. In 1991, the DOJ filed its complaint in federal court, and entered into a court-ordered settlement agreement with Hawaii (citation: US v Hawaii). By the conclusion of the litigation concerning the Hawaii State Hospital in December 2004, implementation of the settlement agreement had resulted in major improvements, including changes to the physical plant, improved staffing, individualized, recovery-oriented treatment planning, and active treatment supported by an off-unit rehabilitation mall. Full dismissal of the federal action occurred at the end of 2006 when the court found that the State had complied with the court ordered plan that increased and improved community-based mental health services while sustaining improvements at the hospital. In its 2006 report, "Grading the States" NAMI recognized the significant improvements Hawai'i had made in the sixteen years since it had last surveyed the states, giving Hawai'i an overall letter grade rank of C. (See [http://222.nami.org/gtsTemplate.cfm?Section=Grading the States&Istid=676](http://222.nami.org/gtsTemplate.cfm?Section=Grading%20the%20States&Istid=676)).

Reforms of the child and adolescent residential services were also required by the DOJ case above. In addition, a second major case (Citation: Felix v. Lingle), a private class action named the Felix Consent Decree had commenced in 1993. This suit mandated that the state provide appropriate services to special needs children. The State Departments of Health and Education worked together to reform the manner in which Hawaii provides mental health services to children and adolescents in public schools. The Felix case was finally dismissed in May 2005.

As is usual when institutional reform is obtained via litigation, major progress was achieved within an often grueling timeframe and primarily in response to legitimate pressure by plaintiffs, their experts and the courts. But this was reactive planning. By its nature, changes were focused to respond to specific requirements, often identified by parties or outside experts.

We now have a chance of a generation to learn from our past, honor the efforts of those who have gone before and dedicate ourselves to the opportunity mental health transformation offers. This CMHP allows us to chart our path for the future.

We can decide locally how we emphasize prevention and resilience, how we provide services that are geographically and culturally appropriate and can be demonstrated to work, and how we assure that recovery is a reality for those who have had to struggle with mental illness. Individually, consumers, family members and youth, collectively the communities in which they live, are the voices we tried to hear in the development of this plan. Having looked back, we can now look forward. We humbly acknowledge we still have much to learn from the past and each other!

Hawai`i Mental Health Transformation State Incentive Grant Process

On October 2006, Hawai`i received a “once in a generation opportunity” when it became the eighth of nine state in the Nation to receive a federal Mental Health Transformation State Incentive Grant (MHTSIG) worth \$10.95 Million over five years. Hawai`i had received a number of grants which focus on a specific age or type of mental health consumer. What makes this grant unique is its focus.

The expected outcome of “transformation” is changing how we, as a State and as a community, work together to provide consumers and their `ohana or family with a network of mental health services from prevention to recovery, delivered when and where the services are needed, utilizing culturally appropriate approaches. The scope of this effort calls for tremendous commitment from many stakeholders and a willingness to honestly review what is and ask what can be. It may require relinquishing the status quo in favor of what works best for each community, redistributing and leveraging resources to create a sustainable quality system of care.

The leadership of MHTSIG was not decided until late May 2007 with the hiring of Dr. Rupert Goetz as Director and Sharlene Chun-Lum as Chief Operations Officer. As co-directors leading the grant, the first task was to inform the many different stakeholders as well as the general public of the Grant and its possibilities.

The official information sharing and gathering began on July 11, 2007, when 168 stakeholders met at the State Capitol for the official kick-off of this transformation process. Commander David Morrissette, SAMHSA Project Officer, and Carol Bianco, consultant, participated in the day-long event that included opening with a traditional hawaiian chant (*oli*) and prayer (*pule*). After opening speeches from Dr. Goetz, Commander Morrissette, Governor Linda Lingle and Department of Health Director Dr. Chiyome Fukino, it was Laura Miyashiro, a consumer from the Friendship House in Kapa`a, Kaua`i, who took the stage to share her story of how becoming a part of the workforce was vital to her recovery and well-being.

Her inspiring message set the stage for the remaining participants to convene in eight breakout groups to share why they came to the kickoff and what they wanted to see as an outcome of the MHTSIG process. Participants were pre-assigned to a group, assuring that a cross-section of interests would be represented. Titles and position were “left at the door” with every participant on equal footing—each voice being valued and heard. Facilitators and recorders helped capture the stories and ideas of their group’s many stakeholders in the morning session.

At noon, participants were welcomed by Lt. Governor James R “Duke” Aiona Jr. to Washington Place, the home of Hawaii’s last Queen, Lydia Lili`uokalani, and the symbolic residence of the Governor. The gesture of opening the Governor’s home to the participants for a brief respite and light refreshments before reconvening again at the State Capitol emphasized the idea that this process would value and honor inclusive participation.

Participants returned to their groups after lunch to agree upon and to visually capture the themes that emerged from their morning sessions. The powerful messages depicted in each group's poster continue to be used by MHTSIG for major conference, training and Town Hall Meeting announcements.

Early commitment to working with MHTSIG came from the Judiciary, when Chief Justice Ronald Moon hosted a reception at Supreme Court Conference Room that same evening. The guests, including SAMHSA leaders, judges and Judiciary staff, the office of the Attorney General and behavioral health leaders, discussed what other states are doing and what actions Hawaii's Judiciary could adopt to improve the way people with mental illness are treated in our Criminal Justice System. This opened the door for engaging the services of the GAINS Center in November 2007. (The GAINS Center's primary focus is on expanding access to community based services for adults diagnosed with co-occurring mental illness and substance use disorders at all points of contact with the justice system.)

Soon after the O`ahu kick-off, thirteen Town Meetings were conducted in communities across the island chain, from Pahala, Hawai`i to Hanapepe, Kaua`i—to include the input of more than 350 voices to inform the transformation process. It was at these broad grassroots gatherings that members of the Sub-Working Groups (SWG) were first recruited. Participants were invited to volunteer to be part of seven SWGs that would meet monthly for at least half a day and spend additional hours on their own, responsible for reviewing data, investigating best practices and making recommendations for the CMHP.

Building on New Freedom Commission goals and Hawaii's unique needs, key focus areas (SWG titles) were determined to be:

1. Promoting & Understanding Mental Health;
2. Consumers & Families as Drivers;
3. Early Intervention and Assessment;
4. Accelerating & Expanding Quality Services;
5. High Tech & Local Touch;
6. Workforce & Community Supports;
7. Evaluation

Consistent with executive direction at the outset, two overarching themes were given all groups to consider: making mental health culturally and geographically accessible, as well as making them accountable.

Response to participating in the process was enthusiastic. More than 200 people representing every island in the state signed up to participate at the SWG meetings. Moreover, the Transformation office continued to receive e-mail inquiries or calls from individuals wishing to volunteer. They had learned of the MHTSIG effort from those who attended the town meetings or from employers or peers. Wait lists were kept for SWGs

already filled with 50 volunteers and new volunteers were encouraged to join less populated SWGs.

While lists and materials for the first SWG meetings were being finalized, MHTSIG was also preparing a location to host the work of the SWGs. In Pearl City, O`ahu, a building that until the 1990's had been home to young boys and adults who suffered from developmental disabilities was undergoing DOH renovation. This building was chosen to take on new life as offices for MHTSIG operations and the Performance Utilization and Quality Assurance Units of the Adult Mental Health Division and MHTSIG staff could be co-located, sharing valuable expertise and resources. On August 25, 2007, the building was blessed, rededicated and renamed *Uluakupu*, which means "to develop or grow". The building became completely functional in late September.

When the first meeting of the volunteers was held at the Pearl City Cultural Center near the MHTSIG offices on September 5, 2007, more than 120 attended, including 32 members from the Neighbor Islands. Their charge for the day was to complete a SWG charter. They were to:

- Introduce themselves and share what brought them to the group,
- Recommend others who should be in the group,
- Select a facilitator and recorder,
- Select co-chairs, at least one of whom should be a consumer or family member of a consumer,
- Define the work of the group to forward the MHTSIG process,
- Define strategic priorities,
- Determine meeting dates and locations.

All SWG monthly meetings, except for one, were subsequently convened at Uluakupu. MHTSIG staff make all travel and ground arrangements for Neighbor Island (NI) participants. In addition to being culturally important, providing light refreshments to sustain the members for the three- to four-hour long meetings was critical for NI participants, who devote their entire day to coming to the meetings.

Three additional efforts supported MHTSIG's working group process in this first year. The Western Interstate Commission on Higher Education (WICHE), the National GAINS Center and Hawaii's (children's) Communities of Practice (CoP) provided additional consultation on workforce development, criminal justice and children's issues, respectively.

- In October, Dennis Mohat and Deborah Kupfer from WICHE held two days of workshops and meetings focusing on workforce development. Supported by an NTAC grant, they began the process of developing a white paper on the situation in Hawai'i. On the first day, two three-hour sessions were open to consumers and professionals to discuss national trends and to gather information about our needs. On the second day, the consultants met with members of five Clubhouses to discuss

barriers to and wishes for employment. Later that afternoon, meetings with members of SWG 6 provided this group with technical assistance.

- In late November Dan Abreu and Robert Weisman came as consultants from the GAINS Center, again supported by a national grant. During a four day event, criminal Justice issues as they intersected with mental health were the focus. Participants included representation from judges, chiefs of police, prosecutors, public defenders, Public Safety (adult corrections here in Hawai`i), juvenile justice, Department of Health, Office of the Attorney General and members of the Legislature. Workshop days covered Hawaii's practices for handling persons with mental illness, in the criminal justice system as well as national trends and the GAINS sequential Intercept Model. As a result, we are in the process of developing a Task Group, under the leadership of Judge Marcia Waldorf (ret.), who joined the MHTSIG staff in a part-time role in November. She has been meeting with stakeholders to clarify issues and determine who should be part of the group.
- A major, local collaborative was instrumental in addressing children's needs. Hawaii's Communities of Practice (CoP) and MHT SIG together sponsored a "Children's Mental Health Summit" on December 10th. More than 130 key stakeholders attended the all-day event at the Windward Community College. The Summit featured Robert Friedman specialist in developing systems of care and Mark Weist, Specialist in school based behavioral health to provide a national perspective on best practices. Participants from the Departments of health, Education and Human Services, together with representatives from primary care developed a series of strategic goals. On the following day, key stakeholders refined these, with linkage back to the CoP at their January meetings. The major recommendation is to ask the Governor to convene and Executive Summit of children-involved partners to set direction. Focus would be on youth-guided and family-driven planning as well as systems integration.

In November 2007, teleconferencing equipment was installed in one of the two MHTSIG conference rooms, making it possible for NI members who are near DOH Video Conference Centers (VCC) to join the meetings without the inconvenience of air travel. This is especially important to members wishing to participate but whose work or family commitments make it difficult to travel. Though VCC was an option, it was important to many, including consumers, to attend the meetings in person, establishing direct relationships.

With the work of the SWGs underway, it was time to convene the Transformation Working Group (TWG). The TWG was selected by Governor Linda Lingle to be broadly representative, including members of her Cabinet, the Department of Education, the Judiciary, NI Counties, the Legislature, organization leaders, Chairs of each Subcommittee, and consumers and family members. Consistent with the Governor's direction for inclusiveness, the group brings together over 58 members. It is the charge of this group to act as the "steering committee" for the CMHP. The first meeting on November 6, 2007 was held at the State Capitol Auditorium. The agenda allowed TWG members to learn more about the grant, to review the ideas being considered for recommendations from the SWGs, and to provide initial input and feedback.

In December 2007 and January 2008, SWGs worked with NA/RI information and guidance from MHTSIG to begin to solidify their recommendations. MHTSIG staff helped summarize the recommendations, needs/rationale, and action steps from each SWG and put them into a similar format for presentation to the TWG.

At the second TWG meeting held at the Queen's Conference Center in January 14, 2008, members had four opportunities to provide input and direction on the SWGs' recommendations that would ultimately be the basis for the CMHP:

1. TWG members joined the specific SWG table where they felt they could contribute the most, to review the three to five recommendations being made and to provide the co-chairs with additional information to strengthen them.
2. Back in the plenary, as SWG representatives briefly presented the results from the first process, members were asked to comment on each recommendation. They were given a two-part NCR form and told to add specific comments and select seven recommendations they felt were most important. Members kept a copy of the form for their own records. (The comments from all TWG members were later compiled by MHTSIG staff and shared with the SWGs to consider as they refined their recommendations.)
3. TWG members also filled out an evaluation form to rate each of the (then) 27 SWG recommendations as to "priority" and "feasibility". (These were analyzed by the UH Evaluation Group and the results were also shared with the SWGs. See Appendix.)
4. At the end of the meeting, TWG members indicated which seven recommendations they had selected using seven dots to place on poster-sized reproductions of the recommendations. This created a visual indication of how the collective group viewed the recommendations and led SWGs to refining their recommendations.

Since this was the first time SWG co-chairs had the opportunity to gather, the TWG meeting allowed all to see where recommendations or action steps overlapped between SWGs or had similar purpose. The idea of consolidating some recommendations under braided, overarching themes was introduced.

Having received input from the TWG, the next focus was returning to the communities for their grassroots response. From January 22 to February 7, 2008, a second series of town meetings was conducted by MHTSIG Staff and accompanied by an evaluation team member. Meetings were held on the islands of Hawai'i (4), O'ahu (3), Kaua'i (2), Maui (2), Lana'i (1), and Moloka'i (1). This fulfilled the promise made earlier by DOH and MHTSIG leadership to return to the communities for review of the recommendations being considered for inclusion into the CMHP.

These two-hour meetings included participation from SWG community members, representatives from the State Planning Council on Mental Health, and other key stakeholders. Two slide show presentations gave the audience a quick MHTSIG update and an abbreviated version of the SWG recommendations. Participants were asked to provide comments on the same two-part NCR form used at the TWG meeting

and to fill out a revised survey form that asked their opinions of each recommendation's "priority", "feasibility" and "impact". (The "impact" rating was added to capture how "transformational" recommendations would be perceived by the MHTSIG participants and grass-roots. The UH Evaluation team received 180 surveys and have compiled the results as additional data for consideration. The comments collected on the NCR form were also compiled for use by the SWGs and TWG. (See Appendix.)

SWGs held meetings in February to reflect on the newly provided data and to refine their recommendations to make them "SMART"—Specific, Measurable, Achievable, Relevant, and Time-bound. Working closely with SWG co-chairs, MHTSIG staff consolidated the recommendations into individual reports that are included in full in the Appendix to this CMHP.

Preparing the document made us keenly aware that there are synergies that truly belong in overarching themes. By clustering these recommendations with attention to specific overlap, conceptual similarity and implementation concerns, five areas of focus emerged:

1. Public Education
2. Systems Integration
3. Workforce Development and Training
4. Research/Dissemination
5. Financing

At the February 25th TWG meeting, we engaged members in thinking through the overarching themes, implementation of recommendations, as well as the governance implications. Spirited discussion about the wording and meaning of the overarching themes allowed members take ownership of the final themes chosen. These appear in the chapter entitled "Overarching themes."

It was noted that different dimension were mixed and that a conceptual model was needed to bring everything together. We had been able to identify the Common Vision from the process so far. In this discussion, we attempted then to distinguish "Values" from "implementation issues" that require attention by each of the Task Groups:

- Values:
 - Consumer, Family and Youth Involvement
 - Cultural and Geographic Access (from SWG original charge)
- Implementational Issues:
 - Use of a Public Health Model
 - Address Services Across the Life-Span*
 - Address Public-Private Partnerships
 - Address Technology Use

*Note: As part of this discussion, it was noted that children's issues had been addressed by a Task Group. The TWG was clear in its direction that conceptual clarity and integration was essential. No single age span should be singled out, possibly implying that this would be more important than another. Further work will be required to reconcile this direction with the TWG direction for inclusiveness.

As in the January TWG meeting, members received a score card on which they assigned each recommendation to one of the five revised overarching themes. The results of this thinking are discussed in this CMHP's core chapter on overarching recommendations.

On March 11, 2008, six months after the initial formation of the SWGs, MHTSIG called together a meeting of all SWGs to celebrate the completion of the first year's version of the CMHP and look forward together. This milestone could only have been reached through the collective efforts of all involved.

The final draft version of the CMHP was sent to the Director of Health, Deputy Director of Health and the Governor's Policy office for review and comment. Suggestions for revisions were addressed and are now in this final version of the first year CMHP.

As this first year's plan is submitted, we are energized by the growing community support and look forward to our future efforts, building upon our strengths --celebrating our cultural and geographic diversity and weaving the collective knowledge of these assets into a powerful comprehensive system of care for our `ohana (family) with mental health needs.

Comprehensive Mental Health Plan Chapters:

From the Federal perspective, one of the main goals of the Mental Health Transformation State Incentive Grants was to help states “build a solid foundation for delivering and sustaining effective mental health and related services” (citation: RFA). The RFA goes on to note that the program will advance “the vision and goals of the final report of the President’s New Freedom Commission on Mental Health”. As a consequence, this CMHP was to be organized according to the six goals of the New Freedom Commission (NFC), with the addition of a chapter on Governance.

Recognizing “that each applicant will start from a unique point in the process of infrastructure and service delivery transformation and will serve populations with specific needs” (citation: RFA) one of first tasks Hawaii’s MHTSIG leaders embarked upon was to consider how Subgroups should be organized. One way would have been to organize six subgroups, one around each NFC goal. However, discussions with the Interim Steering (representing key mental health stakeholder agencies) quickly revealed that two major areas were essential to Hawaii’s plan. Shortage of a qualified, culturally sensitive mental health workforce in all areas, including rural regions was as big of an issue, as was organizing mental health services around principles of outcomes measurement. Thus, the decision was made to focus a workgroup on each of these issues. At the same time, executive direction to the new leaders at the start was to assure that the project would make real differences for Hawaiians in all areas, with special attention to rural and cultural needs. Therefore, the decision was made to consider NFC Goal #3 (Disparities in Mental Health Services are Eliminated) an essential requirement all subgroups were to consider.

Over the course of this first project year, two additional themes emerged, requiring attention. In Hawai`i one of the historically grown routes into mental health services is through the criminal justice system. No state has similar numbers of persons suffering from mental illness on their conditional release rolls (citation: Office of the Governor). At the same time, mental health services in Hawai`i were significantly shaped by now resolved litigation (see Introduction). One of these had been the consent decree (citation: Felix) that affected how mental health services were provided to school-age children. As a result of resolving the case, Hawai`i is now in the midst of mapping its own way forward in the area of children’s services. Existing work between education and mental health agencies needed to be coordinated with transformation. We captured both themes as Task Groups (TGs).

All together, we convened seven Sub-Working Groups (SWGs) and two Task Groups (TGs). The following table helps illustrate the cross-walk between Federal and Hawai`i priorities.

Table SWG/TG: Cross Walk of NFC and Hawai`i Goals

SWG/TG	NFC Goal	Hawai`i Goal (SWG Name)
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SWG #1	1. Understanding MH is Essential to Overall Health Care	Promoting and Understanding Mental Health
SWG #2	2. MH Care is Consumer and Family Driven	Consumers & Families as Drivers
Cross-Cutting Theme	3. Disparities in MH Services are Eliminated	All SWGS to attend to culturally and geographic access
SWG #3	4. Early MH Screening, Assessment and Referral to Services are Common Practice	Early Intervention
SWG #4	5. Excellent MH Care is Delivered and Research is Accelerated	Accelerating and Expanding Quality Services
SWG #5	6. Technology is Used to Access MH Care Information	High Tech and Local Touch
SWG #6	(Part of NFC Goal #5)	Workforce and Community Supports
SWG #7	(Implied in NFC, especially NFC Goal #5)	Evaluation
TG CJ	(Part of NFC Goal #2)	Criminal Justice Issues
TG C	(Part of NFC Goal #4)	Children's Issues

To meet both the requirement of the grant as well as Hawaii's unique needs, three sets of chapters follow: 1) The chapters required under the grant that address the NFC Goals. (Note that NFC Goal 3 was considered an overarching theme that all groups were to address.) Based on important feedback to keep the CMHP readable, we present only a brief summary, including the "charge" to the group (often the NFC Goals), the membership, their recommendations and the rationale in the body of this plan. Full reports are placed in the Appendix and include significant detail, including the groups' thinking about rationale, implementational detail (action steps) suggested and time frames. 2) The chapters that similarly summarize topics specific to Hawai'i. They begin with Workforce and Evaluation, and end with the recommendation that two task groups be formally constituted to address criminal justice and children's issues. 3) A chapter laying out overarching themes emerging from the collected recommendations. Their "overarching" nature is based on concordance between SWG's work, on TWG and/or community ranking, and/or on NA/RI information.

Following these three sets of chapters is the Governance and Organizational Structure chapter. **It, together with the Overarching Themes chapter constitutes the heart of this CMHP.**

President's New Freedom Commission Goal Chapters

President's New Freedom Commission (NFC) Goal #1:

SUB-WORKING GROUP (SWG) #1: PROMOTING & UNDERSTANDING MENTAL HEALTH

My name is Laura and I'm a consumer diagnosed with a mental illness at the age of 42 that I have had most of my life. I have lived in chaos for many years- depressed, suicidal, and miserable. I became a drug addict and alcoholic to cope. I became a single parent of three children at the age of 34 and had a mental breakdown, when I moved here 8 years ago.

I was not on any medication and through the year saw a physician on and off but with no help. I tried to commit suicide thank God I'm still here.

Today I am on medication, have a case manager, consumer support group, doctor "that knows my case" and supportive friends. My life is better but I still find many days difficult. But I have the help and education and support that I need. Life is much better and is getting better, God willing each day.

SWG #1 Guidance:

NFC Goal 1: Understand that Mental Health Is Essential to Overall Health.

NFC Recommendations include:

- 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
- 1.2 Address mental health with the same urgency as physical health.

SWG #1 Membership:

Co-Chairs: Suzanna Dee and Marya Grambs

Facilitator: Deborah Arendale

Members: Laura Adams-Clarke, Charlotte Boyd, William "Bud" Bowles, Jody Chow, Diane Fujio, Aimee Leong, Donna Makaiwi, Ernest Neves III, Charlene Paden, Veronica Pahia, Noe Perreira, Kathleen Rhoads Merriam, Diane Robinson, Darryl Salvador, Sharon Usagawa, Steven Vannatta.

MHTSIG support: Sharlene Chun-Lum, Tercia Ku, Carol Medina, Marcia Waldorf, Daryl Fujii

SWG #1 Recommendations:

- 1.1 Design and implement a public education campaign to promote the understanding of mental health issues.
- 1.2 Reduce the rate of suicide and suicide attempts.
- 1.3 Equalize and integrate physical and mental health care.

Rationale:

In considering its charge, the SWG noted that stigma of mental illness creates an unnecessary and undesirable separation between mental health and physical health, discourages many from seeking mental health services, and prevents communities from supporting persons with mental illness. These factors ultimately relate to the significant suicide risks persons in Hawai`i face. Accordingly, the members chose to make a public education campaign their top priority, thereby elevating awareness of mental health. The SWG also identified suicide intervention skills and prevention activities as a high priority. The combination of these emphases lays the foundation for further steps to equalize and integrate mental and physical health and eliminate stigma.

President's New Freedom Commission (NFC) Goal #2:

SUB-WORKING GROUP (SWG) #2: CONSUMERS & FAMILIES AS DRIVERS

The experience that I always take with me that fuels my passion for mental health transformation is this:

One day as I was driving home from work, I drove past a middle-aged, homeless man who appeared sad and all alone. He was pushing all that he contained in his life in a grocery cart. I couldn't help but noticed that this man resembled my father at first sight, which broke my heart to tears and I realized that he could be my father! This incidence affected me as I felt a deep compassion, to transform my life through education, so that I could use my life as an agent for change for what could have been my own father.

SWG #2 Guidance:

NFC Goal 2: Mental Health Care Is Consumer and Family Driven.

NFC Recommendations include:

- 2.1 Develop an Individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery
- 2.3 Align relevant Federal programs to improve access and accountability for the mental health services.
- 2.4 Protect and enhance the rights of people with mental illnesses.

SWG #2 Membership:

Co-Chairs: Alfred Arensdorf (stepped down), William Lennox and Sunday Nelson

Facilitator: Lucas Bruno III

Members: William "Bud" Bowles, Charlotte Boyd, Leah Chang, Phyllis DeKok, Sarah Eum, Peter Gonzalez, Rachael Guay, Randolph Hack, Karen Hale, Toby Hazel, J.Kaoi Hulama, Charlotte Kamauoha, Darryl Lum, Donna Makaiwi, Patricia McGrath, James Mihalke, Kenneth Ming, Maile Ohira, Kathleen O'Malley, Michael Pablin, Rena Reid, Mincha Saito, Kalei Sombelon, Alton Tamashiro, Paula Wong, Jessica Wong-Sumida.

MHTSIG support: Sharlene Chun-Lum, Tercia Ku, Carol Medina, Daryl Fujii, Cori Gift, Steve Onken

SWG #2 Recommendations:

- 2.1 Accountable consumer and family driven policies with education and oversight within systems are implemented by 2011.
- 2.2 Ensure that Consumers are serviced with aloha, courtesy and respect by professionals.
- 2.3 Provide more options for care, including alternative and indigenous practices.
- 2.4 Create a rapid response, trauma informed system of mental health and wellness care.

Rationale:

Beginning with the premise that consumers and families should be drivers of mental health services and systems, members of SWG #2 first noted that consumers needed to be empowered, services should be more consumer-friendly and well coordinated in one-stop centers. There was a confusing array of services, services were at times not available and delivered under/with different assumptions in different locations. The views of consumers and family members should be respected and they should have a voice in the development and implementation of policies that are accountable to their clients. On an experiential level, users of mental health services at times felt more tolerated than welcomed, seen as an object of work than as partners in a health care discussion. This should be addressed directly by challenging providers of services to emphasize aloha (courtesy and respect). Options for care were also seen by members as at times limited to specific mental health treatment, not the full range of services needed. SWG members felt co-occurring conditions and indigenous practices should be addressed early, particularly in crisis situations, like the emergency rooms or when in contact with law enforcement. A trauma-informed model of care should be used to make progress toward “friendly spaces in natural places”.

President's New Freedom Commission (NFC) Goal #3 (Cross Cutting Theme):

Cross Cutting Theme: CULTURAL AND GEOGRAPHIC ACCESS TO QUALITY CARE

I work in mental health: A former member of my agency remained in touch with me. She called me last week to tell me her daughter died three weeks ago. Her funeral was last week. A former member of my agency OD'd last Monday - and was in the hospital all week. The hospital released her on Friday with none of her support in place. She called her psychiatrist but got no return call. I saw her. (I was visiting the island and went to see her.) She gave me some more of her pills that she had taken for her OD.

I would have appreciated a half way mental health house for her to stay at - she is still at strong risk for self injury. Also why did the hospital just release her on Friday? Weekends are hard.

Guidance to all SWGs:

NFC Goal 3: Disparities in Mental Health Services Are Eliminated.

NFC Recommendations include:

- 3.1 Improve access to quality care that is culturally competent.
- 3.2 Improve access to quality care in rural and geographically remote areas.

Recommendations from all SWGs:

Recommendations from each Sub-Working Group include:

- 1.3 Equalize and integrate physical and mental health care.
- 2.3 Provide more options for care, including alternative and indigenous practices.
- 3.2 Improve utilization of, and develop community resources for early intervention across the lifespan by 2011.
- 4.1 Hawaii will have a comprehensive, integrated, coordinated, community based system that conducts and reviews research that will expand access to evidence-based mental health interventions and innovations that work for Hawaii's population.
- 5.4 Expand the use of tele-health to improve the quality of health services for underserved populations by improving access to mental health specialists and to culturally sensitive evidence based training/education.
- 6.2 Appoint and convene an ongoing Mental Health Workforce Development Collaborative comprised of key stakeholders to develop and implement long-term solutions to produce a diverse, locally developed mental health workforce.
- 6.4 Establish and sustain mental health training centers on each island that support culturally competent and consumer and family driven recovery,

resilience and early intervention. The centers will honor indigenous knowledge and practices of the host and other local cultures.

- 7.2 It is recommended that an entity be established to: 1) accumulate literature on cultural healing mirroring Hawaii's diverse ethnic population, 2) coordinate and oversee outcomes research on indigenous and traditional cultural ways of healing, well-being and treatment, particularly approaches addressing health, mental health and substance abuse problems, and 3) disseminate this literature to inform clinical services.

Rationale:

In considering SWG composition from the beginning, it quickly became apparent that access to services would be one of the top concerns for MHTSIG. Accordingly, all SWGs were asked to attend to this topic and in fact all made relevant recommendations. These are collected in one place to illustrate the critical nature of this element.

President's New Freedom Commission (NFC) Goal #4:

Sub-Working Group (SWG) #3: EARLY INTERVENTION

My story is simple and sadly I see it repeating over and over again in our communities.

I have a child who has a serious mental health illness, who could not obtain psychiatric services in our rural community. Meds were prescribed by our pediatrician with psychological services paid for out of pocket until doing so was financially impossible. Upon requesting assistance from the Department of Education, our family fell victim to systems barriers. Simple refusals for medication monitoring, modifications, delays beyond 45 days to take a meeting and the resulting escalation of behavior have torn our family apart... When faced with continued barriers and behavioral escalation with false allegations, I made a decision to place the child in mainland setting...

Coping with all this is overwhelming only further burdening a parent who being forced to make such a terrible choice suffers for themselves (loss, fear, self doubt) all the more traumatic. Having survived this ordeal, I am working to promote system change, educate families on their rights and how to work with the system in hope that no other families suffer as we have.

SWG #3 Guidance:

NFC Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.

NFC Recommendations include:

- 4.1 Promote the mental health of young children.
- 4.2 Improve and expand school mental health programs.
- 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports

SWG #3 Membership:

Co-Chairs: Ramona Chinn and Sherry Sorenson

Members: Laura Adams-Clarke, Paul Ban, Leonard Batungbacal, Jennifer Baughan, Jeny Bissell, Gail Breakey, Judith Clark, Deedee Fronius, Loretta Fuddy, Clayton Takemoto, Howard Garval, Butch Gima, Patricia Harnish, Tina Hatayama, Toby Hazel, Run Heidelberg, Robyn Inada-Tiave, Heidemarie Koop, Michael Moore, Albert Pacheco Jr., Daryl Selman, Joe Shacter, Virginia Shaw, Katherine Sweetser, Joan Takamori, Art Tani, Sharon Usagawa, Po Kwan Wong, Kathy Yoshitomi.

MHTSIG support: Sharlene Chun-Lum, Tercia Ku, Carol Medina, Cori Gift

SWG #3 Recommendations:

- 3.1 Develop and expand prevention, early intervention and treatment services to promote the emotional well-being for young children and their families by 2011.
- 3.2 Improve utilization of, and develop community resources for early intervention across the lifespan by 2011.
- 3.3 Develop an interdisciplinary training institute for early intervention and improve systems integration by 2009.
- 3.4 By 2010, screening, identification and management of mental disorders in primary care, across the lifespan, become standard of practice.

Rationale:

In considering its charge, members of SWG 3 noted a particular lack of focus on the youngest children, when attachments are developed and risk can be addressed early. Accordingly, this was their first area of recommendation. Similar to an earlier group, the members were impressed with the complexity of mental health service settings across the life span. Accordingly, communities will support wellness, develop prevention programs and assure the creation of “one stop shops” that serve all age groups. However, even with such physical locations were available, it was noted that practices and expectations varied significantly. An interdisciplinary approach to the training of staff in such facilities was needed. Finally, using a public health approach, care should be shifted more from treating identified or obvious problems to universal screening, supporting earlier referral and intervention.

President's New Freedom Commission (NFC) Goal #5:

Sub-Working Group (SWG) #4: ACCELERATING & EXPANDING QUALITY SERVICES

I have become involved in MHTSIG after the death of my partner last year. He suffered from dementia due to Hepatitis C in the last five years of his disease and died at the young age of 60. As his primary support system, I did not understand the word "dementia", as it was applied to the viral destruction of the liver, until I had to live through this slow-moving, chronic disease with my friend and partner. There was very little help from doctors, clinics, emergency rooms, and finally the occasional call to the police when the viral counts would dramatically increase and cause severe confusion.

The symptoms of this relatively new mutation of liver disease are extremely hard on family and loved ones. Support is critical as well as the recognition of dementia as mental disorder.

SWG #4 Guidance:

NFC Goal 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated. NFC Recommendations include:

- 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
- 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

SWG #4 Membership:

Co-Chairs: JoAnn Ahuna and Ha`aheo Mansfield

Facilitator: Linda Appel

Members: Ike Ahmed, James Allegretti-Davis, Steve Balcom, Paul Ban, Barbara Bradish, Judy Brasel, Mary Brogan, Joy Canute, Michael Christopher, Jon Emura, Carol Evans, Arlanda Fields, Loraine Fleming, David Fray, Keith Izawa, Marilyn Kerker, Eva Kishimoto, Kathleen Libao-Laygo, Kristen Low, Jean Luka, Malia Manol, Carol Minn, Rena Reid, Constance Santana, Margaret Shepherd, Marvin St. Clair, Anne Sturgis, Denise Tamala, Sharon Usagawa, John Viesselman, Marie Vorsino, Michael Wurtz.

MHTSIG support: Rupert Goetz, Sharlene Chun-Lum, Tercia Ku, Carol Medina, Daryl Fujii, Cori Gift

SWG #4 Recommendations:

- 4.1 By 2010 establish a comprehensive, integrated, coordinated, community based system that conducts and reviews research that will expand access to evidence-based mental health interventions and innovations that work for Hawaii's population.
- 4.2 By 2010 establish a system that makes sure that all providers are doing what works best. This will include having an infrastructure to disseminate evidence-based services and best practices addressing the priority needs of its population.
- 4.3 By 2010 create a results-driven accountability system that evaluates the effectiveness of mental health services and measures the quality of service delivery.
- 4.4 By 2010 establish a system with the necessary conditions, leadership and authority to advance research and expand and sustain quality services.

Rationale:

SWG 4 began with considering what constituted excellent practices, noting the different types of "evidence" that might assist in determining effective practices and services delivery models. In addition to "evidence based practices", members felt they should also include the development, dissemination and continuous improvement of services across Hawaii's communities that are sensitive to its needs. None of this could be accomplished without strong leadership and authority to implement a comprehensive, integrated, coordinated, community-based, culturally sensitive system that conducts and reviews research that will expand access to evidence-based mental health interventions and innovations that work across Hawaii's population.

President’s New Freedom Commission (NFC) Goal #6:

Sub-Working Group (SWG) #5: HIGH TECH & LOCAL TOUCH

I am motivated by one of the first consumers I met when I moved here. I still get invited to her recovery planning meeting occasionally. She told her “intake story”, seven times trying to get into our system. I was trying to get her a case manager but she was seen as “non-compliant, difficult, manic, dangerous, drugged and homeless.” I learned about the array of services we have and went through each success with her. Her journey resulted in several case managers, jail and HSH.

She has been my teacher, my mentor, my colleague and I think of her as I participate in my working group. I love the themes that have emerged and the mission statement. Our consumers deserve us working more effectively together.

SWG #5 Guidance:

NFC Goal 6: Technology is Used to Access Mental Health Care and Information.

NFC Recommendations include:

- 6.1 Use health technology and tele-health to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- 6.2 Develop and implement integrated electronic health record and personal health information systems.

SWG #5 Membership:

Co-Chairs: Sarah Eum and John Jansen

Members: Yoko Ancil, Traci Brown, Michael Fukuda, Chad Koyanagi, Karen Krahn, Connie Mitchell, Lorna Nekoba, Michael Palazzo, Chris Perreira, Jan Rumi, Steven Vannatta, John Viesselman, Art Williams, Jennifer Wong.

MHTSIG Support: Rupert Goetz, Tercia Ku, Daryl Fujii

SWG #5 Recommendations:

- 5.1 Review and potentially change state regulations making technological collaboration easier for providers while maintaining the consumer’s right to privacy.
- 5.2 Plan, phase-in and help coordinate the development of compatible electronic health record systems that improve efficiency and access for consumers and providers.
- 5.3 Promote consistent and streamlined processes across provider agencies to facilitate continuity of care. This includes sharing policies, procedures and

technology supporting “One Stop Shop” opportunities for care and eliminating redundancies.

- 5.4 Expand the use of tele-health to improve the quality of health services for underserved populations by improving access to mental health specialists and to culturally sensitive evidence based training/education.

Rationale:

Aware of the need to use technology to uniformly serve the mental health needs of the people of Hawai`i, one of the greatest barriers was considered by members of this SWG to be the state’s own regulatory framework. All too often, collaboration stopped with citation of confidentiality, even when providers were serving the same person. Thus, members recommended addressing this as the top priority. Considering the two most important emerging technologies, electronic records and telehealth, members thought that electronic records presented the most complex set of issues and should be addressed next. It was emphasized that there could be no “one size fits all” approach and that coordinating development among all providers, large and small, would be needed. Members felt that it should be clearly stated that technology and telehealth should be used to empower local providers to provide training, education and mental health services. Therefore, this became their third recommendation. Finally, members wanted to emphasize that tele health, while critical to providing services, coordination and training in rural and underserved areas, it would always be critical to assure this occurred in a culturally sensitive manner.

Hawai`i Goal Chapters

Sub-Working Group (SWG) #6: WORKFORCE AND COMMUNITY SUPPORTS

My passion and dedication to be involved with transforming our mental health system, comes directly out of my own transformation. It was because of the Peer Specialist certification class and the hope and inspiration that it instilled in me, that I realized I could be more than just a day treatment attendee.

My life since certification has totally changed. I know recovery and consumer helping consumers works. I know transforming the system will allow more consumers to blossom above and beyond even their wildest imaginings.

If it hadn't been for me seeing and hearing my HCPS instructor's stories of their recovery, I would never have thought it were possible in me. I had been in intense therapy for 10 years before this and truly, it took another consumer to spark my recovery. Now, I am social, I serve on several boards and can interact with almost anyone in public.

I know transformation can make a positive difference for the community.

SWG #6 Guidance:

Hawaii's Need to Improve and Expand the Workforce

Areas of focus include:

1. A stable workforce is developed, trained and retained.
2. Individuals and communities that provide natural supports are themselves recruited and supported.

Related to President's New Freedom Commission (NFC) Recommendation 5: Excellent Mental Health Care is Delivered and Research is Accelerated

SWG #6 Membership:

Co-Chairs: Ellen Awai (resigned), Melissa Ortega and Robert Surber

Members: Jeffrey Akaka, James Allegretti, Beth Ananda-Stout, Joan Apo, Pauline Arellano, Barbie-Lei Burgess, Steve Chelminiak, Michael Christopher, Sarah Eum, Lydia Hemmings, Barbara Hughes, Tiare Kailiawa, Malina Kaulukukui, Winston Kong, Nathan Marder, Michael McMullen, Dawn Mendiola, Caroline Meyer, Penny Morrison, Teru Morton, Michael Palazzo, Genevieve Parks, Anela Patterson, Charlene Ryerson, Jason Schiffman, Michele Scofield, Debbie Shimizu, Lesley Slavin, Kelly Stern, Eddie Suarez, Kathleen Sullivan, Sharon Tamanaha, Cynthia Wicks, Michael Zarate.

MHTSIG Support: Rupert Goetz, Tercia Ku, Carol Medina, Patrick Uchigakiuchi

SWG #6 Recommendations:

- 6.1 Immediately declare a state of emergency in hiring qualified mental health workers in the public and private sectors, urgently mobilizing resources to streamline the state hiring process and develop timely recruitment, training and retention strategies.
- 6.2 Appoint and convene an ongoing Mental Health Workforce Development Collaborative comprised of key stakeholders to develop and implement long-term solutions to produce a diverse, locally developed mental health workforce.
- 6.3 Articulate and instill core competency standards for all Behavioral Health Care Providers.
- 6.4 Establish and sustain mental health training centers on each island that support culturally competent and consumer and family driven recovery, resilience and early intervention. The centers will honor indigenous knowledge and practices of the host and other local cultures.

Rationale:

Spirited discussion and a broad range of ideas characterized SWG 6 members' early exploration of this critical topic. Thanks to consultation from WICHE, national and local issues could be compared in some detail. Existing positions could not be filled because of complex hiring practices and salaries lagging behind comparable positions. Recruitment, training and retention was, similar to earlier noted service fragmentation, also confusing and poorly coordinated. Particularly striking was the disjunction between rural and urban opportunities. Accordingly, members chose to "declare an emergency" noting that significant immediate action would be required to address the most pressing needs. Longer range issues could then be addressed by developing an ongoing workforce planning collaborative, establishing a clearly-defined, minimum set of competencies that would support the entry of newly trained individuals directly into community practice and finally recommending a concerted effort to place culturally relevant training, supervision and research centers in each of the islands, emphasizing "grow your own" opportunities.

Sub-Working Group (SWG) #7: EVALUATION

What fuels my passion for solving Hawaii's mental health workforce problems is my experience consulting with and trying to help contracted provider agencies improve their programs. I've seen that many of our residential programs for children and youth are very short-staffed, and at times they can be essentially "one-person away from chaos". Often programs leaders feel unable to demand competent work from their staff because replacing workers is so difficult. When programs have inadequate staff and clinical leadership, children and youth suffer.

SWG #7 Guidance: (Also a Cross Cutting Theme) Evaluation for Continuous Improvement and Sustainability

Areas of focus include:

1. Needs Assessment and Resource Inventory (NA/RI)
2. Collection and/or analysis of data or information for sub-working groups
3. Required measurements
4. Outcomes Evaluation

Related to President's New Freedom Commission (NFC) Recommendation 5: Excellent Mental Health Care is Delivered and Research is Accelerated

SWG #7 Membership:

Co-Chairs: Daryl Fujii and Alex Walter

Members: Paul Ban, Andrew Breton, Iwalani Else, Kevin Furatani, Cori Gift, Charmaine Higa-McMillan, Debbie Hill, Jeremy Hill, Susan Iwaoka, Cera Kim-Sunada, Lynnette Mau, Caroline Meyer, Janelle Oishi, Steven Onken, Colleen O'Shea Wallace, Dawn Pang, Ana Rosal, Steve Shiraki, Pamela Speers, John Steffen, Patrick Uchigakiuchi, Steven Vannatta, David Weiner.

MHTSIG Support: Rupert Goetz, Tercia Ku

SWG #7 Recommendations:

- 7.1 Establish a data system with capacity for appropriate information sharing to: 1) facilitate coordinated health and mental health treatment and services, and 2) provide historical data and consumer preference in legal and/or health related crisis situations to facilitate decision-making.
- 7.2 Establish an entity to: 1) accumulate literature on cultural healing mirroring Hawaii's diverse ethnic population, 2) coordinate and oversee outcomes research on indigenous and traditional cultural ways of healing, well-being and treatment, particularly approaches addressing health, mental health and substance abuse problems, and 3) disseminate this literature to inform clinical

services.

- 7.3 The state commission a study exploring the care provided by natural support systems for people with mental illness and in particular the direct and indirect costs in providing such care and assistance. People with mental illness (children, adults and elders) receive care and assistance through natural support systems such as `ohana, family, friends, churches, and other community groups.

Rationale:

While SWG 7 members initially served primarily as an advisory committee to the MHTSIG Evaluation Team, it quickly became apparent that significant barriers existed to the use of data and outcomes evaluation (as a basis for research as well as constant self-improvement). Accordingly, members chose to make three recommendations, first addressing data sharing, particularly for services and in crisis situations. A second priority became the development of an entity to coordinate, evaluate and disseminate culturally important services. Finally, it was noted how often natural supports made the critical difference for persons struggling in Hawaii. Understanding that no payment can reimburse for such dedication, members felt it important to gain a better understanding of this critical resource, so that it could be more recognized, honored and supported.

Task Group (TG): CRIMINAL JUSTICE

It doesn't take years on the bench to see the need for the criminal justice system to respond differently than it historically has to those with mental illness who encounter and enter "our world" of laws and procedures. It does, however, take collective years of experience, expertise and understanding in many disciplines to see HOW we should respond in a way that serves the individual, families, and the community—and then to develop a strategy to make it happen. This is the excitement that the Transformation effort in Hawai'i offers and which, I'm happy to say, is an offer that is widely and fervently embraced. My decades on the criminal bench at all trial court levels have compelled me to be part of this effort.

...Marcia J. Waldorf, Circuit Judge, retired

Task Group Guidance:

The Intersection of Mental Health Issues and the Criminal Justice System

Areas of focus include:

1. Establish a Criminal Justice Task Force
2. Use the Sequential Intercept Model (SIM) as an organizational tool
3. Confirm and refine priorities initiated by GAINS Conference in November 2007
4. Finalize recommendations to be included in Comprehensive Mental Health Plan (CMHP) Update September 2008

Related to President's New Freedom Commission (NFC) Recommendation 2: Mental Health Care is Consumer and Family Driven.

TG Membership:

Criminal Justice Specialist (CJS): Marcia Waldorf, Circuit Judge [retired]
CJS is identifying and compiling a list of interested persons to participate in this TG.

TG Recommendations to be included in CMHP Update

Rationale:

While not one of the original SWGs, the significant intersection of criminal justice and mental health in Hawaii was recognized early on. With the help of the GAINS Center, meetings were held and it became clear that an ongoing focus would be needed. Accordingly, Judge Marcia Waldorf was asked to join the MHTSIG process and, with this recommendation, MHTSIG is committing to develop a Task Group to recommend and implement needed changes.

Task Group (TG): CHILDREN'S ISSUES

My grandmother was hospitalized on and off with bipolar disorder her entire adult life. It was never discussed openly in the family just whispered about like a "bad" family secret. Of course, kids imagine the worst. Had the stigma against mental illness not been present in community and in family, would have grown up with a lot less stress and better understanding of a woman I loved dearly.

Task Group Guidance:

Working Toward a Community System of Care for Youth and Families

Areas of focus include:

1. Assure mental health services meets needs of children and families
2. Assure coordination of state services for children and families
3. Provide continuous review to assure quality of services
4. Assure children and youth provided services in own communities
5. Plans to be Youth-guided and Family-driven by 2011

TG Membership:

Representatives from the Communities of Practice (CoP), CAMHD and the DOE

TG Recommendation:

1. The Governor, through the MHT SIG process, convene an Executive Summit in June 2008 of child-involved partners' leaders* to consider the sub-recommendations and develop accountable strategies that will be implemented within each entity.

*including Board of Education (BOE), Department of Education (DOE), University of Hawai'i (UH), Department of Health (DOH) including Child Adolescent Mental Health Division (CAMHD), Department of Human Services (DHS) including Office of Youth Services (OYS) and Child Welfare Services (CWS), Family Court (FC), Judiciary (JUD), Primary Care, Family/Youth

Rationale:

Also not one of the original SWGs, children's issues quickly intersected with MHTSIG. The Hawaii Communities of Practice reached out and effectively sought to broaden the scope beyond considering school-based mental health services following the end of the Felix Consent Decree. Important meetings in larger and smaller groups ultimately led to the recognition that an executive level meeting would be required to chart next steps in this complex and critical interagency area.

Overarching Themes

This chapter is the heart of the CMHP. The clustered recommendations, together with the draft timeline and implications for Governance and organization discussed in the second half of a later chapter give the CMHP’s “Big Picture” and represent the State’s commitment to mental health transformation.

Overarching themes are those that stand out and present themselves most for implementation. They draw on the strength of combining overlapping SWG recommendations with community/grassroots feedback and the direction of the TWG. The goal is to collect in one place what will most help transform Hawaii’s mental system.

Hawaii’s vision of transformation is braiding our opportunities into one (see Preface). Beginning with the first set of Town Hall Meetings at which participants laid out their personal visions for a transformed mental health system in Hawai`i (citation: Town Hall), followed by the work of the SWGs and tested in the second set of Town Hall meetings, a **Common Vision** began to emerge:

Hawaii’s transformed mental health system will focus on prevention, effective intervention and recovery across the life span, providing coordinated, culturally sensitive services state wide that are sustainable and consumer-driven.

In achieving this vision, **Values** must be woven throughout the process. These are derived from the TWG direction as well as community and SWG feedback:

- 1. Inclusive of consumer input and direction**
- 2. Respectful of cultural and community protocols**
- 3. Building capacity of consumers and family as well as providers to ensure sustainability, and**
- 4. Encouraging collaboration and innovation.**

Applying these values to achieve the vision of this CMHP, we next bring together the recommendations into one place for implementation.

CMHP Recommendations in Context

The MHTSIG process gives us the opportunity as well as challenge to reconcile numerous, potentially non-aligned forces to achieve Hawaii’s vision for mental health transformation.

In bringing the grassroots together with the beginning leadership engagement described in the CMHP process (see Introduction), we recognize that the SWGs worked rapidly, in a highly dedicated manner, but largely individually. Echoing the evolution of the current mental health system, they each recognized the overarching nature of some of the problems and tried to address them. Thus a “saturation of ideas” emerged which we tried to honor.

Drawing on this and the data provided through community feedback, MHTSIG staff compiled a first version of this chapter, suggesting five themes under which the recommendations might be clustered. The five overarching themes that ultimately resulted from the February 25th TWG meeting were:

- 1. Educating the Public**
- 2. Systems Integration**
- 3. Consumer and Professional Workforce Development and Training**
- 4. Research, Evaluation and Dissemination**
- 5. Financing and Sustainability**

These overarching themes (together with Criminal Justice, previously established and confirmed by the TWG) will be used to name our six Task Groups. Each TG will be charged with first reviewing the full SWG Reports (found in the Appendix) and the relevant NA/RI information. They will then consider the recommendations referred to their group (together with other recommendations they may see as related), prioritize them for implementation and develop work plans to accomplish what is possible under TWG direction. The following initial referrals resulted from suggestions by TWG members and by the SWGs themselves, augmented by MHTSIG staff input to facilitate grouping of related items.

Task Group (TG) #1: Educating the Public

TG #1 areas of focus include the following SWG Recommendations:

- 1.1 Design and implement a public education campaign to promote the understanding of mental health issues.
- 1.2 Reduce the rate of suicide and suicide attempts.
- 2.1 Accountable consumer and family driven policies with education and oversight within systems are implemented by 2011.
- 3.2 Improve utilization of, and develop community resources for early intervention across the lifespan by 2011.

Task Group (TG) #2: Systems Integration

TG #2 areas of focus include the following SWG Recommendations:

- TG2 The Governor, through the MHT SIG process, convene an Executive Summit in June 2008 of child-involved partners' leaders to consider the sub-recommendations and develop accountable strategies that will be implemented within each entity.
- 1.3 Equalize and integrate physical and mental health care.
 - 2.1 Accountable consumer and family driven policies with education and oversight

- within systems are implemented by 2011.
- 2.3 Provide more options for care, including alternative and indigenous practices.
- 2.4 Create a rapid response, trauma informed system of mental health and wellness care.
- 3.1 Develop and expand prevention, early intervention and treatment services to promote the emotional well-being for young children and their families by 2011.
- 3.2 Improve utilization of, and develop community resources for early intervention across the lifespan by 2011.
- 3.3 Develop an interdisciplinary training institute for early intervention and improve systems integration by 2009.
- 3.4 By 2010, screening, identification and management of mental disorders in primary care, across the lifespan, become standard of practice.
- 5.1 Review and potentially change state regulations making technological collaboration easier for providers while maintaining the consumer's right to privacy.
- 5.2 Plan, phase-in and help coordinate the development of compatible electronic health record systems that improve efficiency and access for consumers and providers.
- 5.3 Promote consistent and streamlined processes across provider agencies to facilitate continuity of care. This includes sharing policies, procedures and technology supporting "One Stop Shop" opportunities for care and eliminating redundancies.
- 5.4 Expand the use of tele-health to improve the quality of health services for underserved populations by improving access to mental health specialists and to culturally sensitive evidence based training/education.
- 7.1 Establish a data system with capacity for appropriate information sharing to: 1) facilitate coordinated health and mental health treatment and services, and 2) provide historical data and consumer preference in legal and/or health related crisis situations to facilitate decision-making.

Task Group (TG) #3: Consumer and Professional Workforce Development and Training

- TG #3 areas of focus include the following SWG Recommendations:
- 1.2 Reduce the rate of suicide and suicide attempts.
 - 2.2 Ensure that Consumers are serviced with aloha, courtesy and respect by professionals.
 - 2.3 Provide more options for care, including alternative and indigenous practices.
 - 2.4 Create a rapid response, trauma informed system of mental health and

- wellness care.
- 3.1 Develop and expand prevention, early intervention and treatment services to promote the emotional well-being for young children and their families by 2011.
 - 3.2 Improve utilization of, and develop community resources for early intervention across the lifespan by 2011.
 - 3.3 Develop an interdisciplinary training institute for early intervention and improve systems integration by 2009.
 - 3.4 By 2010, screening, identification and management of mental disorders in primary care, across the lifespan, become standard of practice.
 - 4.2 By 2010 establish a system that makes sure that all providers are doing what works best. This will include having an infrastructure to disseminate evidence-based services and best practices addressing the priority needs of its population.
 - 5.4 Expand the use of tele-health to improve the quality of health services for underserved populations by improving access to mental health specialists and to culturally sensitive evidence based training/education.
 - 6.1 Immediately declare a state of emergency in hiring qualified mental health workers in the public and private sectors, urgently mobilizing resources to streamline the state hiring process and develop timely recruitment, training and retention strategies.
 - 6.2 Appoint and convene an ongoing Mental Health Workforce Development Collaborative comprised of key stakeholders to develop and implement long-term solutions to produce a diverse, locally developed mental health workforce.
 - 6.3 Articulate and instill core competency standards for all Behavioral Health Care Providers.
 - 6.4 Establish and sustain mental health training centers on each island that support culturally competent and consumer and family driven recovery, resilience and early intervention. The centers will honor indigenous knowledge and practices of the host and other local cultures.

Task Group (TG) #4: Research, Evaluation and Dissemination

TG #4 areas of focus include the following SWG Recommendations:

- 2.3 Provide more options for care, including alternative and indigenous practices.
- 4.1 By 2010 establish a comprehensive, integrated, coordinated, community based system that conducts and reviews research that will expand access to evidence-based mental health interventions and innovations that work for Hawaii's population.

- 4.2 By 2010 establish a system that makes sure that all providers are doing what works best. This will include having an infrastructure to disseminate evidence-based services and best practices addressing the priority needs of its population.
- 4.3 By 2010 create a results-driven accountability system that evaluates the effectiveness of mental health services and measures the quality of service delivery.
- 4.4 By 2010 establish a system with the necessary conditions, leadership and authority to advance research and expand and sustain quality services.
- 7.1 Establish a data system with capacity for appropriate information sharing to: 1) facilitate coordinated health and mental health treatment and services, and 2) provide historical data and consumer preference in legal and/or health related crisis situations to facilitate decision-making.
- 7.2 Establish an entity to: 1) accumulate literature on cultural healing mirroring Hawaii's diverse ethnic population, 2) coordinate and oversee outcomes research on indigenous and traditional cultural ways of healing, well-being and treatment, particularly approaches addressing health, mental health and substance abuse problems, and 3) disseminate this literature to inform clinical services.
- 7.3 The state commission a study exploring the care provided by natural support systems for people with mental illness and in particular the direct and indirect costs in providing such care and assistance. People with mental illness (children, adults and elders) receive care and assistance through natural support systems such as `ohana, family, friends, churches, and other community groups.

Task Group (TG) #5: Financing and Sustainability

TG #5 areas of focus include the following SWG Recommendations:

- 3.2 Improve utilization of, and develop community resources for early intervention across the lifespan by 2011.
- 4.4 By 2010 establish a system with the necessary conditions, leadership and authority to advance research and expand and sustain quality services.
- 7.3 The state commission a study exploring the care provided by natural support systems for people with mental illness and in particular the direct and indirect costs in providing such care and assistance. People with mental illness (children, adults and elders) receive care and assistance through natural support systems such as `ohana, family, friends, churches, and other community groups.

Task Group (TG) #6: Criminal Justice

- 1.1 Design and implement a public education campaign to promote the understanding of mental health issues.
- 5.1 Review and potentially change state regulations making technological collaboration easier for providers while maintaining the consumer's right to privacy.
- 7.1 Establish a data system with capacity for appropriate information sharing to: 1) facilitate coordinated health and mental health treatment and services, and 2) provide historical data and consumer preference in legal and/or health related crisis situations to facilitate decision-making.

By no means is this meant to be an exclusive charge. Each list above is merely a starting place for developing work plans. TGs will recognize additional overlap as they more carefully scrutinize NA/RI information and the detailed SWG Reports. Where recommendations were referred to more than one group, the expectation is that these will fit into the overall work and that there will be careful coordination between TGs as priorities emerge and work plans take shape.

SWGs in turn will continue to have a critical role. As groups, they will monitor the work of the TGs to assure fidelity to their prior efforts. As individuals, they may chose to become part of a TG. Together with community feedback through continuing Town Hall Meetings, and under the direction of the TWG, the Update of the CMHP and the beginning implementation of recommendations from this CMHP will take place in full public view.

Combined Time-Line

Organizing and supporting such a complex process is will be difficult. However, if we are to learn from this year's process, it is to assure clear expression of what is happening and to anticipate clearly the schedule and opportunities for involvement.

The following gives a calendar overview of the MHTSIG process. It first looks back to the past year, then looks ahead to year two. The two figures also give a template for following years, recognizing that in those years CMHP recommendations may need to be modified.

Year 1 of the grant was extended, due to a delayed start-up schedule. It was primarily focused on getting the transformation process started and developing this first CMHP.

MHT SIG Schedule (“Year 1”)

Note: SAMHSA/CMHS allowed extension of the first project year (CY 2006-2008)

	October 06	November 06	December 06	January 07	February 07	March 07	April 07	May 07	June 07	July 07	August 07	September 07	October 07	November 07	December 07	January 08	February 08	March 08			
State Wide Meetings	◆ Grant Awarded	Interim Steering Comm			◆ Leaders Announced			◆ Int. Stg. Comm.			◆ Int. Stg. Comm.										
National Meetings	◆ Grantee Meeting												◆ Grantee Meeting								
Town Hall Meetings	Capitol Kickoff ◆												◆◆◆◆ Town Hall Series 1			◆◆◆◆ Town Hall Series 2			(Plenary)		
Subgroup 1 Meetings	◆												◆			◆			◆		
Subgroup 2 Meetings	◆												◆			◆			◆		
Subgroup 3 Meetings	◆												◆			◆			◆		
Subgroup 4 Meetings	◆												◆			◆			◆		
Subgroup 5 Meetings	◆												◆			◆			◆		
Subgroup 6 Meetings	◆												◆			◆			◆		
Subgroup 7 Meetings	◆												◆			◆			◆		
Consultations													WICHE			GAINS			Children's Summit		
Trainings/Conferences													(Plenary)			SVT Conference ◆					
TWG Meetings													TWG Meeting 1 ◆			TWG Meeting 2 ◆			TWG Meeting 3 ◆		
Deadlines													◆ (Normal Due Date of CMHP and NA/RI)			CMHP Due ◆					
Legislative Session													Legislative Session			Legislative Session			(Extension Granted: Actually part of Budget Year 2)		

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In the following years, it is SAMHSA’s expectation that Hawaii’s MHTSIG return to the schedule followed by all grantees. Therefore, implementation will have to consider the following yearly schedules.

This means that the second year will largely be taken up with full inclusion of the NA/RI information, refinement of the CMHP and development of the implementational framework. Where possible, immediate or short-term action steps will be part of the second year’s activities.

MHT SIG Schedule (Year 2 - Projected)

Note: SAMHSA/CMHS requires return to original grant schedule (CY 2008)

	April 08	May 08	June 08	July 08	August 08	September 08
State Wide Meetings	◆ MH-	◆ Children's Day	◆ Annual MHT SIG Update			
National Meetings	◆ Grantee Meeting					
Town Hall Meetings	Town Hall Series 3 ◆◆◆◆					
Task Group 1	◆		◆	◆	◆	◆
Task Group 2	◆		◆	◆	◆	◆
Task Group 3	◆		◆	◆	◆	◆
Task Group 4	◆		◆	◆	◆	◆
Task Group 5	◆		◆	◆	◆	◆
Task Group 6	◆		◆	◆	◆	◆
Consultations	◆ WICHE Summit		◆ Children's Executive Summit			
Trainings/Conferences	◆ IVAT Conference	◆ EBP Conference	◆◆◆◆ Mini Grant Trainings		◆ Legislative Training	
Subgroup Meetings	◆					
TWG Meetings	TWG Meeting ◆			TWG Meeting ◆		
Deadlines	◆ (CMHP II Due)					
Legislative Sessions	Legislative Session					

Summary Note

In this chapter, we have attempted to draw together overarching themes. It must be emphasized that this can be successful only in the larger context of the full SWG and TG chapters, which are in the Appendix, as well as NA/RI information. We would be losing critical detail if this chapter (together with the section on Governance near the end) were to be considered a full summary of this year’s work.

Governance and Organizational Structure (Required SECTION VII):

Current Mental Health Governance and Organizational Structures

As in all other states, many families, communities, agencies and organizations share the burden of mental illness in Hawai'i. Similarly, opportunities for prevention, to support resilience as well as active treatment and recovery are not to be found in any one, coordinated place. Thus, a deep understanding of the interwoven, historically grown structures that are currently in place in Hawai'i is necessary before we can begin to think about what, if any changes should be considered.

One way to approach such a complex analysis may be to distinguish the individual person, the provider, the agency and the systems level. The individual person level includes the consumer, the family member, the natural supports, the community within which they live and the advocacy organizations that represent them. They are the recipients (or not) of services. For governance, the question is where the persons served and their immediate family/friends have a voice. The second level is that of the providers. This includes all those individuals in direct contact and serving the former; it also includes their professional and member organizations. Frequently the focus is on clinical practices. The third level is made up of all the agencies that directly employ the providers. Accordingly, their primary attention may be on recruitment and retention, clinical policies and procedures, and on financial solvency to continue their work. The fourth (the systems) level is made up of those agencies or organizations that collectively represent or govern the agencies. They share similar concerns to the agencies themselves, but often face much differing pressures. Naturally, these levels are porous. Consumers may be providers (e.g.: peer counselors) and professional organizations may, in part be service agencies.

In the following, we will briefly sketch some of the key governance and organizational relations that currently involve these four levels of mental health care. We will then briefly look to other organizations that "grow" (such as schools) or draw on these levels (such as criminal justice setting). We will also briefly note the critical relationship with the legislative and judiciary branches of government. (A more detailed description of government resources can be found in citation: Marumoto.) This section is not meant to reprise the overviews typically provided in the Block Grant applications. Instead, it is as much to point to transformation linkages that have been or are yet to be established. It must be noted that the following is only a very brief overview of the rich tapestry of organizations supporting mental health in Hawaii. Inclusion (or absence) here only means that we have in this first year had some form of contact; much more remains before we can claim that the overview is in any way comprehensive!

A. Consumers, Families and Youth

The individual recipient of care is at the heart of any system of care. As in any public health system, each mental health encounter hopefully occurs with a focus on prevention, effective intervention and support of recovery. To assure that this is in fact

the case, the following collective opportunities exist within Hawaii's current mental health system for consumer, family member and youth involvement.

Self-directed organizations include the United Self Help (adult consumers), the Mental Health Association in Hawaii (adult consumers), Hawaii Families as Allies (families with youth) and the National Alliance on Mental Illness (NAMI, families of consumers). AA, NA and numerous support groups provide both assistance and opportunities for input.

A relatively new, but very rich resource in Hawaii is the evolving set of now ten state- and one privately-operated Clubhouses. These member-driven psychosocial rehabilitation programs for adults provide a supportive environment, offer services to improve the quality of life, and build skills to help reach individual goals and aspirations.

Various councils and advisory bodies are in place. The State Council on Mental Health is focused by the state's Block Grant requirements and the Disabilities Council focuses on developmental disabilities. Multiple other opportunities for consumer, family and youth input also exist, such as the consumer councils or boards that advise various organizations (such as the Consumer Council at the Hawaii State Hospital). Besides these more local opportunities, large national efforts, such as the Vet Centers play an ever more important role with the number of soldiers returning to Hawaii.

B. Providers

Hawai'i has a full range of mental health providers, each with their own professional organizations. The Hawai'i Psychiatric Medical Association (HPMA) and the Hawai'i Psychological Association (HPA) represent the two most commonly found doctoral level providers. Social Workers are represented by a Hawaii chapter of the National Association of Social Workers, and certified substance abuse counselors (CSACs) are represented by the Hawaii Affiliate of the National Association for Addictions Counselors.

Many Nurses in Hawaii are represented by the Hawaii Nurses Association (HNA), which functions both as a Union and a professional organization. Nurses that belong to other unions (such as HGEA) or are not represented may be in a variety of other organizations. Form mental health, the primary one is the Hawaii chapter of the American Psychiatric Nursing Association (APNA). Additional, specialized organizations exist, such as student's nursing and forensic nursing associations.

Overarching organizations in Hawaii that include physicians is the Hawaii Medical Association. Specialty medical organizations, such as the Hawaii Academy of Family Physicians and Hawaii Academy of Pediatrics are only two examples of professional organizations deeply affected by the mental health service system in Hawaii.

C. Provider Agencies

We will distinguish provider agencies by inpatient, residential and outpatient.

Hawaii Health Systems Corporation (HHSC) is a public benefit corporation with over 1,200 staffed beds in twelve facilities, located in five different regions. This includes most of the psychiatric inpatient beds on the “neighbor islands” outside of Oahu. On Oahu, the Queens Medical Center (QMC) and Castle Medical Center (CMC) are the two largest providers, with the addition of private facilities, such as Kahi Mohala. A notable exception is the Hawaii State Hospital, the state’s only public, tertiary psychiatric care facility that serves mostly as a forensic facility. (It is part of the Department of Health, see the section below.)

Specialized Residential Treatment Providers include a mental health program by Care Hawaii in Kaneohe and Hina Mauka, Po’ailani, and Sand Island Treatment Centers, which provide residential substance abuse treatment. Specialized programs developed in partnerships, such as Hale Imua (a conditional release program) and a Community Based Fitness Restoration program are recent additions, often drawing on established mental health and residential services providers, such as Steadfast Housing.

A range of housing options extends from 24 hour and 8-16 hour group homes to semi-independent living, supported housing and shelter plus care. The Institute for Human Services (IHS) and Safe Haven provide shelter space, as do safe houses (for domestic violence). Licensed Residential Crisis Services provide limited (up to two weeks) alternatives for stabilization.

Community mental health providers are distinguished by State and Purchase of Services (POS) providers. Each of the islands has community mental health centers (state), as well as POS contracted providers for adults. Children’s services are generally provided through contracted providers. Service levels include Assertive Community Treatment (ACT), Intensive Case Management, Targeted Case Management, and Crisis Mobile Outreach, to name only a few. Nine State community mental health centers are available on the islands, as are private, contracted services. Major providers include Care Hawai`i, Helping Hands Hawai`i, and North Shore Hawai`i, again only naming .

Agencies with a complementary focus are numerous. Substance abuse counseling agencies provide day treatment, intensive and outpatient treatment on the different islands. Major organizations include for example BISAC and DASH (on Hawaii Island), Care Hawaii, Helping Hands and Salvation Army (on Oahu). The Life Foundation serves persons with HIV and AIDS. Lanakila Rehabilitation Center provides Adult Day and Workforce Development Services and the Sex Abuse Treatment Center serves persons who have undergone sexual assault.

With Hawaii’s cultural diversity, health and mental health organizations that emphasize this are particularly important. Ke Ola Mamo is one of five native Hawaiian health systems. Other systems and centers, including Kalihi-Palama, Kokua Kalihi Valley, Ko’olauloa, Waikiki, Waimanalo and Waianae Coast Comprehensive all strive to serve Hawaiians in a culturally appropriate manner.

D. Mental Health Systems of Care

The State's Administration of mental health services centers around several Departments. The Department of Health (DOH) coordinates public health. It includes several administrations, including Behavioral Health (which brings together adult mental health, children's mental health, alcohol and drug, as well as developmental disabilities services). An often critical entry resource is the ACCESS Line, maintained by the Adult Mental Health Division. The Health Resources Administration (HRA) includes family health, community health and early intervention/prevention, all of which relate heavily to this CMHP. Special branches or offices focus on areas of specific interest, such as the Executive Office on Aging.

Three additional Departments deserve particular mention, as they are often seen as related systems, but in fact have assumed an ever-growing role in mental health services. The state's Department of Education (not technically a Cabinet-level Department, as it is governed by its own statutory Board), provides significant School-Based Behavioral Health Services, in close conjunction with the DOH Children and Adolescent Mental Health Division. The Department of Human Services (DHS) directs its resources toward protecting and helping persons with disability (including child welfare, youth services –corrections-, adult protective services and vocational rehabilitation) and is the state's Medicaid Agency. Finally, the Department of Public Safety has jurisdiction over the state's prisons, which (together with local jails that often have only limited, less than 24 hour services) house and treat a large number of mental health consumers.

Besides the State agencies noted above, a number of private organizations additionally represent the Provider Agencies. An example is the Hawaii Primary Care Association, which represents community and native Hawaiian health centers. Other organizations, such as Papa Ola Lokahi focus specifically on improving the health of native Hawaiians and Pacific Islanders.

E. Related Systems

Numerous systems must be seen as directly related to the planning (such as State Health Planning and Development Agency – SHPDA), delivery (such as the Veteran's Administration – VA) and financing of mental health (such as Health Insurances). Others are more indirectly, but nevertheless powerfully involved, such as public provider Unions (e.g.: HGEA and UPW) and advocacy/oversight organizations (such as Hawai'i Disabilities Rights Center).

One of the largest of such related systems is comprised of the organizations and schools that prepare the mental health workforce. Ranging from high schools to graduate schools, major players include the University of Hawaii (with its Medical School, Schools of Nursing [and Dental Hygiene] and Social Work, and its College of Social Sciences, with its Department of Psychology). Programs at bachelor's, masters' and doctoral level are offered. Seven community colleges, in ten campuses are also

available. Private colleges and universities with mental health related offerings include Argosy, Hawaii Pacific, Brigham Young and Chaminade.

The islands of Hawaii are divided up into four Counties (Oahu, Hawaii Island, Maui and Kauai), each headed by a Mayor. Significant elements, including law enforcement (police), are county functions.

Stepping back, the other two not previously mentioned, major branches of government must be included: the Legislature and the Judiciary. Both are organized similar to most states. The legislature makes appropriation decisions and has been involved in many, specific mental health related efforts, from the number of patients at the State Hospital (SCR 117) to healthcare workforce development. The Judiciary is also a critical stakeholder. Many recipients of public mental health services are under court order, meaning Public Defender's Office, Prosecutors and numerous Courts are directly involved. Growing mental health and drug courts and diversion recognize this.

Faith-based organizations are also a critical group as are neighborhood associations and boards that heavily affect siting of mental health facilities and residences. Similarly, both state and county departments related to transportation (to be able to get to treatment and activities of daily living) and housing are critical partners in comprehensive, individualized mental health planning. Local branches of National organizations (such as Habitat for Humanity) and local dedicated services (such as the Hawaii Food Bank or Meals on Wheels) further augment Hawaii's resources. A special role, as many others rely on them is Susannah Wesley, which provides language interpretation (beside youth and vocational services).

In addition to these, Hawai'i has been given numerous grant opportunities to develop and or improve services that are directly or indirectly related to mental health. Chief among the latter is the State Incentive Grants (COSIG) for Treatment of Persons with Co-Occurring Substance-Related and Mental Disorders. The Federal Communications Commission (FCC) Rural Health Pilot Program grant is another, recent and important addition. Additional grants include those supporting Evidence-Based Practices (which sponsors an important, annual conference) and various jail diversions.

Implications of this CMHP for Governance and Organizational Change

As can be seen from even the limited summary above, there is great opportunity for disjunction between elements of Hawaii's mental health system. Each historically developed to address significant issues, there has been little opportunity for all to sit down together and consider how better to meet the mental health needs of the state's citizens. Frequently in the past, two or more of the parties involved have met to coordinate service, but one of the most prevalent themes heard in the community (as anticipated in the NFC) is still the fragmentation perceived by individuals looking at mental health care from the outside. The MHTSIG process gives us the opportunity and responsibility to pause and consider the implications of the recommendations collected here for governance and organization.

The first brief, but broad discussion of the implications of this current CMHP for governance occurred at the TWG meeting on February 25th. Discussion turned first to other states and how they had responded to the opportunity. Several states' examples were noted. Options for re-thinking the current Hawai'i system were then considered, including updating Hawaii Revised Statutes relevant to mental health and development of a single Mental Health Authority. Cognizant of an immediately previous, year-long, joint process to recommend changes that affected the census of the Hawaii State Hospital (citation: Office of the Governor), caution about the timing of such a complex and potentially protracted process was advised by the TWG.

A TWG consensus emerged that considering specific changes in the first year's CMHP would be premature. The Systems Integration TG would clearly be required to lay out a framework and this would group should be given a chance to suggest focus for change. As a state, we would define our functions first (for example as outlined in the vision), then identify issues that need to be addressed in implementation (as the TGs will do), then consider the structure that would support these changes.

As time is of the essence, the further discussion of this topic was determined to be one of the main agenda items at the next TWG meeting. Discussion then will set the stage for TG and NA/RI work to be incorporated into the next, updated CHMP. We will build on earlier efforts, such as the Lingle-Iona Administration 2007 Initiatives.

Aside from the discussion above on governance, organizational considerations are key to MHTSIG. The first is relationship of this grant effort with the State Council on Mental Health. Second is relationship of this grant effort to others and third is the overall completion of the full stakeholder analysis and engagement.

From the beginning of MHT SIG and the State Council on Mental Health developed a collaborative process. MHTSIG staff were regularly part of the State Council's agenda, and the Council was one of the groups asked to give feedback on the SWG recommendations. In the other direction, members of the State Council participated in the SWGs and the TWG. In the coming year, specific content areas of concern to both bodies will provide even more basis for a collaborative interrelationship, while recognizing that MHTSIG will be only a five year process to support sustainable change.

Several other Hawai'i grants were particularly noted by MHTSIG. Most prominent was the COSIG. Leaders from both this grant and MHTSIG met early on, remaining in contact as the COSIG wound down and culminating in a formally developed cross-over plan of COSIG initiatives for MHTSIG (see Appendix). Established grants include those on Evidence Based Practices (EBP), Strategic Prevention Framework (SPF), Jail Diversion and Policy Academy for housing. New grants include the Access to Recovery (ATR) grant and the FCC Infrastructure grant. With the emphasis in MHTSIG on tele-mental health to support both services and training, this is a liaison that will have particular importance in the coming year.

In a broader sense, MHT SIG expects to augment the strong, grass-roots approach in the coming year with concerted outreach to organizations not yet fully recognized and engaged. Building both on NA/RI analysis and MHTSIG staff analysis of governance, we will be looking for opportunities to support existing and potentially help foster new collaborations. In the past year, working with the Hawai`i Communities of Practice on children's issues proved critical. Work of the Psychiatric Access Collaboration was important, as this group met to improve access to psychiatric services in rural settings. Using the concept of "intergenerational trauma" to engage consumers, families and youth into a collaborative may be such an opportunity. We have much in place and can build on group- and boundary-spanning individuals to expand our efforts.

Summary and Next Steps:

With this CMHP, Hawai`i makes a strong commitment to mental health transformation. We have developed a clear vision, values and initial recommendations. These, together with a clear process of moving from planning to implementation will assure that we meet the NFC goals and those of our citizens.

Confident of these strengths, we nevertheless have limits to acknowledge. The logic model behind our process had to be adjusted to accomplish our “grass-roots” intent while still meeting critical milestones. All of this occurred within a very short period of time. Nevertheless, we experienced an outpouring of support, even when our process had to be compressed. More than once, we heard: “this is different” and there seemed to be universal agreement that the task was important. Paradoxically, we may have lost opportunities for dissent and the inevitable learning that comes with its resolution.

SWGs also faced technical difficulties. It was a challenge to rapidly come together, choosing leaders with diverse backgrounds and experience, mastering the content areas and achieving consensus, all the while assuring clear documentation of the process and outcome. Besides the strong, continued support of the participants, it was the SWG co-chairs who deserve extra recognition for helping us develop their reports despite time constraints.

We had set ourselves high expectations of family, consumer and youth involvement. Many participated, but we will be working even harder with local advocates and national experts (such as Laverne Miller from Howie the Harp/The GAINS Center) to do more. To assure this, we recently brought on board our consumer, family and culture specialist and we are asking a youth to join our MHTSIG staff.

There is huge strength in the recommendations. Nevertheless, some topics had to be pushed aside. An example is Supported Employment. Despite a strong base of Clubhouses in Hawai`i, SWG #6 (Workforce) had to focus on mental health workforce (including peer counselors) and SWG # 4 (Quality Services [Evidence-Based Practices]) looked at services more broadly. As a result, meaningful jobs for persons with mental illness do not figure prominently in this first version of the CMHP. Homelessness in the current Hawai`i housing market is another such topic area, while financing and sustainability was often the “elephant in the room”. We expect to address such issues in this coming year, the latter with a dedicated task group.

We will do this with a clear process and specific milestones. First, we will take the opportunity to focus on our vision:

Hawaii’s transformed mental health system will focus on prevention, effective intervention and recovery across the life span, providing coordinated, culturally sensitive services state wide that are sustainable and consumer-driven.

Using a western analogy, we have identified key areas which we hope will be the fulcrum around which we can move the whole. Using our chosen Hawai`i analogy, we have identified the *haku lei* braiding material that will give strength and beauty to the whole.

Then, we will then consider our **Values** as we charge the Task Groups with implementation, beginning with recommendations collected from the SWG reports:

- 1. Inclusive of consumer input and direction**
- 2. Respectful of cultural and community protocols**
- 3. Building capacity of consumers and family as well as providers to ensure sustainability, and**
- 4. Encouraging collaboration and innovation.**

Task Groups will include:

- 1. Educating the Public**
- 2. Systems Integration**
- 3. Consumer and Professional Workforce Development and Training**
- 4. Research, Evaluation and Dissemination**
- 5. Financing and Sustainability**
- 6. Criminal Justice**

We will recruit individuals or representatives of organizations identified as major players in addressing the recommendation and developing action plans. We will confer with SWGs on their recommendations and on the intent of the members in participating in the TGs. SWG co-chairs may be on one or more TGs depending on where their recommendations were assigned. Additionally, each SWG will select two representatives from the SWG to participate among the various TG. The exact make up of the Task Groups (TG) is currently being discussed but for manageability, each TG will be comprised of less than 20 members. Each TG will always include representatives from Consumer or Family groups and representation from all counties. Cross-agency support would also be expected.

Within the TG, individual members, operating in groups of two when possible, will volunteer to head specific recommendations or projects. They will be encouraged to invite additional ad hoc participants as needed to develop effective action plans. Each "project" will provide monthly status reports back to the total TG. The TGs will receive support and guidance from MHTSIG and the Evaluation Team. The TGs will report back to the TWG and SWGs at their respective meetings. We envision the TG members to be identified by late April or early May, with the first meetings to occur in June 2008.

Each TG will have access to an allotted amount of MHTSIG funds to assist them implementation steps. These funds may be offered through the MHTSIG Mini-Grant Program being developed or through specific dedicated funding from MHTSIG for their TG. Wherever possible, TGs will be asked to identify and, if appropriate, seek additional sources of funding for carrying out the recommendations. The MHTSIG Mini

Grant Program will be introduced in June, after we have received approval from SAMHSA and have worked out the payment schedules with the State. Grant-writing training will be conducted on all islands, with special emphasis on building the capacity of community based nonprofit organizations and encouraging collaborations among agencies.

SWG continuation will be critical for continuity. Members spent significant time and energy grappling with complex issues, narrowing down choices in an informed manner and making recommendations. We will need their help in assuring that the next steps of the MHTSIG process maintain fidelity to their work and continues the grass-roots process, which we expect to do with a third series of Town Hall meetings showcasing early work plans this summer.

As we await approval from SAMHSA of the CMHP, we will finalize a set of specific, measurable milestones that will help us move clearly through the coming, short year:

- All SWG members will be asked to come together on March 11th to review the MHTSIG status and look forward together.
- WICHE's recently completed report (citation: WICHE) will be a starting point for a facilitated, day-long leadership session in April 8th to consider the charge our workforce development task group will carry forward.
- MHTSIG will have its own web site operational by late April, significantly facilitating public involvement and inter-group communication.
- The next TWG meeting, considering CMHP implementation, TG composition and mental health governance issues will be in May.
- We will identify potential TG members, recruit them and call together a first, plenary planning meeting of the new groups in June. At that meeting, we will review their charge, the coordination with the SWGs and the expected process.
- Building on the GAINS conference in November 2007, part-time MHTSIG staff member Judge Marcia Waldorf (ret.) is working to form the Criminal Justice Task Group by June.
- Children's Task Group met in January 2008 to develop recommendations. We will clarify our task group process with the Communities of Practice and continue work on an Executive Summit for Children's Mental Health in late June.
- An annual, state-wide meeting (begun with the kick-off at the state Capitol last year) will update the public on progress in July.
- A third series of Town Hall Meetings will follow in late July or early August, and
- A TWG meeting in August will consider the CMHP update.
- We expect to submit this first update of our CMHP in September, placing us back on a yearly schedule with other states.

As we noted early on, this CMHP is a powerful first step toward the transformation of Hawaii's mental health services. We have experience an outpouring of support. If we can accept the challenge of such expectations, the coming year promises to be productive in achieving the kind of mental health system the NFC and Hawaii's citizens envisioned!

Glossary of Acronyms:

ACT	-Assertive Community Treatment
ADAD	-Alcohol and Drug Abuse Division (DOH)
AMHD	-Adult Mental Health Division (DOH)
ANA	-American Nurses Association
APNA	American Psychiatric Nurses Association
BOE	-Board of Education (Hawaii)
CAMHD	-Child & Adolescent Mental Health Division (DOH)
CASSP	-Child & Adolescent Service System Principles
CMC	-Castle Medical Center
CMHC	-Community Mental Health Center
CMHP	-Comprehensive Mental Health Plan
CMHS	-Center for Mental Health Services (SAMHSA)
COLA	-Cost-of-living Adjustment
CoP	-Communities of Practice
CSAC	-Certified Substance Abuse Counselor
CSSS	-Comprehensive Student Support System
DDD	-Developmental Disabilities Division (DOH)
DHHL	-Department of Hawaiian Homelands
DHHS	-Department of Health and Human Services (US)
DHRD	-Department of Human Resources Development (Hawaii)
DHS	-Department of Human Services (Hawaii)
DOE	-Department of Education (Hawaii)
DOH	-Department of Health (Hawaii)
DOT	-Department of Transportation (Hawaii)
DPS	-Department of Public Safety
HAIS	-Hawaii Association of Independent Schools
HCDH	-Hawaii Public Housing Authority (Hawaii) (formerly: Housing and Community Development Corporation of Hawaii)
HFAA	-Hawaii Families as Allies
HGEA	-Hawaii Government Employee Association
HIPAA	-Health Information Privacy & Accountability Act of 1996
HPA	-Hawaii Psychological Association
HPMA	-Hawaii Psychiatric Medical Association
HRA	-Health Resources Administration (DOH)
HYHY	-Hawaii Youth Helping Youth
KS	-Kamehameha Schools
KSBE	-Kamehameha Schools Bishop Estate
LOFGC	-Leeward Oahu Family Guidance Center
NFC	-(President's) New Freedom Commission on Mental Health
MHSRET	-Mental Health Services Research, Evaluation and Training Program (UH)
MHTSIG	-Mental Health Transformation State Incentive Grant
NAMI	-National Alliance on Mental Illness
NA/RI	-Needs Assessment and Resource Inventory
NASW	-National Association of Social Workers

OHA	-Office of Hawaiian Affairs
OSTR	-Out Service Training Request Form
PFC	-President's (New) Freedom Commission on Mental Health
PSD	-Department of Public Safety (Hawaii)
POS	-Purchase of Service
QLCC	-Queen Liliuokalani Children's Center
QMC	-Queens Medical Center
RFA	-Request for Applications
SAMHSA	-Substance Abuse and Mental Health Services Administration
SBBH	-School-Based Behavioral Health
SHPDA	-State Health Planning and Development Association (Hawaii)
SCMH	-State Council on Mental Health
SWG	-Sub Working Groups
TAF	-Travel Approval Form
TG	-Task Group
TWG	-Transformation Working Group
UH	-University of Hawaii
UPW	-United Public Workers
VA	-Veteran's Administration
WICHE	-Western Interstate Commission for Higher Education

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Appendices:

- A. Cross-Walk of Recommendations:
 - 1. SWG Recommendations and New Freedom Commission (NFC) Goals

- B. Town Hall Meeting Reports (First Round):
 - 1. O`ahu Kickoff Meeting Technical Report No. 070912
 - 2. Rural O`ahu and NAMI Town Hall Meetings Technical Report No. 071214
 - 3. Hawai`i County Town Hall Meetings Technical Report No. 071210
 - 4. Maui County Town Hall Meetings Technical Report No. 071130
 - 5. Kaua`i Town Hall Meetings Technical Report No. 071120

- C. Sub-Working Group (SWG):
 - 1. Membership List
 - 2. Report of SWG #1: Promoting and Understanding Mental Health
 - 3. Report of SWG #2: Consumers and Families as Drivers
 - 4. Report of SWG #3: Early Intervention
 - 5. Report of SWG #4: Accelerating and Expanding Quality Services
 - 6. Report of SWG #5: High Tech and Local Touch
 - 7. Report of SWG #6: Workforce and Community Supports
 - 8. Report of SWG #7: Evaluation

- D. Task Group
 - a. Report on Criminal Justice
 - b. Report on Children's Issues

- E. Transformation Working Group (TWG):
 - 1. Membership List
 - 2. Summary of Recommendations Work Sheets
 - a. January 2008
 - b. February 2008
 - 3. Summary of Work Sheet Results for TWG Votes/Comments
 - a. Results by Dots January 2008
 - b. Summary of Comments January 2008
 - 4. Recommendation Referrals by TWG/SWG to New Task Groups

- F. Town Hall Meetings (Second Round):
 - 1. Press Release
 - 2. Summary of Recommendations Work Sheet
 - 3. Summary of Ranked Results of Recommendations
 - 4. Summary of Town Hall Comments of Recommendations
 - 5. Summary of Rating Scale and Ranking for SWG Recommendations

- G. COSIG History and Cross-Over Initiatives for MHTSIG
- H. WICHE Report (The Behavioral Health Workforce in Hawai`i: A Status Report)