



News Community Plan Edition

February, 2003 volume 3 issue 2

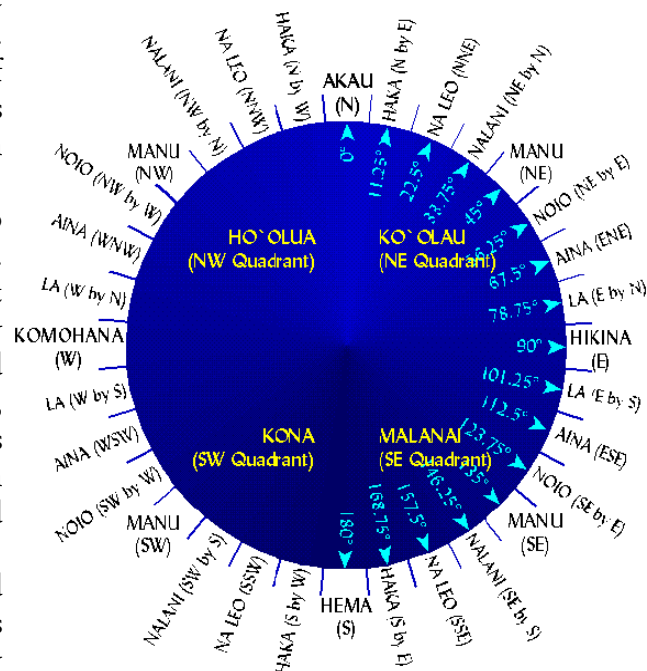
Navigating the Way...

From the Chief...

This month's edition of *AMHD News* features information about The Community Plan for Mental Health Services (The Community Plan). I hope that the navigational theme and graphics look familiar for those of you who have attended one or more of the recent information sessions about The Community Plan. For those of you who haven't yet been introduced to The Community Plan, let me explain.

I like to think of The Community Plan as a navigation tool akin to those that guided the ancient Polynesians on their voyages of discovery. Hawai'i's Polynesian ancestors navigated thousands of miles in the vast Pacific Ocean in small boats using the stars to find their way. They understood that the ocean and wind patterns upon which they relied would not always make for smooth sailing, and were, in fact, forever changing, but those intrepid voyagers were confident that those very same forces would bring them, eventually, to a new world. The voyages of Polynesian discovery required careful planning and preparation, faith, courage, and dedicated team-work.

Similarly, AMHD has launched its efforts to develop a fully integrated community mental health system for Hawai'i, using The Community Plan as our guide. We hope for smooth sailing, but are experienced enough to know that there may be rough patches ahead. Our journey also requires courage and dedicated team-work. We must be prepared, anticipate change, and move forward to meet our goal of enabling the consumers who need our services to complete their own voyages toward recovery from mental illness.

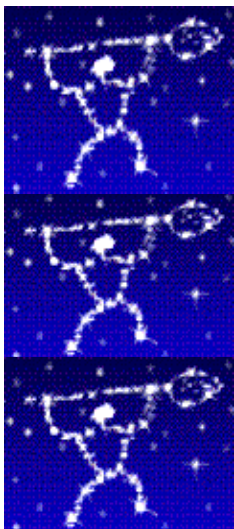


Hawaiian Star Compass



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Community Plan Roll-Out Focus at Recent AMHD Provider Meeting

Mental health providers and representatives from the Community Mental Health Centers (CMHCs) from all islands met on January 16, 2003 at Kāhi Mōhala for an AMHD-hosted orientation to The Community Plan. Following introductions by Eva Kishimoto, who moderated the presentation with clarity and good humor, the group heard from Kāhi Mōhala administrators and the new AMHD Medical Director, Dr. Alan Radke.

Federal court special monitor, Kris McLoughlin, provided a helpful context for the development of The Community Plan by explaining the history and the status of the lawsuit filed in 1991 that challenged the conditions at Hawai'i State Hospital. Implementation of The Community Plan, along with the Hawai'i State Hospital (HSH) Remedial Plan adopted last year will lead us to the conclusion of that litigation.

Members of the AMHD Services Research and Evaluation Unit lead the group in a review of the Guiding Principles of The Community Plan. Dr. John Steffen addressed the concept of mental health recovery, and the importance of AMHD providing recovery-based, consumer-focused services. Learn more about recovery in "Recovery as a Guiding Principle" on page 5 of this newsletter.

Dr. Deborah Altschul presented an overview of cultural competency, and described practical applications to integrate cultural competency in Hawai'i's public mental health settings. For more information about cultural competency, please see, "Integrating Cultural Competency into Public Mental Health" on page 6 of this newsletter. Dr. Mike Wylie discussed the target population covered by The Community Plan. To find out more about the Target Population, please read, "Target Population: Who Is Included?" on page 7 of this newsletter.

John Jansen and Catherine Jenkins explained the array of mental health services that AMHD will develop as it implements The Community Plan. Eva Kishimoto ended the session with a brief overview of AMHD's revised organizational structure. Each of these presentations provided valuable, specific information about The Community Plan, the changes it makes to the roles and responsibilities of CMHC staff, and its impact on private purchase of service (POS) providers. More information on AMHD system-wide changes is presented in "Highlights of The Community Plan" on pages 3 and 4 of this issue and in "Who's Who in the New Community Plan" on page 9.

We are grateful for all the efforts of the presenters and the close attention of the providers at the Provider Orientation Meeting. Special thanks, also, to our gracious hosts at Kāhi Mōhala.

Announcements

MHSIP Consumer Survey

Please be on the lookout for the AMHD Consumer Survey. This survey will be distributed throughout the State at the end of February. Thanks to all staff for helping with the statewide distribution! Thanks also to consumers for providing insight into the mental health system! Your opinions are important!

Any questions about the survey? Please contact Debbie Altschul at altschul@hawaii.edu or 539-3943.

Join The Community Plan Listproc

We have established an email listproc to facilitate communication about The Community Plan among all stakeholders and other interested parties in the community.

What is a listproc? A listproc (short for list processor) allows you to send messages to large numbers of people at one time. With our Community Plan listproc you can send a message to one email address (communityplan-l@hawaii.edu) and all of the subscribing members on the list will get a copy of that message. Our goal is to provide a rapid, internet based, means of cross communication to all of the people whose lives are going to be affected by The Community Plan.

How do I subscribe? Send an email message, from the address where you want to receive your Community Plan messages, to listproc@hawaii.edu with the following command in the body of your message:

subscribe communityplan-l <Firstname Lastname>

So, if Jane Doe wants to subscribe, she will send the command **subscribe communityplan-l Jane Doe**

Important!: That's an "l" (ell) after the "communityplan-" part, NOT a "1" (the number one). Don't put anything in the subject line and remove any signature from the body of your message before you send the subscribing message. Information about The Community Plan Listproc will then be sent to you and you can start getting and sending messages on The Community Plan.



Highlights of The Community Plan

Changes at Community Mental Health Centers

The Community Plan calls for significant changes to the structure and functions of our CMHCs. Each CMHC will now be headed by the CMHC Manager, who is responsible for the day-to-day administration of the state operated CMHC including:

- Efficient and effective operation of the CMHC
- Implementation of AMHD standards, service definitions, policies and procedures and reporting requirements, all in accordance with the provisions of The Community Plan
- Coordination of services to meet the clinical and social needs of the AMHD target population
- Participation, with other AMHD funded providers, in a continuous, integrated system of mental health care
- Participation in the development and implementation of a Comprehensive Integrated Service Area Plan (CISAP) for each county (or “service area” in the terms of The Community Plan).

Joining the CMHC Manager at each center are the following: the CMHC Medical Director, and the CMHC Coordinators for Case Management, Forensic Services, and Mental Illness/Substance Abuse (MI/SA) Services. The Medical Directors will ensure that psychiatric medical services adhere to current AMHD and professional standards. The specialized CMHC Coordinators, with technical assistance from their counterparts at AMHD, will ensure that their respective areas of service also adhere to current AMHD and professional standards. Additionally, the CMHC coordinators will train CMHC staff, and direct the provision of services to consumers.

All CMHC Managers report now to the new CMHC System Administrator, who is responsible for efficient and effective operation of the CMHCs, and the implementation of AMHD standards, service definitions, reporting requirements, policies and procedures, and the requirements of The Community Plan. The CMHC System Administrator also manages the contract for the privately operated CMHC in Wai‘anae, Oahu. All CMHCs and privately contracted providers will be held to the same performance standards and requirements, which include fidelity to national models of service delivery. The Community Plan specifies a minimum service array for each of the CMHCs, but the Centers are not limited to providing the minimum services. Each Center will be able to develop other services, and in concert with their Service Area Boards, will have the opportunity to tailor services to meet local needs.

Service Area Administrators

The Community Plan designates each county as a Service Area, and defines a new position: that of Service Area Administrator (SAA). The SAA will be responsible for the coordination and supervision of service delivery in the Service Area. Four full time SAAs assigned to Hawai‘i County (Big Island), Kaua‘i County, Maui County, and the City and County of Honolulu (Oahu) are responsible for the quality and continuity of AMHD funded services provided by the CMHCs and private contractors in their respective counties. Each SAA reports directly to the AMHD Chief, and works directly with all stakeholders in the county to develop an annual plan titled Comprehensive Integrated Service Area Plan or CISAP, for short. Each SAA will provide a Division presence in her or his county, working with the Service Area Boards, private providers, public providers and local consumers, families and advocates to ensure localized input for both service delivery and the statewide planning process. The SAAs will participate also in the development and selection of AMHD funded Requests for Proposals (RFPs), promote compliance with AMHD designated models of service, including the focus on recovery; and, promote effective interagency and intergovernmental branch coordination within each Service Area.

Changes for POS Providers

The Community Plan also makes significant changes to the private provider system. A full time AMHD Provider Relations Director serves as the single point of contact for POS providers who need assistance or problem resolution. The responsibilities of the Provider Relations Director include:

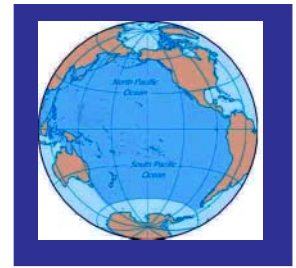
- Coordination and facilitation of the RFP and contracting process
- Communication of provider’s concerns to the AMHD Chief
- Development and maintenance of the POS provider manual
- Development and implementation of the annual training and technical assistance schedule
- Provision of logistical support for meetings with providers and advocacy groups, and
- Publication of *AMHD News* highlighting service development.



Five Core Services and the Two Special Populations

AMHD will employ Service Directors for each of the five core services:

- Case Management and Support Services
- Treatment Services
- Crisis Services
- Psychosocial Rehabilitation Services, and
- Community Housing Services.



Division level Service Directors will also oversee service development for two special populations:

- Forensic Services, and
- MI/SA Services.

The Service Directors will help train public and private providers, providing onsite technical assistance, and other supports to promote fidelity to evidenced-based practices that integrate the recovery perspective in all services. The Service Directors also participate in the statewide planning process by producing Statewide Service Plans for each of their services, which are then reviewed at the local level during the formulation of each county's CISAP.

Changes for Consumers of Mental Health Services

AMHD is deeply committed to building a system of care rooted in the recovery model. The cornerstone of the recovery process is that the individual consumer is central to the process of defining personal meaning and purpose. The recovery model recognizes that in the midst of ongoing illness, personal growth and development continue for each mental health consumer. Building on these beliefs, The Community Plan calls for development of a public mental health system that fosters hope, purposeful living, acceptance, responsibility, and mutual help. These principles of recovery guide service delivery in each mental health setting and in each clinical encounter. The Community Plan clearly states that all AMHD funded services will be grounded in the philosophy of recovery-focused treatment. The Plan also promotes inclusion of consumers at every level of the system. Additionally, services are culturally informed, delivered in the least restrictive setting, based on national standards and evidence-based practices, adapted for area differences, and supportive of families.

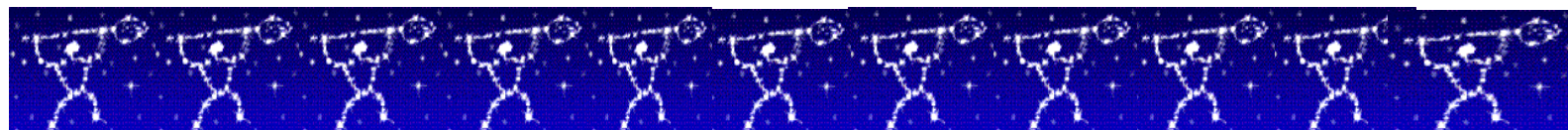
In keeping with this philosophy, the treatment planning process requires consumer involvement, with treatment goals prioritized according to the consumer's preferences, strengths and needs; and, consumer determination of the measure of success for the treatment plan goals. AMHD will also advocate strongly for consumer representation on the State Mental Health Planning Council and on the Service Area Boards.

Development of the Office of Consumer Affairs

The Community Plan calls for the development of an Office of Consumer Affairs, with a recipient of services as the full-time Consumer Affairs Director. The Consumer Affairs Director will advise the AMHD Chief and advocate for members of the target population and their families. The Director serves as a full member of the AMHD leadership team, and the Office will be involved in the following areas:

- Establishment of a training and certification process for peer specialists
- Promotion of the use of mental health peer groups by AMHD funded providers
- Assistance in the development of consumer operated services and businesses
- Monitoring of the inclusion of consumers throughout all levels of the AMHD system
- Leading AMHD's efforts to implement illness self-management, and
- Assisting in the resolution of consumers' complaints about access to and quality of AMHD funded services.

As evident from this short description, The Community Plan supports the development of a comprehensive system of mental health care. The Community Plan has been adopted as an order of the Federal Court, and has moved into its implementation phase. We look forward to the exciting changes that will improve Hawai'i's system of mental health care.



Recovery as a Guiding Principle

The Community Plan is based on the belief that recovery from mental illness is possible for all consumers and their families. Recovery means that people whose lives are touched by mental illness can hope for better lives, take charge of what needs to be done, and enjoy personally satisfying activities, including employment, despite the difficulties they experience because of their illnesses.

One of the strengths of the recovery approach is its flexibility. No one has to recover in the same way. People can pursue their own recovery or help others do so in a variety of ways. The key is to find what works for each person.

Much has been written about recovery, particularly from the perspectives of consumers and their families. Research has also been done in this area. Key to the recovery idea is the fact that people who have mental illnesses have the ability to lead hopeful and fulfilling lives.

The recovery model has different meanings for different people. Consumers may view recovery as taking charge of their lives and having hope for the future. Family members may see recovery as having more choices that allow them to help their loved ones. Providers may find that they can work together more readily with consumers and their families toward common goals.

In a recovery based mental health system, consumers, family members, providers, and administrators all become partners. Everyone has a role to play in the recovery process and everyone has a voice. Understanding that different people recover in different ways, we still know enough about the recovery process to base The Community Plan on these five guiding principles:

- Hope. Consumers have the potential to grow and change.
- Purpose. Consumers have the potential to find positive self-images and purpose in life.
- Acceptance. Consumers realize they have a long-term illness, but that they can move forward even when setbacks happen.
- Responsibility. Consumers take charge of themselves so they can lead satisfying lives, accepting their illness but not being defeated by it.
- Mutual help. Consumers use their experiences to help others.

It is important to remember that recovery isn't just for consumers. The entire Community Plan is anchored by the principles of recovery. Everyone involved in our mental health system will be asked to think about the ideas of recovery, and learn how skills based on those ideas can be used to fully develop our system of mental health care.

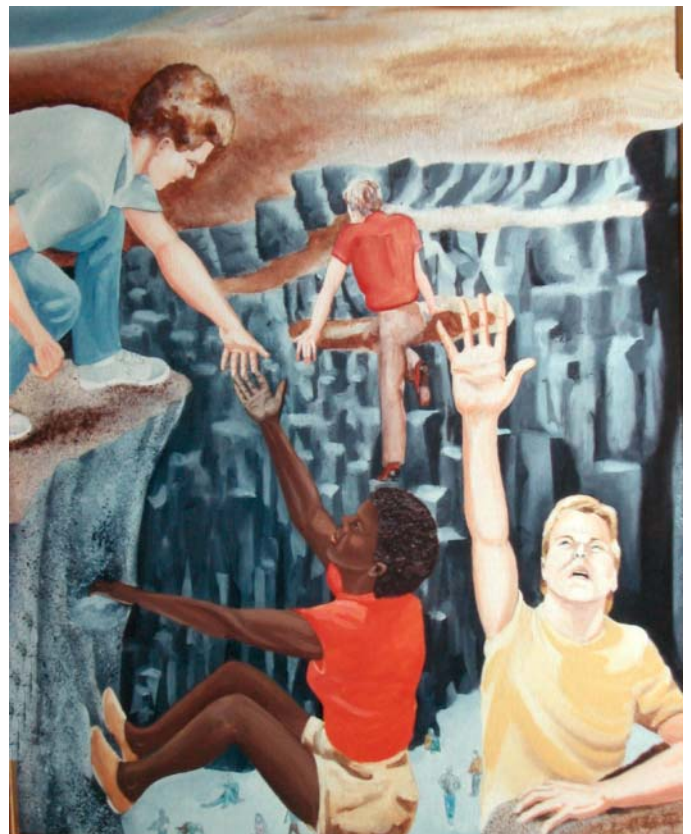
Contact John Steffen at Services Research and Evaluation (539-3961, sjohn@hawaii.edu) for technical assistance on incorporating recovery principles within the mental health system or to work on recovery promotion projects.

The Spiritual Phase Second in Series of Twelve Step Paintings

In the February newsletter we feature the second in a series of 12 Step paintings. As described in the January 2003 *AMHD News*, we will feature one of the twelve step paintings each month of this year. Please see the January edition of *AMHD News*, available on the AMHD public information website, for information about this series. The second painting and step relate to "The Spiritual Phase."

The Spiritual Phase:

We came to believe
that a power greater than ourselves
could restore us to sanity.



Integrating Cultural Competency into Public Mental Health

The Community Plan calls for AMHD to provide services that are culturally informed, sensitive and responsive; in other words, we need to develop cultural competence. Cultural competence, a new term for many, is defined as a set of congruent practices, skills, attitudes, and policies that come together in a system, institution, or agency to enable effective mental health treatment within the context of cultural differences. Due to the rich diversity of Hawai'i's population, it is imperative to ensure that our mental health services are culturally appropriate and effective.

The resource guide "Towards a Culturally Competent System of Care: Volume I" identifies five elements to attaining cultural competence on an organizational level. These elements are useful for local agencies and organizations as we strive to integrate cultural competency into Hawai'i's public mental health system. The first element is that organizations value and respect the diversity of the populations for which they provide services. Simply stated: we need to know who lives in our local community, and learn about their cultural values.

The second element of cultural competence is the capacity for self-assessment. Organizations need to be willing to explore their current level of cultural competence. An organizational assessment helps service agencies identify their areas of strength and the areas in which they need to improve.

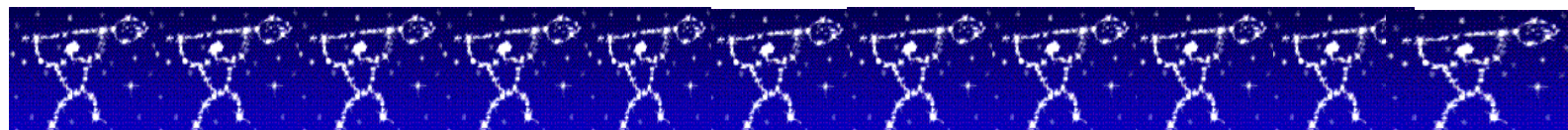
Third, organizations need to be aware of the dynamics of cultural interaction. We need to understand that our culture helps us to understand our world, and that different cultures negotiate the world in different ways. All of us view the world through our particular cultural lenses. Communication without awareness of the effect of our differing worldviews can lead to misinterpretation of words and actions. We will all benefit, therefore, from thinking about our own worldviews and how they differ from the worldviews of other persons and organizations with whom we work.

Similarly, it is important to have access to institutionalized cultural knowledge. Knowing about the cultural history and current cultural values of the persons we serve will help us identify the most effective treatment strategies. The ability to understand consumers' worldviews, as well as other providers' worldviews is critical to the development of culturally competent services.

Finally, creative service development results when provider agencies have the ability to adapt the services they offer to meet the diverse cultural needs of their local populations. For example, for a consumer who identifies with the Hawaiian culture, offering the opportunity to learn traditional Hawaiian skills in a therapeutic setting, incorporating Hawaiian methods of healing, or meeting with others of the Hawaiian community for mutual support may be beneficial, and should be considered valid treatment strategies. Ideally, all of Hawai'i's mental health facilities will develop innovative services incorporating options that resonate with theirs.

It all begins with organizational self-assessment to identify how we need to adapt our services. So—let's get started! Some things you can do as a consumer or staff member of your local agency include: (1) find out more about the diversity of your community; (2) conduct an organizational self-assessment; (3) gather resources. The National Center for Cultural Competence at Georgetown University has an excellent resource website (<http://www.georgetown.edu/research/gucdc/nccc>). Another resource is the Hawai'i Mental Health Multicultural Services Advisory Committee. This newly formed Committee will identify priority areas at AMHD for developing cultural competence, including: an organizational self-assessment of the public mental health system, policy development, statewide training, resource development, and technical assistance. We encourage representation on the new Committee from consumers, family members, POS providers, CMHC staff, and all interested stakeholders.

For more information about the new Hawai'i Mental Health Multicultural Services Advisory Committee or technical assistance related to cultural competency, please contact Debbie Altschul (539-3943) or Eva Kishimoto (539-3944). Together, we can make a difference!



Target Population: Who Is Included?

The Community Plan assures the availability of a core set of services to individuals discharged, transferred, or diverted from Hawai'i State Hospital (HSH) and to those at-risk of hospitalization at HSH. This group is defined in The Community Plan as the "target population" and the target population is a subset of the population eligible for services through AMHD (the "eligible population"). As of January 31, 2003, the target population as defined in The Community Plan consisted of 1,877 individuals. The AMHD served a total eligible population of approximately 4,500 individuals during the last fiscal year.

Although The Community Plan will be evaluated with regard to the target population, the AMHD will continue to maintain existing services to the AMHD eligible population (i.e., individuals meeting the AMHD eligibility criteria). The AMHD eligibility criteria and policy are referenced specifically in The Community Plan, and are included as an attachment to the Plan. As such, the AMHD eligibility policy is available to you on the AMHD public information website. Look for The Community Plan, and check Attachment B to the Plan (see <http://amh.health.state.hi.us>).

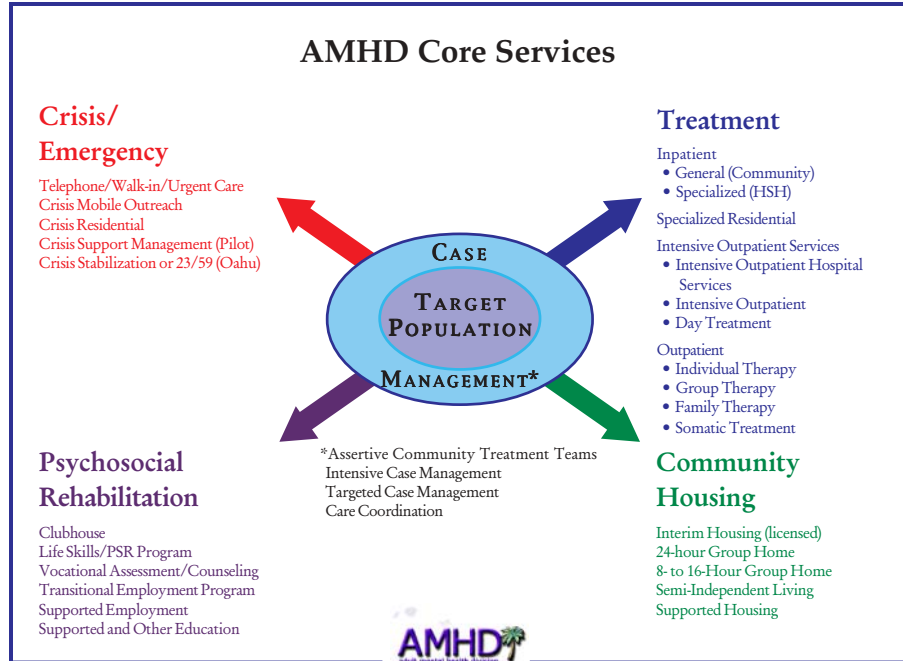
The Community Plan defines four groups that comprise the target population. The *discharged* group includes persons who have been discharged from HSH since the initiation, in 1991, of the lawsuit challenging conditions at HSH. Individuals admitted to and then *transferred* from HSH to another psychiatric hospital, since 2001, are also included in the target population. The group of individuals *diverted* from HSH consists of two groups: (1) persons, who, since 1991 were court ordered to the custody of the Director of Health for care and treatment of mental illness who were not admitted to HSH; and (2) persons who, since January 2003, are referred by non-judicial agencies for admission to HSH, meet current AMHD inpatient level of care criteria, but are not admitted to HSH. During the last fiscal year, the AMHD provided services to approximately 650 individuals who are in the discharged, transferred, or diverted groups of the target population.

The larger part of the target population are individuals *at-risk of hospitalization at HSH* ("at-risk") and this group included an additional 1,231 individuals as of January 31, 2003. The inclusion in the target population of individuals who are at-risk helps assure that core community services that will help prevent hospitalization are available to adults with severe and persistent mental illness. This approach enables AMHD to develop a comprehensive rather than a two-tiered mental health system.

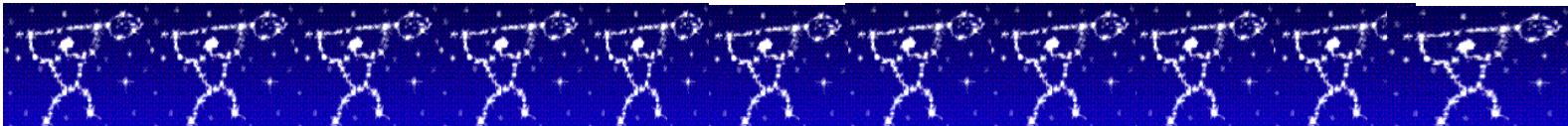
The Community Plan defines the at-risk group as persons who, from January 2003 on, currently receive any AMHD funded community service, who were never admitted to HSH, and who have a similar diagnostic, functional, and service utilization profile as the group of persons currently receiving AMHD funded community services who, since 1991, have been admitted to HSH. Dr. Robert Randall, a

statistician and faculty member in the Department of Psychology at the University of Hawai'i, worked with the AMHD to develop a statistical model to predict risk of hospitalization using logistic regression. Dr. Randall will work with the AMHD Services Research and Evaluation Unit and the Information and Resource Management Unit to produce an annual target population report providing a valid estimate/count of the target population and a valid profile of the clinical characteristics of the target population statewide and by county. Importantly, these reports will be used to support statewide and county service planning, and as the basis for prioritizing service development and modification.

The target population includes 256 individuals living in Hawai'i County, 147 individuals in Kaua'i County, 162 in Maui County and 1,271 persons residing on Oahu. The majority of individuals in the target population have a diagnosis of schizophrenia (70%) and 15% are diagnosed with a mood disorder. The average Global Assessment of Functioning (GAF) score of the target population is 46. This is indicative of an individual with serious symptoms of mental illness or with a serious impairment in social, occupational, or school functioning. Approximately 3% of the target population report that they are homeless.



Bob Randall, Statistician



Consumer Voices: Randolph Hack On the Recovery Workshop

Rita Gorospe, Randolph Hack, Tom McCormack, and John Steffen, participated in the recovery breakout session at the January Quarterly Providers meeting. Dr. Steffen provided literature and an introduction to recovery principles. Recovery is described as the process of overcoming physical and mental illnesses through the principles of health and wellness.

Rita, Randolph, and Tom added perspective to the topic by sharing their personal views from a consumer/survivor standpoint. The consumer/survivor view is vital in providing realistic and meaningful services to the public. This voice is also important in maintaining quality services. In particular, many in the audience were moved by Rita's story.

Recovery experts recommend that we use "people first" language in all written and verbal communication. For example, instead of using the depersonalized term "the schizophrenic" use the phrase "a person with schizophrenia," or "a person overcoming mental illness." This terminology gives greater emphasis to the human element in describing persons who are engaged in the process of recovery or healing. After all, consumers of mental health services are, first and foremost, people; not just syndromes or diseases.

The recovery presenters reminded all providers to maintain awareness of both the mental and physical challenges faced by many consumers. For example, many consumers have extensive histories of trauma and abuse and may need further professional or specialized mental health services to recover from trauma and abuse. Additionally, many consumers have primary healthcare problems such as diabetes, arthritis, and cardiovascular problems, which also require treatment. Recovery emphasizes the whole person, not just the diseased parts. It is, therefore, the whole person who should be considered by the professionals responsible for providing treatment services. It is important to remember that previously untreated trauma, and many primary healthcare problems can exacerbate mental health problems. The mental health service providers were urged to work more closely with primary care providers to coordinate the delivery of high quality care and support services.

A final thought: Recovery planning needs to begin as soon as possible after admission to a psychiatric unit or hospital; either upon the consumer's arrival at the facility, or as soon as possible after the consumer has stabilized enough to participate in recovery planning. Early commitment and willingness are important to the recovery process.

Thanks to Eva Kishimoto, for all her planning of the Quarterly Providers Meeting; Mark Miyashiro for videography; Eve Okumura, for graphics and slides; and all others who helped make the event a raging success.

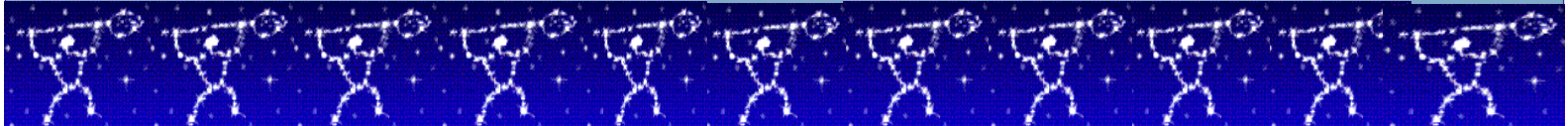
Draft of New AMHD Eligibility Policy Included With Community Plan

The AMHD Eligibility Policy attached to The Community Plan represents a refinement and evolution of the criteria by which AMHD decides who is able to access AMHD funded service, rather than a major policy shift concerning eligibility. The new policy clarifies many aspects of the previous policy, and expands the included psychiatric diagnoses; allowing services for persons with Borderline Personality Disorder and several specific anxiety disorders including Panic Disorder with Agoraphobia, Obsessive Compulsive Disorder, and Post Traumatic Stress Disorder, in addition to Schizophrenia and Other Psychotic Disorders, and Mood Disorders. The new AMHD eligibility policy responds to the problems presented by substance use and abuse in two ways:

- Persons with an included diagnosis in addition to a substance use disorder are eligible for AMHD services for both mental illness and the substance use disorder
- Persons with a primary diagnosis of substance induced psychotic disorder that does not resolve in thirty days of first assessment are also eligible for AMHD services.

The policy also makes clear that a person subject to court orders for detention, criminal or civil commitment, conditional release, or revocation of conditional release is eligible for AMHD funded services with or without an included diagnosis for as long as the person is subject to the court's jurisdiction. After a case ends, the person may still be eligible for services if, after assessment, AMHD determines that there is an alternate basis for eligibility.

The new policy consistently uses the nationally accepted descriptor of "adults with severe and persistent mental illness" when referring to the population served. In the previous policy, the population served was referred to as adults with "serious mental illness." This wording change relates to national definitions of mental illness rather than a change in the focus of eligibility for services. As in the previous policy, the AMHD provides safety net services in three areas: 1) time-limited services for anyone in urgent crisis; 2) continuing services for adults with severe and persistent mental illness; and, 3) disaster services following traumatic statewide or community events. For further information, see Attachment B of The Community Plan on the AMHD public information website.



Who's Who in the New Community Plan?

The Community Plan calls for many new and exciting changes throughout the state mental health system (see "Highlights of The Community Plan" article in this newsletter for more information). Several positions were created or revised in response to The Community Plan. Dr. Tom Hester, the AMHD Chief, has made many temporary assignments to fill all positions beginning January 31, 2003. Staff members who are deployed temporarily to fill all positions described in The Community Plan will continue to serve in those positions until AMHD makes permanent assignments to those positions.

The Division's "central office" staff now includes (1) Kathleen Yoshitomi as Treatment Services Director; (2) Noelani Wilcox, Crisis Services Director; (3) Pamela Haina, Case Management Services Director; (4) Meripa Godinet, Psychosocial Rehabilitation Services Director; (5) Bernie Miranda, Community Housing Services Director; and (6) Alan Radke, Mental Illness/Substance Abuse Services Director. The Chief plans to announce the Forensics Service Director soon. AMHD Service Directors are developing statewide service plans, providing technical assistance to CMHCs and POS providers, and ensuring that services are provided in accordance with current AMHD and professional standards.

Other temporary details at AMHD include Martie Drinan as Director of the Office of Planning and Compliance, Randolph Hack as Director of the Office of Consumer Affairs, and John Jansen as the Director of the Office of Information and Resource Management. These three offices report directly to the Chief, and are charged with providing system-wide technical assistance and program oversight. Wayne Law, the new CMHC System Administrator, also reports directly to the Chief.

Other AMHD positions related to The Community Plan implementation include: Director of Access and Assessment, Edna Magpantay-Monroe; Director of Quality Management and Administration, Catherine Jenkins; Director of the Clinical and Support Service Administration, Alan Radke; and Director of Provider Relations, Vivian Minamishin. In addition, although not explicitly required by The Community Plan, Dr. Hester announced two other initiatives: the Multicultural Advisory Committee, co-coordinated by Deborah Altschul and Eva Kishimoto, and the Center for Evidenced-Based Practices coordinated by Eva Kishimoto.

Many changes described in The Community Plan have also been implemented at the local level. A Service Area Administrator (SAA) has been appointed for each of the four counties to oversee service development and delivery in their respective Service Areas. Each SAA ensures localized input into service delivery and planning, promotes compliance with AMHD designated service models, and promotes interagency and intergovernmental collaboration by serving as the Division representative in the local communities. Temporary SAA deployments include Martie Drinan for Oahu, Thomas Vendetti for Maui, Florence Dunn-O'Neal for the Big Island, and Jan Overland for Kaua'i.



Martie Drinan, Oahu

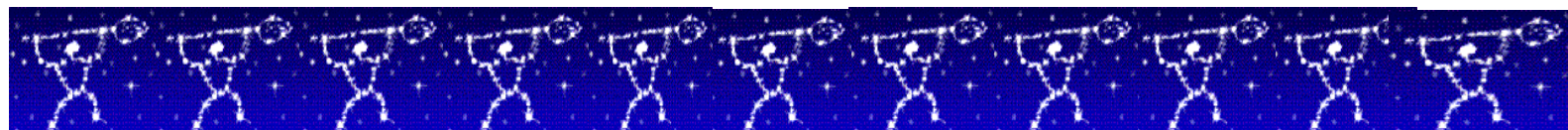


Jan Overland, Kaua'i

CMHC Managers are now responsible for the day-to-day administration of CMHCs. Statewide, AMHD has designated eight state operated CMHCs. Temporary details for the CMHC Manager positions include: (1) Keith Claypoole, Kaua'i; (2) John Balog, Maui; (3) Beverly Liberato, Hawai'i-Hilo; (4) Felicia Kimura, Hawai'i-Kona; (5) Roena Fermantez, Oahu-Windward; (6) Debbie Dean, Oahu-Central; (7) Irv Cohen, Oahu-Diamond Head; and (8) Ken Ishikawa, Oahu-Kalihi-Palama. The Wai'anae Coast Community Mental Health Center, Inc. (Hale Na'au Pono) continues to operate as a CMHC under a private contract agreement.

A Medical Director has been designated temporarily for each CMHC as follows: (1) Dr. Harold Goldberg, Kaua'i; (2) Dr. John Balog, Maui; (3) Dr. Michael McGrath, Hawai'i-Hilo; (4) Dr. Michael McGrath, Hawai'i-Kona; (5) Dr. Eugene Carvalho, Oahu-Windward; (6) Dr. Carol Minn, Oahu-Central; (7) Dr. Jeffrey Akaka, Oahu-Diamond Head; and (8) Dr. Thomas Leland, Kalihi-Palama.

AMHD is excited about all these new developments, and the AMHD Chief appreciates the willingness of all temporarily assigned staff to "step up to the plate," so that The Community Plan can get underway as soon as possible. All permanent assignments will be confirmed by December 31, 2003.



This plan acts as a navigational tool, you take the journey...



Hokule'a (Hawai'i) Sailing to Rapa Nui, 1999

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*We're on the Web!
See us at:*
<http://amh.health.state.hi.us>

